Tees, Esk and Wear Valleys
NHS Foundation Trust

SPECIAL MEETING OF THE BOARD OF DIRECTORS

25 June 2024
at 4.00 pm

Via MS Teams

AGENDA

Standard Items

1.	Welcome and introduction (verbal)	Chair	4.00 pm
2.	Apologies for absence (verbal)	Chair	
3.	Declarations of interest (verbal)	All	

Strategic Items

4.	Report of the Chair of Audit & Risk Committee (verbal)	Cmt Chair (JM)	4.05 pm
5.	NHS Foundation Trust Annual Report and Accounts 2023/24: a) To approve the Annual Report and Annual Accounts 2023/24 b) To approve the Letter of Representation. c) To authorise the signing off of: i. The Annual Report ii. The Performance Report iii. The Remuneration Report iv. The Annual Governance Statement v. The Statement on the Accounting Officer's Responsibilities vi. The Foreword to the Accounts vii. The Statement of the Financial Position viii. The Letter of Representation d) To approve the submission of the Annual Report and Accounts to NHS England/Improvement and Parliament. *Note: Any additional information or updated documents will be circulated prior to the meeting.*	CEO/ DoFE&F	4.15 pm
6.	The Quality Account 2023/24	CEO/ Co Sec	4.45 pm

BAF Risk 7: Cyber Security

7.	Data Security and Protection Toolkit	Asst. CEO	5.05 pm

Exclusion of the Public:

8.	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	5.15pm

Strategic Items

9.	Chief Executive's Confidential report (verbal)	CEO	5.15pm

David Jennings
Chair
19 June 2024

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Tees, Esk and Wear Valleys
NHS Foundation Trust

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Annual Report and Accounts

1 April 2023 – 31 March 2024

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Tees, Esk and Wear Valleys NHS Foundation Trust Annual report and accounts 2022/23

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

Contents

Foreword by the chair and chief executive

We would like to open this annual report for 2023/24 by saying a huge thank you to all of our colleagues, our patients and carers, partners and people in our communities who have worked so hard with us. Together we have been through many challenges, delivered extraordinary improvements and made a difference to thousands of lives every day. The last twelve months have been significant for us in many ways and your support and belief in what we are doing has been instrumental in seeing us through this past year.

This annual report signals three years since we collectively embarked on Our Journey to Change, setting out our commitment to improving the experience for people in our care, families and carers, our colleagues, and to be a great partner.

So where are we now, what progress has been made in the last year and what are the future plans to support us on our journey?

Across the country we continue to see pressure on all mental health, learning disability and autism services. The need for support in our communities is significant. We represent a diverse range of places, but across our area we see that need remains significant and those that we support have a wider range of complex health and social requirements. Finances are tight across the public sector and some specific skillsets are hard for us to find. We hold a critical role here and more than ever we are working alongside partners to tackle health inequalities.

At a regional level, there continues to be a real emphasis on place-based care and it's vital that we continue to work in partnership with other organisations and work with our communities to deliver the mental health services that our communities need and deserve.

Reflecting on the last 12 months in our Trust, there have been some significant events. The Care Quality Commission (CQC) prosecution concluded in April 2024. The CQC investigators found that we failed to provide safe care and treatment to two individuals, who sadly died in our care at West Lane Hospital in 2019 and Roseberry Park Hospital in 2020, and we pleaded guilty to those charges at the first opportunity. We acknowledged that the care and treatment for those two individuals wasn't acceptable - they deserved better. We have previously expressed our profound apologies for the failings in care, and remain deeply sorry for the events that led to these tragedies. We were found not guilty of a third charge brought by CQC. This related to safe care and treatment of an individual at Lanchester Road and our thoughts remain with their loved ones.

In October 2023 the CQC published their latest inspection report of the Trust. This was a comprehensive review of a wide range of our services across our who geography. Reviewing this report against previous ones it is clear to see that we are a very different organisation now. Whilst we accept we remain 'requires improvement' overall, seven out of 11 of our core services are rated 'good', all services were rated 'good' for caring, and nine out of 11 services were rated 'good'

or ‘outstanding’ for effective. This was a clear improvement since our inspection in 2021.

Inspectors could also see a positive change in our culture and patients said staff were ‘kind and considerate’, ‘friendly, kind and supportive’ and that they were ‘actively involved in their care planning’.

Whist we know there is more to do, it’s positive to see the impact of Our Journey to Change every day across the Trust, and importantly the difference it’s making to people in our care, families and carers, colleagues and partners.

In the last year we’ve welcomed over 150 newly qualified nurses, increased our peer support workforce by 27% and our junior doctors ranked us as the top organisation for training in the North East. We also launched two co-creation boards, retained our 2 star rating from the Carers Trust, introduced new technology to support patient safety – and so much more.

Likewise, working with our partners, and through the community transformation work, there has been some important achievements. This includes the largest ever clinical trial to combat loneliness and depression, the expansion of mental health support teams in schools, the introduction of a peer support network, a pilot to help prevent drug related deaths, new strategic partnerships with local universities, and transformed service models.

This is testament to the hard work, dedication and support of colleagues across our Trust, governors, involvement members, volunteers, partners and many others. Thank you for everything that you do.

However, we are not complacent. Looking to 2024/25 we have a lot of work ahead of us. We know there are challenges but there are also a lot of opportunities. Patient safety, working in collaboration, co-creation, reducing health inequalities, urgent care and making our Trust a great place to work are just some of our priorities – as well as improvement work across our specialities. We are committed to building on the progress made through Our Journey to Change and to continue our focus on providing safe, kind and effective care for our communities.

Dave Jennings
Chair

25 June 2024

Photo and signature

Brent Kilmurray
Chief Executive

25 June 2024

Photo and signature

This annual report, including the annual accounts, has been prepared under a direction issued by NHS England under the National Health Service Act 2006.

The performance report

Overview of performance

Purpose

The purpose of the Performance Report is to provide an overview of the Foundation Trust, our purpose, our strategic direction – including our vision, mission and strategic goals – the key risks to achieving them and information on how we have performed during the year.

Statement on Performance

We have 30 key performance measures that make up our Trust Integrated Performance Dashboard. The measures are grouped under the domains of Quality, People, Finance and Activity - each of our Care Groups also has an Integrated Performance Dashboard following the same format. In addition, we have a set of national quality requirements and a number of ambitions agreed with our local commissioners.

Our overall performance continues to be impacted by national pressures throughout the NHS, and locally within our services in respect of high demand and staffing levels, and we remain concerned that at times, we are not assessing or treating our patients in as timely a manner as we would like.

We are committed to improving the quality of our services and the health and wellbeing of our patients and colleagues, and considerable work is being done to improve our performance in those areas.

This year we have achieved the standards we agreed for 2023/24 for our patient experience measures, although we recognise the importance of maintaining a continuous cycle of improvement within our services and this work is supported by our Care Group Co-creation Boards led by our Lived Experience Directors. Responses to our patient surveys show that over 90% of patients would rate their experience as very good or good; however, we remain concerned that many patients do not feel safe on our wards and a Performance Improvement Plan has been developed within our Durham, Tees Valley & Forensics Care Group, which includes actions to support people to raise questions or concerns about feeling safe in an anonymous/less intrusive way.

We are concerned that a significant number of our patients in Adult, Older People and Children & Young People services do not show the level of measurable improvement following treatment that we would endeavour to deliver. Robust Performance Improvement Plans have been established and continued improvement will be supported by our new Electronic Patient Record system, Cito, which was launched in February 2024.

Pressures on our inpatient services continue and our bed occupancy remains high, with a greater number of patients on our adult and older people wards remaining in beds for over 60 and 90 days than we would aspire to have, and whilst we have seen a decreasing (improving) number of patients being placed in beds external to our Trust, we did not achieve our ambition to eliminate out of area placements this year.

This is particularly a concern within our Durham and Tees services and throughout the year we have implemented daily escalation processes on wards to help address operational and/or clinical barriers to effective and timely discharge. We have also established a Trust-wide, all-age Urgent Care Programme Board to support ongoing work to address national, regional and local issues and to respond to and be prepared for initiatives including: the National Inpatient Quality Transformation Programme, Right Care Right Person and the Rapid Review of Mental Health Data in Inpatient Settings.

We continue to achieve the standard we set ourselves for compliance with mandatory training; however, we are concerned that there are a significant number of outstanding training competencies that have not been completed as required and a Quality Improvement Event in March 2024 reviewed mandatory training requirements for all staff including how/where this is delivered.

Our caseload sizes have increased during 2023/24 and a Task & Finish Group within Corporate Services has been formed to triangulate key measures/data that relate to caseload so we can better understand the issues and how we can support improvement.

In respect of our national quality requirements, we have consistently met the waiting times standards for access to treatment within Talking Therapies Services.

However, we have failed to achieve the standard for the percentage of adult services users followed up within 72 hours of discharge within Vale of York and our waiting times within our York & Selby Early Intervention in Psychosis Teams have been impacted due to a shortage of staff. We have also failed to achieve the waiting times standards for Child Eating Disorders. Whilst there are no identified concerns within our North Yorkshire & York services, Durham, Tees Valley and Forensics Care Group have developed and are implementing a Performance Improvement Plan to drive improvements for effective patient access. These measures have been impacted as a result of going live with our new electronic patient record system and a comprehensive validation of the quarter 4 data will be undertaken.

Whilst we have achieved our ambitions for access to our Children & Young People services, we have not achieved our access ambitions for Talking Therapies (County Durham, North Yorkshire and Vale of York areas), Adult & Older People Services (York & Selby area) and specialist Perinatal services (North Yorkshire and Vale of York areas). Performance Improvement Plans are in place within the Care Groups to drive forward these ambitions.

Within Talking Therapies we have achieved the standard for the number of patients moving to recovery; however, our in-treatment waits (those patients waiting more than 90 days between first and second appointment) are significantly higher than standard. Durham, Tees Valley & Forensic Care Group have revised their Performance Improvement Plan and will be implementing a gatekeeping process for low intensity step ups, in addition to undertaking demand and capacity review.

During 2023/24 we have implemented two significant systems within the Trust. In October 2023, we launched InPhase as our new risk and quality management system, which has provided increased visibility of the areas of poor quality in incident records and several actions have been implemented and/or are ongoing to support improvement in the quality of the incident data recorded. In February 2024, we launched our new electronic patient record record (EPR); Cito. Co-produced by the people who use it, Cito has been built with staff, patients and services in mind and improves the way in which we user our EPR to support care delivery. However, as can be expected with all new system implementations, there will potentially be an impact on data quality and performance as the two systems become fully embedded.

Brent Kilmurray –
Chief Executive 25 June 2024

TEWV at a glance

At Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) we provide a range of inpatient and community mental health, learning disability and eating disorders services.

We serve a population of two million people across County Durham, Darlington and North Yorkshire and are geographically one of the largest NHS Foundation Trusts in England. We also provide mental health care in prisons located in the North East, Cumbria and parts of Lancashire.

We are a catchment area for the largest concentration of armed forces personnel in the UK – Catterick Garrison – and our adult inpatient eating disorder services and adult secure (forensic) wards serve the whole of the North East and North Cumbria.

TEWV was created in April 2006, following the merger of County Durham and Darlington Priority Services NHS Trust and Tees and North East Yorkshire NHS Trust.

In 2008 our Trust became the first mental health Foundation Trust in the North and, since then, it has expanded both geographically, and in the number and type of services provided. Our Trust now has around 8,100 staff, who work out of more than 90 sites, and an annual income of over £480 million.

From education and prevention to crisis and specialist care – our talented and compassionate teams work in partnership with patients, communities and partners to help the people of our region feel safe, understood, believed in and cared for. We nurture the recovery journey of people in our care.

Patients and carers have a say in how they are supported and treated, because we know how important it is to listen and treat people as individuals. Our patients, their families and carers work together with us towards better mental health.

We operate across two care group boards – one covering Durham, Tees Valley and Forensic services and one for North Yorkshire and York.

Across our care group boards, we provide:

- Adult mental health services
- Mental health services for older people
- Children and young people mental health services
- Learning disabilities
- Health and justice
- Secure inpatient services

As a Foundation Trust we are accountable to local people through our Council of Governors and are regulated by NHS Improvement and the Care Quality Commission.

Structure, Objectives and Strategies

Our Trust continues to focus on delivering the mission, vision, values, and goals agreed with stakeholders during 2020 – which are included in 2021's Our Journey to Change strategic framework.

During 2022/23 the Trust developed five supporting strategies, known as our ‘strategic journeys’. Agreed by the Board of Directors on 30 March 2023, these focus on 1) Clinical, 2) Quality and Safety, 3) Co-Creation, 4) People and 5) Infrastructure.

Each sets out a clear vision and principles for the future, and areas of focus. The strategies also drove our delivery planning process during the year and our new Our Journey to Change Delivery Plan shows the actions we will take across 17 priority areas, linked to the five journeys.

The Trust's business model continues to focus on providing secondary level community and inpatient mental health, learning disability and autism-related care. We also continue to support prevention and early intervention activity, as this is important to maximise wellbeing and reduce the demand for our services.

As the Trust is funded by block contracts, supporting demand reduction activity is rational for us as it will help us to provide a higher quality, more quickly accessed set of services for those patients with the highest-level needs.

We continue to be a significant provider of criminal justice pathway related services through our work to support prisons and courts. We also manage many low and medium secure forensic beds. We continue to work with NHS England and Cumbria, Northumberland, Tyne and Wear Foundation Trust as partners to develop a North East North Cumbria secure service model for the future.

Working in Partnership

The Trust and its partners recognise that good quality, effective and timely support for people struggling with their mental health, a learning disability or neurodiversity cannot be achieved by one organisation in isolation. The rising awareness of, demand for, and expectations of care continues to create a challenge for our systems as a whole. To help address this shared challenge, the Trust is actively

engaging in, and supporting leadership of, a range of partnerships across the geography. This, in turn, supports the Trust to assess and monitor on an ongoing basis its effectiveness, both as an organisation and as part of a wider system, and the quality of the services delivered. Examples of how this has been achieved over the past 12 months include:

- Active contribution to, and in some cases leadership of, Integrated Care Board (ICB) planning, transformation and commissioning through local commissioning partnerships and ICB-wide transformation activity (including the national programmes of community mental health transformation and inpatient quality transformation).
- Actively supporting our local police forces to implement Right Care Right Person initiatives in a safe and planned way.
- Contribution to, and leadership of, local place-based partnerships which bring together people with lived experience, third sector colleagues, primary care, social care, education, public health and other colleagues.
- Direct engagement and involvement of partners in internal Trust planning and decision making.
- Strong support for, and engagement in, partnership governance including Overview and Scrutiny Committees, Health and Wellbeing Boards, and ICB Place Committees.
- Beginning to lead and support development of place-based approaches to co-production/co-creation and involvement.
- Active engagement with Healthwatch and other patient forums within each place which has supported the development of more robust and transparent communication about a range of issues, such as crisis care.

Through these partnerships, the Trust has, in turn, been able to engage with wider systems and use population health management data to ensure that collective energy can be targeted at addressing specific population challenges in each place. Triangulation of intelligence, data and feedback from these processes has added a level of richness to the way in which the Trust is able to assess the effectiveness and efficiency of its service delivery. This, in turn, has directly supported and influenced internal Trust planning and decision making.

In addition to this, the Trust continues to be a partner in the North East and North Cumbria Mental Health, Learning Disability and Autism Partnership, a collaboration between TEWV and CNTW to commission and deliver a number of specialised services (adult secure services, adult eating disorder inpatient and intensive day services and children and young people inpatient services) under a formal Provider Collaborative arrangement. Strong, shared governance processes are in place through CNTW (as the Lead Provider) to manage delegated commissioning functions from NHS England, and more operational partnerships are in place for

each service line to provide assurance of the quality and effectiveness of actual service provision across both providers. This is overseen by a Partnership Board, chaired by TEWV's Chief Executive.

All partnership arrangements, challenges and opportunities are reported on a monthly basis to the Trust's Executive Management Team, and reflected in the Partnerships section of the Board Assurance Framework.

Strategic Risks

The principal risks we face in delivering of Our Journey to Change are described in the Board Assurance Framework (BAF) together with relevant controls, assurances on the operation of the controls, gaps in control and assurance and mitigations.

The risks have been reviewed during 2023/24 taking into account the development of our strategic journeys and changes in the external environment.

Information on these risks is provided in the Annual Governance Statement later in the Annual Report.

Going Concern

For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.

After making enquiries, the directors have a reasonable expectation that the services provided by Tees, Esk and Wear Valleys NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Performance analysis - how we performed in 2023/24

How we measure our performance

Our Integrated Performance Report (IPR) enables us to have better oversight of, monitor and report key measures that demonstrate the delivery of the quality of services we provide. The measures for the dashboard (IPD) were identified by the relevant Board Sub Committees and agreed by the Board of Directors. They are aligned to one of our three strategic goals and, where appropriate, support the monitoring of the Board Assurance Framework risks. We have continued to develop the integrated approach to performance (IPA) and this year we have started to develop the committee dashboards that will underpin the Trust IPD providing

oversight and assurance through the Board sub-committees. We have completed work to develop the People & Culture Dashboard, which reports those key priorities identified by the People, Culture & Diversity Board Sub-Committee; this will be launched in April 2024. We have also commenced work to progress the Quality Dashboard, which reports those key priorities identified by the Quality Assurance Board Sub-Committee; this work will be completed in 2024/25.

The IPD measures are reported each month to Board of Directors in our Integrated Performance Report (IPR) to provide assurance that the Trust is continuing to deliver operationally. The report aims to highlight for those measures that are reporting a concern, what the current underlying issues are, including triangulation with other key measures and data, and the actions being undertaken to drive forward improvements. Integral to this approach is the development of actions that are Specific, Measurable, Attainable, Relevant and Time-based. The report is also made available to our patients and carers, commissioners and wider public and is presented and discussed with our Council of Governors as part of the formal Council of Governors meetings.

For those measures that have been identified as key areas of risk or concern, we require Performance Improvement Plans (PIP) to be developed to identify those issues impacting on performance, providing time-limited SMART actions that will drive forward improvement and to demonstrate to the Board that we are focussed on the right things and in a timely manner.

The Board of Directors discusses the Integrated Performance Report each month in terms of where we have positive assurance, but also areas of concern where improvement is needed. If the Board of Directors identifies any trends which could impact on the Trust and operational delivery, then this would be escalated through the Risk Management processes.

The benefits of our approach include:

- Integrated assurance about the quality of services being delivered to ensure we are meeting our Strategic Goals, the standards within the Care Quality Commission domains and mitigating the risks within the Board Assurance Framework.
- Triangulation of data and information (both qualitative and quantitative) about the quality of service being provided which should then enable a better and more informed discussion at the Board.
- Ability to identify areas of concern more easily and understand what else is impacting so we can assess whether the actions being taken will have the desired impact.
- Once fully implemented, one report as opposed to multiple reports where assurance is provided by the Board Sub Committee rather than individual corporate departments.

It is important to note that the Integrated Performance Report also includes reporting on our Mental Health priorities demonstrating progress against the key performance indicators agreed in the contracts we hold with our commissioners and, on a quarterly basis, Trust performance against the NHS Oversight Framework, incorporating national benchmarking where available.

The Integrated Performance Report is supported by two IPRs at Care Group Level, combining individual IPDs, performance against the key performance indicators agreed in the contracts we hold with our commissioners, waiting time summaries and performance against the Commissioning for Quality & Innovations schemes. Oversight of these reports is maintained by Care Group Boards, comprising corporate and clinical senior managers aligned to each respective Care Group and the reports are shared with commissioners on a monthly basis.

We also have a range of waiting time reports, which provide oversight on the number of patients waiting and the length of time waited, supporting clinical services in monitoring and managing risk from a patient safety and quality perspective.

We believe that whilst a performance dashboard is critical in monitoring performance, it is only one part of an overarching performance management framework that supports delivery of high-quality care.

Culture

Through 23-24, the People and Culture Directorate generated monthly workforce reports for services and Executive Directors' Group (EDG) which included indicators of organisational culture and health, such as leavers, sickness, temporary staffing use/ fill rates. In addition, the staff survey and pulse surveys provided nationally benchmarked indications of staff wellbeing.

That data, alongside information on the experience of staff with protected characteristics, feedback from the staff networks, leadership walkabouts, and other qualitative information underpinned reports to the People Culture and Diversity Committee (which met every quarter) articulating progress against the people journey (of which one of the three priorities is 'working in an inclusive and compassionate culture).

The committee time out reviewed these cultural indicators in more detail, integrating data on equality diversity and inclusion and any differentials between groups with different protected characteristics. In addition, a board seminar on workforce and the people journey, gave board members space to discuss context and drivers of organisational issues in more detail and the provide a steer on.

The regular Freedom to Speak Up (FTSU) report provided Board with direct information on frequency of use, themes, and any concerns about detriment. During 23/24 we strengthened the way in which concerns regarding detriment were

managed and then reported to the Non-Executive Director (NED) champion, as well as strengthening our mapping across employee relations and FTSU to identify any shared indicators of areas of concern.

Corrective action was monitored through EDG and the committee as appropriate and the impact of interventions was tracked through the monthly metrics and at a strategic level through the Journey to Change reporting mechanisms alongside the other strategic journeys.

Collectively, this informed the progress on the Board Assurance Framework measure on our ability to recruit sufficiently qualified and skilled staff.

As part of the Trust's commitment to improving the health and wellbeing of its staff members there has been an increase in the investment in the team. Some of the key progress in the past year includes:

- Setting up a staff led Health and Wellbeing Council so that staff can bid for charitable funds to improve their work environments. £52,000 was distributed to 18 projects across the Trust in the first wave with further waves being planned.
- Establishing the Health and Wellbeing Governance Group to oversee the strategic direction of our health and wellbeing activities.
- Supported the setting up of the first TEWV 10K run in York.
- Expanded the provision from Credit Unions so staff can save and borrow responsibly with access to financial education.
- Achieved Silver Better Health at Work Award and working towards Gold accreditation in late 2024.
- Developed a training pilot to support staff to have effective health and wellbeing conversations.
- Increased our thriving network of Health and Wellbeing champions to more than 300.

The organisational development team have worked with experts by experience to refresh the intention to leave process, gaining useful insights into staff experience. We continue to offer Trust wide Schwartz rounds to link with others and reflect on the challenges of delivering care.

Our Postgraduate doctors and Physician Associates are supported by a post graduate wellbeing team, organising celebration and wellbeing events every September and March to coincide with the main doctor rotations with a view to enhance social inclusion.

Our Trust provides a wide range of health and wellbeing support services for colleagues, such as an employee support service, employee psychology service with individual and group sessions. This includes group sessions focussed on burnout and bereavement. The staff mindfulness service provides a comprehensive range of courses and programmes for staff and patients.

In addition to wellbeing support, the Trust invested in the workforce in a number of ways including:

- Developing new roles to strengthen the diversity of offer to our communities and opportunities for staff.
- Setting up a new internal movers process enabling staff to move to new roles of the same type more easily.
- Reviewing job descriptions to remove any unnecessary criteria that prevented people from taking up roles.
- Strengthened executive sponsorship of the staff networks and provided funding for each to develop their work as they needed.
- Establishing independent places where staff could talk about reasons they were considering moving or leaving.
- Maximised our use of our apprenticeship levy meaning over 500 staff were able to engage in paid learning to benefit our services.
- Celebrations of our staff occur at regular points through our internal Facebook group, greatix awards, thank you mugs, prize draws, and living the values awards.

Health and Wellbeing

As part of the Trust's commitment to improving the health and wellbeing of its staff members there has been an increase in the investment in the team. Some of the key achievements in the past year include:

- Setting up a staff led health and wellbeing council so that staff can bid for charitable funds to improve their work environments. £52,000 was distributed to 18 projects across the Trust in the first wave with further waves being planned.
- Establishing the Health and Wellbeing Governance group to oversee the strategic direction of our health and wellbeing activities.
- Expanded the provision from Credit Unions so staff can save and borrow responsibly with access to financial education.
- Achieved Silver Better Health at Work Award and working towards Gold accreditation in late 2024.
- Developed a training pilot to support staff to have effective health and wellbeing conversations.
- Increased our thriving network Health & Wellbeing champions to more than 300.
- Developed a centralised pilot for a reasonable adjustments team. Initial feedback is very positive and the pilot has been extended for another year.
- We are above national average (82 vs 77%) for not experiencing musculoskeletal problems as a result of work activity. This reflects an ongoing improvement over the last three years.

The organisational development team have worked to refresh the intention to leave process gaining useful insights into staff experience. We continue to offer Trust wide Schwartz rounds to link with others and reflect on the challenges of delivering care as well as regular lunch and learn sessions. We have expanded our staff network to include neurodiversity and menopause (we already supported a long term health conditions network). All networks now have an executive sponsor.

Our postgraduate doctors and Physician Associates are supported by a post graduate wellbeing team, organising celebration and wellbeing events every September and March to coincide with the main doctor rotations with a view to enhance social inclusion.

In addition to occupational health services our Trust provides a wide range of health and wellbeing support services for colleagues, such as an employee support service, employee psychology service with individual and group sessions. Group session focus on burnout and bereavement. The staff mindfulness service provides a comprehensive range of courses and programmes for staff and patients.

A more detailed analysis and explanation of the financial and operational performance

The following table is the Trust's dashboard of key performance measures for 2023/24.

Quality

Measure Name	Annual Standard 2023/24	Actual Position 2023/24	Commentary
01) Percentage of Patients surveyed reporting their recent experience as very good or good	92.00%	92.17%	This year we have established a Patient & Carer Experience Group. Co-creation Boards and our Lived Experience Directors have supported the employment of support workers and other key posts
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	75.00%	75.52%	Underlying issues have included engagement with various patient groups. Barriers to collecting feedback are being followed up by the Service Improvement Delivery Group and several actions are being implemented, with further ideas/suggestions being explored as part of ongoing quality visits. The Patient & Carer Experience Team are working with the Recovery College to develop an e-learning package to deliver Carer Awareness training.
03) Percentage of inpatients reporting that they feel safe	New measure and no standard	78.63%	This measure has been in place for several years but only included the response 'yes always' to the question Did you feel safe? Patients in our care will encounter a range of emotions and feelings whilst with us therefore they are not always going to feel safe, and this may be for several genuine reasons e.g., their own illness,

whilst in our care	set for 2023/24 We will revisit the "standard" in 2024/25.		other patients etc. therefore we have expanded the answer option to include 'yes always' and 'quite a lot'. Durham Tees Valley & Forensic Care Group have developed a Performance Improvement Plan. Actions include peer workers and patients creating their own leaflets outlining what they would like other patients to know when they arrive and what would help them feel safe; suggestion boxes on wards to support people to raise questions/concerns about feeling safe in an anonymous, less intrusive way; and a monthly checklist to review numbers attending mutual help activities and psycho-social sessions etc, to ensure activities are tailored to suit the cohort of patients.
04) Percentage of Children and Young People showing measurable improvement following treatment - patient reported	35.00%	24.06%	This measure currently does not include Parent Rated outcomes (which is valid) or some of the newer assessment tools. Throughout 2023/24 we have continued to provide monthly training sessions for all new starters. Durham Tees Valley & Forensic Care Group have developed a Performance Improvement Plan and have updated clinical supervision and caseload management agendas/ processes to include support and discussion around completion of outcomes and reviews of patients not making measurable improvement.
05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	55.00%	44.42%	Throughout 2023/24 work has been undertaken to share staff knowledge, with a view to learning from best practice. Both care groups have developed Performance Improvement Plans (PIP). Durham Tees Valley & Forensic Care Group's PIP includes actions to focus greater discussion and challenge by using team and service level dashboards, and by updating clinical supervision and caseload management agendas/processes to include support and discussion around completion of outcomes and reviews of patients not making measurable improvement. North Yorkshire and York Care Group's PIP focuses on completion rates within caseload supervision and monitoring of outcomes within service leadership huddles and a deep dive to identify focused improvements required to support Mental Health Services for Older People.
06) Percentage of Children and Young People showing measurable improvement following treatment - clinician reported	50.00%	46.53%	Throughout 2023/24 we have continued to provide monthly training sessions for all new starters. Durham & Tees Valley teams are undertaking a patient level review to greater understand the underlying reasons for those patients not showing measurable improvement. North Yorkshire teams are undertaking a deeper investigation to understand the root cause of the decline that is visible within that Care Group.
07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	30.00%	19.58%	*See measure 05 above for comments*
08) Bed Occupancy (Adult Mental Health &	No standard	98.27%	We recognise that occupancy of our assessment & treatment beds within Adult and Older People Services is impacting on our ability to meet the needs of our patients; Out of Area Placements (OAP) are

Mental Health Services for Older People Assessment & Treatment Wards)	set for 2023/24 2022/23 Position 98.39%		intrinsically linked to the pressures on our inpatient services particularly within Durham and Tees.
09) Number of inappropriate Out of Area Placement bed days for adults that are 'external' to the sending provider	No standard set for 2023/24 2022/23 Position 951	516	Throughout 2023/24 we have ensured we have a standard approach to meetings with our Local Authority colleagues to address any barriers to delays in discharging patients that are clinically ready for discharge. We have reinvigorated the Purposeful Inpatient Admission (PIpA) approach on our wards to improve patient flow and minimise lengths of stay, and we have established an Urgent Care Board to support ongoing national work.
10) The number of Patient Safety Incident Investigations reported on the Strategic Executive Information System (STEIS) (*Previously the number of Serious Incidents reported on STEIS*)	No standard set for 2023/24 2022/23 Position 143	126	All incidents are subject to a multi-disciplinary, after-action review by services and then reviewed within the Patient Safety huddle. **The Patient Safety Incident Response Framework (PSIRF) was implemented on the 29th January 2024. In addition to changing the way the NHS responds to patient safety incidents, the term 'serious incident' and the rules applying to them are no longer applicable. Trusts now monitor patient safety incident investigations and to support this we have implemented InPhase as our risk and quality management system. Transfer to the new recording system has highlighted areas where data quality can be improved, and several actions to support improvement in the quality of the incident data have been implemented.
11) The number of Incidents of moderate harm or severe harm	New measure and no standard set for 2023/24	644	All incidents are subject to a multi-disciplinary, after-action review by services and then reviewed within the Patient Safety huddle. This measure has been in place for several years and included incidents involving 'near misses'. In line with the implementation of PSIRF, the measure has been amended to focus on incidents resulting in severe or moderate harm. ** *See measure 10 above for comments relating to InPhase*
12) The number of Restrictive Interventions Used	New measure and no standard set for 2023/24	10,478	This measure was introduced in January 2024 replacing the number of Restrictive Intervention Incidents previously reported. Deep dives have been undertaken to better understand any issues and required improvement actions. Increased support is being provided into our Durham and Tees Valley Adult Mental Health female wards by the Inpatient Lead Psychologist where we have a number of patients with complex needs, and additional leadership support is being provided into Elm Ward as part of a wider action plan. Where required, all female patients have plans in place to ensure that any required interventions are the least restrictive and most appropriate for each individual's care. ** *See measure 10 above for comments relating to InPhase*
13) The number of Medication Errors with a	No standard	11	Throughout 2023/24 we have rolled out EPMA (electronic prescribing & medicines administration) to enable more timely

severity of moderate harm and above	set for 2023/24 2022/23 Position 13		prescribing and administration of medication to patients, which will reduce the risk of errors once embedded.
14) The number of unexpected Inpatient unnatural deaths reported on STEIS	No standard set for 2023/24 2022/23 Position 9	5	For every unexpected unnatural inpatient death, a comprehensive multi-disciplinary after-action review is completed and in line with the National Patient Safety Incident Framework, a full Patient Safety Incident Investigation is undertaken.
15) The number of uses of the Mental Health Act	No standard set for 2023/24 2022/23 Position 4,321	4,016	This measure was refined during 2023/24 to align it to reporting within the Mental Health Services Dataset.

People

Measure Name	Annual Standard 2023/24	Actual Position 2023/24	Commentary
16) Percentage of staff recommending the Trust as a place to work	60.00%	54.80%	We have an extensive programme of work within the Safer Staffing Group focusing on retention, which 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.
17) Percentage of staff feeling they are able to make improvements happen in their area of work	65.00%	60.05%	The Trust has continued its 5-year (November 2027) stepped approach to Quality Improvement Training, supporting staff to identify where improvements can be made and to feel empowered to suggest and develop those improvements. In addition, Our Journey to Change focuses on our cultural development through a wide range of engagement, communication and learning opportunities to enable and empower our staff to make changes in their area of work.
18) Staff Leaver Rate	No standard set for 2023/24 2022/23 Position 12.31%	11.26%	We have a programme of work within the Safer Staffing Group focusing on retention, including flexible working opportunities, an extensive health and wellbeing offer covering Employee Support Services, Employee Psychological Services, financial resilience and intention-to-leave interviews, and a wide range of career development opportunities. A Performance Improvement Plan focuses on the effectiveness of our rosters, including publishing rotas in a timely manner and improving level loading of annual leave to support staff

			wellbeing. The Directors of Nursing have taken responsibility for providing assurance on delivery.
19) Percentage Sickness Absence Rate	5.50%	5.98%	Anxiety/stress is the main reason for sickness absence. People & Culture are focusing on initiatives to improve 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.
20) Percentage compliance with ALL mandatory and statutory training	85.00%	86.69%	The Training Department actively follow up all staff who do not attend booked training, monitor double-booking on courses to ensure availability is maximised, and review the availability of training rooms across Trust premises. A Quality Improvement Event took place in March 2024 to review mandatory training requirements for all staff; workstreams have been agreed to review mandatory training requirements with an implementation date of 30th September 2024.
21) Percentage of staff in post with a current appraisal	85.00%	81.36%	This year we have stood down WorkPal as our appraisal system and have launched TEWVVision. We have developed a new Performance Improvement Plan which includes the booking of all outstanding appraisals, the validation of outstanding staff lists, monitoring compliance in weekly huddles and ensuring appraisals are booked in diaries in advance.

Activity

Measure Name	Annual Standard 2023/24	Actual Position 2023/24	Commentary
22) Number of new unique patients referred	No standard set for 2023/24 2023/24 Position 101,113	99,469	There was a decrease in unique referrals in 2023/24, compared to the previous year. There are currently no specific trends or areas of concern identified.
23) Unique Caseload (snapshot)	No standard set for 2023/24 2022/23 Position 65,595	66,578	Detailed analysis has been undertaken to understand our caseload levels. Durham Tees Valley & Forensic Care Group have revised their Performance Improvement Plan and identified several actions to address the back log of waiters within Children & Young Peoples neurodevelopmental teams, which includes implementing a revised neurological assessment protocol and a refresh of the Patient Tracker meetings. Adult Mental Health Services are to pilot a revised assessment process for the Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorder pathways, working with Primary Care colleagues. North Yorkshire, York & Selby Children & Young Peoples Services are currently undertaking work to identify SMART actions required to drive improvements within their caseload sizes and following completion of demand and capacity work in Mental Health

			Services for Older People memory services, the Integrated Care Board have agreed to undertake a project focusing on a stepped model across the wider system.

Finance

Measure Name	Annual Standard 2023/24	Actual Position 2023/24	Commentary
24) Financial Plan: Statement of Comprehensive Income (SOCI) - Final Accounts – (Surplus)/Deficit	£0	£4,000	The Trust planned to deliver a breakeven adjusted financial position (i.e. zero surplus / deficit) in 2023/24 and achieved this delivering a surplus of £4k. This is before fixed asset impairments (£9.7m), peppercorn lease expenditure (£0.02m), and technical accounting adjustments linked to PFI contracts (£1.9m) which are excluded when assessing NHS provider financial performance. With these items included the Trust delivered a deficit of £11.6m.
25a) Financial Plan: Agency expenditure compared to agency target	£19,601,000	£17,169,000	The Trust planned to spend £19.6m on agency in 2023/24 and spent £17.2m. Usage reduced throughout the year, with zero corporate admin use by the end of 2023/24. Agency use was required to cover sickness, vacancies and to support delivery of safe care.
25b) Agency price cap compliance	100%	100%	The Trust planned to have 100% of agency usage within NHS price caps, and achieved this at the end of 2023/24.
26) Use of Resources Rating (UoRR) - overall score	2	2	The Trust planned to have a UoRR of 2 at the end of 2023/24, and achieved a 2 rating overall.
27) Cash Release Efficiency Savings (CRES) Performance – Recurrent	£15,467,000	£12,209,000	The Trust had an efficiency programme of £20.8m in 2023/24 and delivered this in full. However, planned recurrent efficiencies underdelivered by £3.3m. Specific agency reduction and reduction in OAPs schemes did not deliver in 2023/24 (£1.7m and £1.9m respectively) but were offset by higher than planned interest receivable (£1.5m).
28) CRES Performance – Non-Recurrent	£5,380,000	£8,638,000	See metric 27 narrative.
29) Capital Expenditure (Capital Allocation)	£13,868,000	£13,958,000	The Trust spent £14.0m against the capital allocation of £13.9m. Slippage on some planned schemes enabled delivery of unplanned health and safety schemes identified in year. In year the Trust received £2.8m additional capital funding to support IT networked asset improvements, LED lighting and cyber security (this is in addition to the £14.0m spend reported above).

30) Cash balances (actual compared to plan)	£64,304,000	£59,928,000	The Trust had planned cash balances of £64.3m for end of year 2023/24 but had actual cash balances of £59.9m. This is due largely to higher than planned accrued income at the end of the financial year.

Financial Review 2023-24

Summary of Financial Performance

In 2023-24 the Trust worked with its Integrated Care System (ICS) partners to develop and deliver financial plans for revenue and capital and ensure that investment in healthcare was optimised.

The 2023-24 Financial Plan was agreed by the Board of Directors as part of the Trust's Integrated Business Plan and underpinned the achievement of the Trust's strategic objectives.

Our financial objectives, both planned and achieved, are shown in the following table:

Objectives	Outcomes
Delivering a £0.000m adjusted financial surplus (before impairments, depreciation on peppercorn right of use (ROU) assets and technical adjustments on PFI accounting).	Financial surplus (before impairments, depreciation on peppercorn right of use (RoU) assets and technical adjustments on PFI accounting) of £0.00m realised.
Delivering an EBITDA* of £8.6m.	EBITDA of £5.8m delivered.
Delivery of £20.8m cash releasing efficiency savings (CRES).	Delivery of £20.8m cash releasing efficiency savings (CRES), inclusive of non-recurrent recovery actions.
EBITDA margin of 1.9%.	EBITDA margin of 1.2% achieved.

*EBITDA – earnings before interest taxation depreciation and amortisation is lower than planned as the Trust realised a £1.6m reduction in depreciation costs following revaluation of right of use (RoU) assets, which supported the Trust's higher than planned expenditure in clinical services.

The Trust planned an operating surplus of £0.000m for the financial year and realised a surplus (excluding impairments, depreciation on peppercorn ROU assets and technical adjustments on PFI accounting) of £0.0m.

CRES achieved at 31 March 2024 was £20.8m and was in line with plan. £8.6m was delivered on a non-recurrent basis as we continue to identify recurrent schemes. The

Trust is making good progress with future years plans and has established working groups to facilitate delivery of identified schemes.

Capital Investment

The Trust has worked within its agreed capital allocations to improve our environments and infrastructure and ensure the most modern equipment and technology is available for patient care and to support colleagues. Over the last twelve months and, working with partners to manage the constraints of a North East and North Cumbria Integrated Care System (NENC ICS) capital envelope, we have invested cash balances with the aim of providing the best possible environments and infrastructure. During 2023-24, the Trust invested £17.3m in capital assets. A sale for minimal value was completed in year for a section of unused land.

Asset Valuation

The Trust's land and buildings (including RoU assets) were subject to a market price revaluation exercise, which resulted in impairments* as follows:

	2023-24		
	£m		
	Realised in surplus	Realised in reserves	Total
Impairments	17.0	1.9	18.9
Reversal of impairments	-7.3	0.0	-7.3
Total loss (gain) realised	9.7	1.9	11.6

**An impairment is a reduction in the recorded value of an asset, as determined by an independent expert valuer.*

When recorded as 'realised in surplus', meaning in the Trust's overall Statement of Comprehensive income position), net impairment losses are recognised as a charge to expenditure.

Whilst charged to expenditure, impairments are excluded by NHS England from the assessment of Trust's performance against plan.

A prior period adjustment has been included linked to the revaluation of right of use assets at 31 March 2023, as valuations provided by the Trust's independent valuers

were materially lower than those included in the 2022/23 accounts (which were calculated based on lease payments in line with national guidance). The impact of this is shown below:

	2022-23 (Prior period adjustment)		
	£m		
	Realised in surplus	**Realised in reserves**	**Total**
Impairments	13.25	-	**13.25**
Revaluation gains	-	-1.39	**-1.39**
Total loss (gain) realised	**13.25**	**-1.39**	**11.86**

Working Capital

The Trust retained strong liquidity despite a decrease from 25.9 to 13.9 days, principally due to planned expenditure on capital projects.

Going Concern

For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.

After making enquiries, the directors have a reasonable expectation that the services provided by Tees, Esk and Wear Valleys NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Environmental Matters

A summary of progress on delivery of the Green Plan

In May 2024, a bid was submitted to the 'Carbon Skills Fund'. This is a central fund which organisations may bid against to procure specialist knowledge and consultancy by which to develop a 'Heat Decarbonisation Plan, one of the objectives set out in the TEWV Green Plan. Our bid was well prepared with input from a decarbonisation specialist. There are likely to be more central funding opportunities over the course of 2024/25.

Throughout 2023/24, 16 additional electric vehicle (EV) charging points were installed across the estate and a charging tariff was introduced in April 2024. Early indicators show that our EV charging consumption has significantly reduced, and the associated carbon reduction will be monitored. There are no plans to install further EV charging units in 2024/25 due to our capital constraints.

A bid for c.£800k was submitted against a central carbon reduction fund for LED lighting in 2023. TEWV were one of only two successful bidders in the NENC ICS and secured funding for the full amount. The work set out in the bid was undertaken and completed in April 2024. The carbon reduction is expected to be c.429,480 kgCO2e. This will be closely monitored through our detailed utility reports.

A new Energy and Sustainability Manager will be joining the Trust in June of 2024. This comes after the retirement of the previous postholder leaving a vacancy for close to 12 months. Recruitment in this field is particularly challenging however our new recruit comes from a neighbouring mental health provider and brings with them a lot of experience.

Task force on climate-related disclosures

Reporting on the TEWV Green Plan is via the Executive Strategy and Resources Sub-group and Strategy and Resources Committee.

On the arrival of the Energy and Sustainability Manager, an Energy and Sustainability group will be re-established. This group will be the driver for the objectives set out in the Green Plan and will require input and support from across the organisation and its directorates. The lead is the Executive Director of Finance, Estates and Facilities with responsibility delegated to the Director of Estates, Facilities and Capital.

Health Inequalities

The communities we serve are diverse. As well as wonderful community assets and environments, the area covered by TEWV contains some of the most deprived neighbourhoods in England. This contributes to some of the country's poorest social, physical, and mental health outcomes. Deprivation creates additional stress and exacerbates any health condition (mental and physical), and our services therefore need to meet increased and more complex demand.

The things that drive inequality and poor health outcomes in our patient population are complex and overlapping. People often face multiple challenges at one time across mental health, learning disability, neurodiversity, physical health, and social and economic circumstances. Three of the major drivers of inequality and health harms in our patient population include:

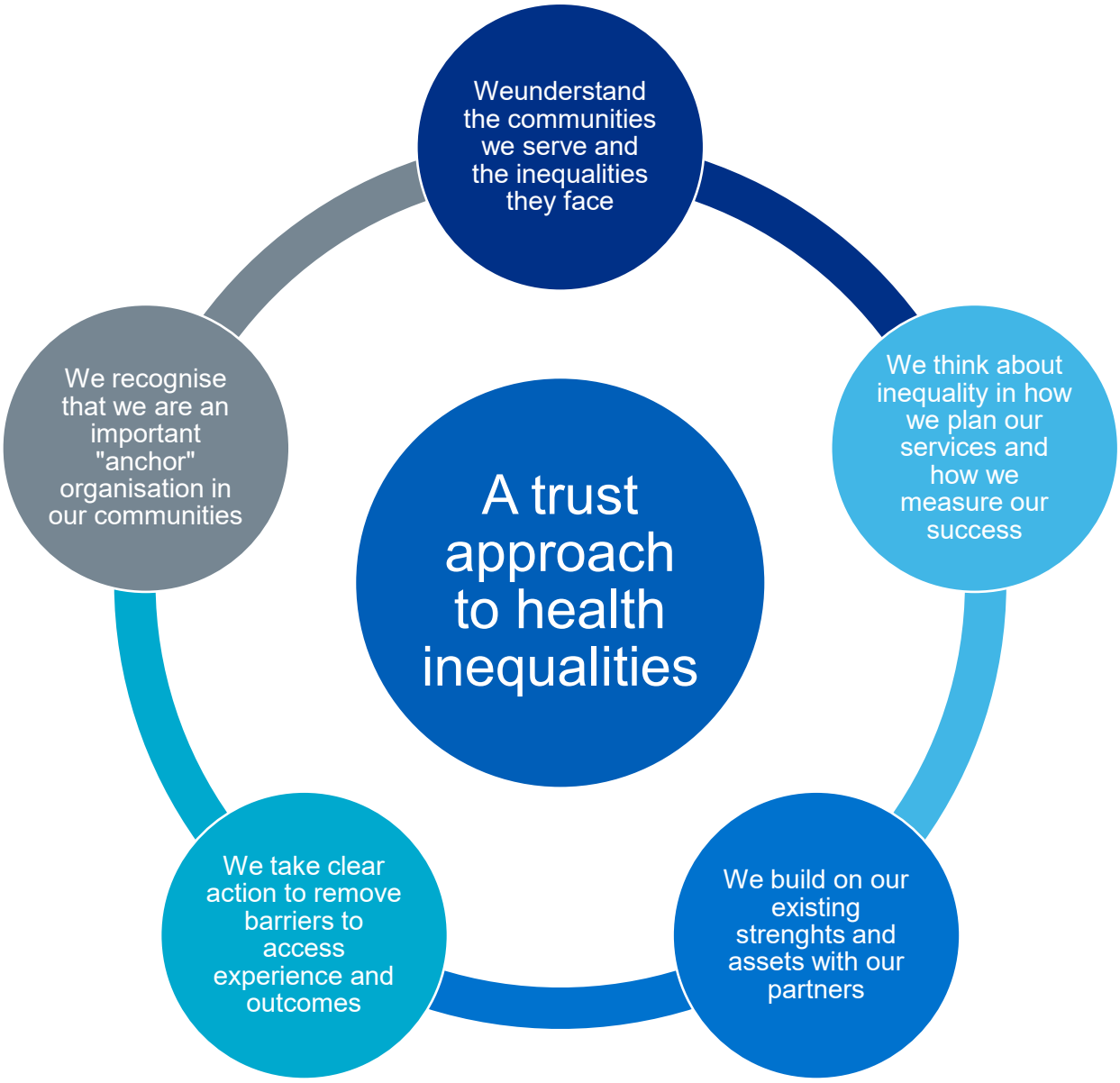
- Physical ill health
- Poverty and financial exclusion

- Drug and alcohol related harm

Rurality and isolation also contribute significantly for some of our communities.

In 2023/24 TEWV developed and adopted a co-created approach to tackling health inequalities within the Trust based around the following commitments (see illustration below). Lived experience engagement was central to the development and initial implementation of this approach and will form a core part of ongoing delivery.

Our Approach to Health Inequalities



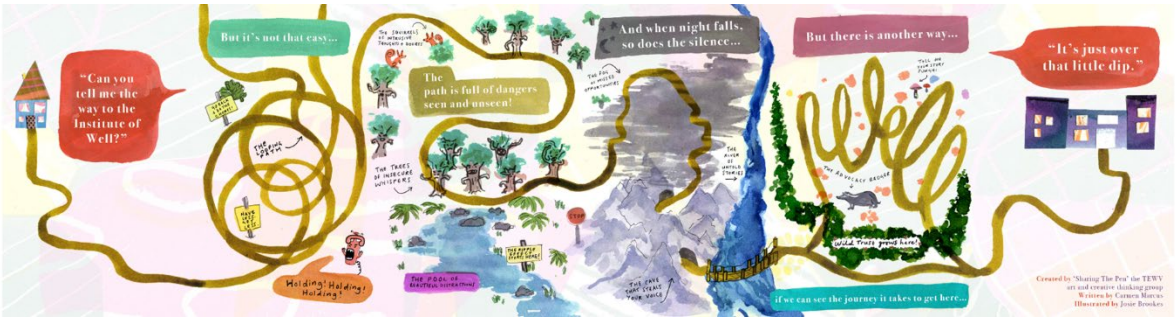
Co-creating a justice-based approach to care and support

Areas of progress in meeting these commitments include:

- A co-created patient safety summit on inequalities.
- A participatory arts project to tell the story of inequality experienced by those who use our services in a creative way (see diagram below).
- Embedding inequalities considerations in our planning processes across the Trust.
- Work to make our clinical environments more accessible to autistic people.
- Roll out of The Oliver McGowan Mandatory Training on Learning Disability and Autism.
- British Institute for Human Rights (BIHR) training provided to clinical leaders.
- A refresh of the Trust wide governance arrangements for physical health.
- Recruitment of specialist diabetes nurse in partnership with an acute partner
- The development of a partnership webinar series on mental health and diabetes.
- Development of pathways to improve screening uptake in inpatient settings.
- A programme of “Poverty Proofing” © service pathways in partnership with Children North East.
- Partnering with local authorities and academic partners to participate in programme of National Institute for Health Research funded research on work and health led by the University of Teesside.
- Progression of action on drug and alcohol related harm including embedding of joint posts, virtual huddles, co-location of staff, crisis in reach, development of a drug and alcohol care team to provide support in our inpatient units in Durham and Darlington and a pilot of community teams carrying naloxone when visiting people at risk of opiate overdose. A thematic review process and learning from deaths where drug and alcohol harm was part of the individual’s life has been established.
- The Reach team in Scarborough have been in place since 2021 taking a multi-agency approach to those with complex needs https://yhphnetwork.co.uk/media/106340/reach-poster-final.pdf
- Our current Trust wide equality objective focusses on Gypsy Roma and Traveller community engagement.
- Learning from the Learning Disability and Autism Annual Report

We continue work towards our transformation programmes with Health inequalities, understanding of and connection to our communities at the heart.

Participatory arts project on health inequalities example output



Health inequalities Priorities for 2024/25 include

- Building awareness and understanding of inequalities across staff groups.
- Improving access to and quality of our data on inequalities.
- Poverty Proofing our service pathways.
- Enhancing our Dual Diagnoses partnerships and approach.
- Gypsy Roma Travellers community engagement.
- Patient carer and race equity.
- Closing the gap in did not attend/was not brought.
- Expanding a community engagement approach to increase service accessibility and inclusive employment.
- Development of a Trust wide physical health strategy.

In response to NHS England (NHSE) statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006) a full health inequality report has been published and can be viewed at LINK TO REPORT TO FOLLOW

Social and community

Engaging with our communities 2023/24

We continue to improve how we listen to our service users, carers and partners. We have established groups and roles dedicated to amplifying lived experience voices. We now have services user and carer groups embedded across each of our specialties. These specialty groups work very closely with services in shaping business as usual policies, as well as redesigning services where necessary. In this manner, we have continued to amplify lived experience voices over the last year, to underpin how we deliver care.

Last year saw the launch of the co-creation boards in both care groups. This was an innovative step towards transforming how the trust is governed – with lived experience a core part of this governance. As the co-creation boards continue to develop and mature, we are seeing our service users and carer members develop their lived experience leadership. This is crucial as the co-creation boards evolve to be the pillars which support each care group with accountability for co-creation across our services.

We continue to refine our Co-creation Framework to provide our colleagues, patients and carers a toolkit to support better working together in partnership to make our services better for everyone we serve. Another area of focus in refining this toolkit, is to help us clearly demonstrate the value and measurable impact of co-creating with our service users and carers.

Our patients, carers, and lived experience community partners have played a central role in shaping and developing our major transformation work across the Trust. This includes our urgent care programme, driving the trust's approach towards personalised care plans, and the way we implement the use of Oxevision.

Our services continue to ensure lived experience underpins safety plans, and there's work is underway to embed patient safety partner roles within our wards.

The trust also produces and publishes an annual Quality Account to NHS England. This year our quality account was for the first time co-created with service users and carers. They defined the three main priority areas which the organisation will focus for improvements.

Some of our specialty areas such as mental health services for older people have fully embedded service user and carer involvement in its business plans, and this continues to be norm with development of Our Journey to Change with regular participation in workshops.

We have completed the review of our complaints process, co-created from start to finish with people with lived experience of our services and organisation.

We are also now in the preparatory phase of reviewing our patient experience service. This will improve how we listen, capture and learn from our service users' experiences of our services. This will be led by our lived experience directors, ensuring that people with lived experience of our services and organisation, are involved in any improvements and that we learn from their experiences.

We continued to focus on some key areas as part of our co-creation journey including:

- Expanding and developing lived experience roles and leadership, including peer support workers - partnership working and system leadership continues through co-delivery of systemwide training with Teesside University and launch of first regional network for peer support workers in Tees Valley. The launch of a second regional network in Durham is scheduled for June 2024. Work is also in motion to set up a third regional network in York alongside voluntary, community and social enterprise organisations.
- Improving and accurately capturing patient experience data - the quality visit programme continues across the Trust. Increasing response rates continues to be a priority and forms part of the service improvement action plans for each of the care groups. In March 2024 those that would recommend TEWV services to friends and family was 92.17% exceeding the national benchmark of 87%. During 2024 we will be undertaking a series of quality improvement reviews in readiness for the re-procurement of the Meridian system but also to consider the role and function of patient and carer experience in the future.
- Review/transform PALS and complaints pathways with co-creation principles - following go live of the testing of our new approach early signs are positive with the following benefits being identified to date:
    - Caseloads within the Complaints Team are reducing.
    - Complaints responded to within the originally agreed timescales have improved.

- We are seeing more concerns being dealt with as either local issue resolution or within the Complaints Team as early resolution resulting in less formal complaints.
- We are receiving less calls relating to other NHS Trusts
- Ward/Teams have embraced responding to issues locally.
- A small number of complaints have been resolved via face-to-face meetings.
- New responses to complaints include the action that we are taking as a result of the complaint.

Embed and grow co-creation across the organisation - continued progress has been made on this priority:

- 410 people remain on the involvement register. Recruitment of young people and Adult Learning Disability (ALD) and service users with Autism and carers is ongoing, including their involvement on co-creation boards.
- The Involvement and Engagement team continue to explore opportunities to reach more diverse communities and are working with BAME networks and seldom heard groups to understand the barriers to engagement.
- 32 new involvement opportunities were sent out during this reporting period, covering a range of cocreation activities.

Bribery

Our commitment and approach to preventing bribery is set out in our "Anti-fraud and Corruption Policy". No instances of bribery were discovered during the financial year.

Human rights issues

Control measures are in place to ensure that all of our obligations under equality, diversity and human rights legislation are complied with. Human rights issues are reported to the Equality, Diversity and Human Rights Steering Group. We are also working with the British Institute of Human Rights to provide training to colleagues on human rights issues.

Equality Objectives 2023 - 2027

A revised set of equality objectives was approved by the Board of Directors in January 2023 in order to more fully realise the vision, mission and strategic goals of the Trust. As part of the development of this strategy a consultation was held with service users, carers and staff during 2022. Clear themes emerged from this consultation and these themes helped shaped the objectives.

Objectives 1 and 3 relate to service delivery and supports the Trust's ambition to co-create a great experience for our patients, carers, and families.

- **Objective 1 Trans and non-binary - To monitor the experiences of staff and service users who identify as Trans or non – binary and to identify actions to improve their experiences.**
    - Focus groups were held with service users and staff, looking at themes and issues in relation to supporting Trans people in our services. A number of areas of work were identified: inpatient admissions; work in the community; training and support for staff; medication – for some medications it is vital to know if someone could become pregnant. Work on inpatient admissions was prioritised and the following actions taken: updating the part of the Privacy and Dignity Policy relating to the admission and care of Trans service users; developing a reference group to support staff making complex decisions about the admission of trans service users.

- **Objective 3 Working in partnership with other stakeholders to explore how to improve access to mental health, learning disability and Autism services for the Gypsy, Roma, Traveller (GRT) community.**
    - A Gypsy, Roma, Traveller (GRT) Working Group has been established and which has representation from both care groups and corporate services. The Trust has been working in partnership with the specialist GRT nurse in Durham who has delivered training to over 150 staff. The University of York are undertaking a project on our behalf to understand how we can cocreate with the GRT community and how the community understands and responds to mental health. We are seeking to engage with the community through a variety of offers including a volunteer to career programme.

The Publication of Patient Information

The Trust published annual information that demonstrates how we comply with the three aims of the public sector equality duty. The information helps us to understand whether and why particular groups in the community are under or overrepresented in its patient population and to act as appropriate. It identifies any differences in experience between protected groups and the patient population in general to ensure high quality care is delivered for all.

This information includes access to services, patient experiences and clinical outcomes.

The full report can be found at: https://www.tewv.nhs.uk/about/equality-and-diversity/approach/

Equality Delivery System (EDS) 2022

The Trust completed the EDS 2022 and published the report in March 2024. One of the aims of the EDS is to help the Trust to improve the services they provide for the local communities, improving patients access, health outcomes and experience.

The full report and action plans can be found at:

https://www.tewv.nhs.uk/about/equality-and-diversity/approach/

Important events since end of financial year - CQC prosecution

In April 2024 we attended Teesside Magistrate's Court for a Care Quality Commission (CQC) sentencing hearing. The CQC investigators found that we failed to provide safe care and treatment to two individuals, who sadly died in our care at West Lane Hospital in 2019 and Roseberry Park Hospital in 2020. We pleaded guilty to the two charges as soon as we were able to. The prosecution was against the trust and not about any individuals and we received a fine from the CQC totalling £200,000.

The care and treatment for those two individuals wasn't acceptable - they deserved better. We are deeply sorry for the events that led to these tragedies and our thoughts are with their families.

The Accountability Report

In the Accountability Report we provide information on our governance arrangements, staffing and the remuneration of Directors and Senior Managers in order to demonstrate how we comply with best practice and key rules and requirements.

Brent Kilmurray

Chief Executive

25 June 2024

The Directors' Report

David Jennings, Chair of the Trust and the Nomination and Remuneration Committee.

David is a qualified accountant and auditor with 36 years' experience in local government and the NHS. He worked for several years as a senior finance professional with Redcar and Cleveland Council covering finance, IT, assets and the strategic capital programme. Before that he had 27 years working for the Audit Commission, as a district auditor and later as a senior inspector. He has previously been a Non-Executive Director with TEWV, as well as with South Tees NHS Foundation Trust, Northumbria University, Bernicia Housing, and Newcastle University Development Trust.

Qualifications: Chartered Institute of Public Finance & Accountancy. Hons Degree

Principal Skills and experience: Senior NHS non-executive leadership experience. A professional career in Governance, Performance Improvement, strategic and cultural change, and the delivery of outcomes, including user experience. Specific professional expertise in finance.

Term of office: 1 September 2022 to 31 August 2025

Date of Initial appointment: 1 September 2022

Roberta Barker, Non-Executive Director, Freedom to Speak Up NED Champion

Roberta is Director of People and Culture for Teva Pharmaceuticals, a global $17bn business, covering Commercial, R&D and Manufacturing Operations across the UK and Ireland. She leads on all People Strategy for the organisation and ongoing transformation of the business.

Roberta began her career in Finance and General Management with Sky, Orange and Nike. Her final role with Nike was Head of Learning and Development EMEA and it was at this point she entered her first HR Director role. From there, she moved on to Daichii Sankyo EMEA as Director of People and Performance before taking on responsibility for the Director of People and OD role for the Business Services Authority, covering multiple divisions of services for the NHS.

Roberta has held various permanent and interim leadership positions within the Health Service including Trust Director of Workforce People and OD at Medway NHS Foundation, Director of Workforce and OD at Yorkshire Ambulance Trust, Director of People and OD at NHS Digital and Director of HR and OD at Royal Surrey County Hospital.
Qualifications: Master of Business Administration, Durham University, Common Purpose, Sunderland University.

Principal skills and expertise: HR and OD strategy, change management, strategic planning, operational implementation, communications and employee engagement, stakeholder management.
Term of Office: 1 September 2022 to 30 August 2025
Date of initial appointment: 1 September 2022 (prior to her appointment Roberta served as a non-voting Associate Non-Executive Director of the Trust)

Dr Charlotte Carpenter, Non-Executive Director, Chair of the Strategy and Resources Committee

Charlotte is Executive Director of Growth and Business Development at Karbon Homes, a leading social landlord within the North East. She is responsible for Karbon's development programme of over 600 new homes a year, the investment plans for Karbon's existing 32,000 properties, and also leads the strategy and insight, and communication and business development teams.

Charlotte began her career in the Civil Service Fast Stream and has a passion for housing's role in the economic and social regeneration of the North East. This was borne from senior roles with One Northeast and The Northern Way – a precursor to the Northern Powerhouse.

Charlotte joined the social housing sector in 2008, working for Home Group as Director of Strategy, Policy and Communications.

Charlotte is an alumnus of Cambridge and York universities and holds a PhD in Medieval History.

She is vice chair of the CBI North East Council, and a member of the CBI's National Net Zero and Domestic Competitiveness Committee and chairs the Chartered Institute of Housing's Policy Advisory Committee. She also holds a CaCHE Fellowship exploring the role that housing associations can play in the Foundation Economies of 'Left Behind Places'.

Qualifications: PhD, MA (Cantab), MA (York).

Principal skills and expertise: Strategy and strategic planning, communications, marketing and public affairs, organisational transformation, research and insight, programme and project management.

Term of office: 1 September 2021 to 31 August 2024

Date of initial appointment: 1 September 2021

John Maddison, Non-Executive Director, Chair of the Audit and Risk Committee and the Commissioning Committee and Digital/Cyber NED Champion

John retired in June 2019 after working in the NHS for 37 years. He studied economics and accountancy at Loughborough University and joined the NHS as a graduate trainee accountant in Yorkshire. The majority of John's career was based in the North East working in finance, primarily in the acute sector and senior positions at the strategic tier including NHS England. He was Director of Finance and Informatics at an acute FT in the North East and a large teaching hospital in the North Midlands prior to joining Gateshead Health FT in 2014 as Group Director of Finance and Informatics and latterly as Deputy Chief Executive and Acting Chief Executive for the final year prior to retirement.

Qualifications: BSc Econ/Acc. Chartered Institute of Public Finance and Accountancy.

Principal Skills and Expertise: Operational and strategic finance and planning, governance and risk management and performance management.

Term of Office 1July 2023 to 30 June 2026

Date of Initial appointment: 1 July 2020 (prior to his appointment John served as a non-voting Associate Non-Executive Director of the Trust)

Jill Murray, Non-Executive Director, Chair of the People Culture and Diversity Committee and Wellbeing NED Champion

Jill is an accomplished chief executive and housing professional with extensive leadership skills, knowledge and experience. Having spent the majority of her 42 year housing career in social housing, working with diverse and disadvantaged communities, she has a wide exposure of working with people who are affected by mental health issues.

Her experience in housing has included a path of continuous learning, growth and personal development which has afforded her a diverse range of skills and knowledge across housing association, local authority and the private sector.

Throughout her career, her enthusiasm for excellence in leadership has inspired her to develop further and to develop others. Jill's work on leading and empowering staff and communities has attracted both regional and national recognition, including various personal and organisational awards. The story surrounding the success of her leadership approach has been included as a chapter in a book titled 'Hope Under Neoliberal Austerity' published in April 2021.

Jill's employment as the chief executive of a housing association for over nine years, provided her with an in-depth and specialist knowledge of strategic leadership, planning, culture, good governance, assurance, risk management and collaborative working. Her broad skill set includes strategy development, finance, governance, risk management, housing management, housing development, regeneration, business

growth, sales and marketing, communications and PR, and customer service excellence.

Jill is the President of the Chartered Institute of Housing, the independent professional standards body of the housing sector. She has a Bachelor of Arts Degree in Housing and Development; is a Fellow Member of the Chartered Institute of Housing and is also a Chartered Management Institute, Level 5 Coach and Mentor.

Qualifications: Fellow Chartered Institute of Housing, Bachelor of Arts Degree Housing Studies and Chartered Management Institute - Coaching and Mentoring Level 5 Certificate.
Principal skills and experience: Excellence in Leadership, Culture and Performance, Business Transformation, Strategic Planning, Finance, Governance, Risk Management, Coaching and Mentoring.

Term of office: 1 September 2021 to 31 August 2024

Date of Initial appointment: 1 September 2021

Jules Preston, Non-Executive Director, Senior Independent Director

Jules has extensive experience in the NHS, having served as the inaugural Chairman of the Northumberland, Tyne and Wear NHS Foundation Trust, one of the largest mental health and learning disability Trusts in the country. During his period of chairmanship, the trust successfully came together having been three separate organisations and it achieved Foundation Trust status in 2009/10. In 2012 Jules began a new Chairman's post at Mid Yorkshire Hospitals NHS Trust.

Jules had previously been a Non-Executive Director of other NHS organisations, including the former Sunderland Health Authority (1996-2000) and the then Northumberland, Tyne and Wear Strategic Health Authority (2000-2006).

Jules has also held senior positions with the Manpower Services Commission (Department of Employment) and Chief Executive of Sunderland City Training and Enterprise Council and Business Link. Following that he was, for more than two years, part-time Chief Executive of the National Glass Centre in Sunderland.

He was until 2012 an assessor, both in the UK and internationally, of organisations that were working to achieve 'Investor in People' status and received an MBE in 1999 for services to training, particularly for those with special needs.

Qualifications: Left school at 16 and trained as articled clerk in Chartered Accountancy for 2½ years focussing on audit work before joining the Civil Service as a clerical officer. Principal grade within 20 years, focusing on adult and youth training, small business development and Investors in People. Training and education through personal development, on the job.

Principle Skills and Experience: People skills, leadership, change management, understanding of finance, 25 years involved as a non-executive within the NHS.

Term of Office: 1 September 2022 to 30 August 2025

Date of initial appointment: 1 September 2022 (prior to his appointment Jules served as a non-voting Associate Non-Executive Director of the Trust).

Bev Reilly, Non-Executive Director, Deputy Chair and Chair of the Quality Assurance Committee

Bev has been a Nurse for 37 years. Bev was the Director of Nursing and Quality for NHS England covering Cumbria and the North East with a significant delivery portfolio. Her long career has spanned a number of organisations across acute, primary and community care settings at a local, regional and national level. She is experienced in quality assurance and regulatory requirements having led on this as part of her role within NHS England and close working with NHS Improvement and the Care Quality Commission.

Qualifications: RGN, BA (Hons)

Principal skills and expertise: Nursing leadership, quality assurance, patient safety, patient and staff experience, risk management, strategic planning, partnership working.

Term of Office: 1 September 2022 to 31 August 2025*

Brent Kilmurray, Chief Executive

Brent has been an NHS executive director since 2005, working in senior roles across a range of acute, community health and mental health NHS organisations. He joined us after two years as Chief Executive of Bradford District Care NHS Foundation Trust, a combined community and mental health trust providing services in Bradford and the Yorkshire Dales, as well as children’s services in Wakefield.

His Board level experience includes executive and divisional roles at City Hospitals Sunderland NHS FT, joint Managing Director at NHS South of Tyne and Wear Community Health Services, Executive Director of Business Strategy and Performance for South Tyneside Foundation Trust, and Chief Operating Officer and Deputy Chief Executive for Tees, Esk and Wear Valleys NHS Foundation Trust.

Brent also chairs the Humber North Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative and is joint Senior Responsible Officer for the Mental Health and Learning Disability Programmes in the North East North Cumbria ICS.

Qualifications: MA European Studies and BA (Hons) Government and Politics.

Principal skills and expertise: Quality improvement and innovation, strategy development and deployment, leadership development, partnership and system working, operational service management, performance management, tendering and

business development, contract management, commercial matters, system leadership and partnership development.

Appointed: June 2020

Zoe Campbell, Managing Director, North Yorkshire and York Care Group

Zoe has extensive experience in the health and social care sector built up across local authority, the private sector and local and national charities. She has held several leadership positions including leading improvement and efficiency programmes across health and regional government, business development within a national provider of domiciliary and home-based health care; and as Director of Operations at a dementia charity covering England, Northern Ireland and Wales. Her previous roles have encompassed commissioning, service/continuous improvement, business development, strategy development and she has successfully delivered several large scale transformational change and improvement programmes at local, regional and national levels. Alongside this, she has understanding and experience gained as a volunteer at the Citizen' Advice Bureaux, as a Governor in a Social, Emotional and Mental Health school, a mentor for young people; and a Trustee at a mental health and learning disability charity.

Qualifications: B.A.(Hons) Social Policy. Post Grad Diploma Coaching for Strategic Leadership. Lean Six Sigma Green Belt.

Principal skills and expertise: Leadership, continuous improvement, programme/project management, commissioning and contracting, co-production.

Appointed: June 2022

Beverley Murphy, Chief Nurse

Beverley has worked as a Chief Operating Officer, Chief Nurse and Deputy Chief Executive in a number of mental health organisations and is back leading where she first trained as a nurse in 1985. Having worked as a mental health nurse for over 39 years, Beverley has a held a range of clinical leadership roles including in nurse led eating disorder care, in acute inpatient care and in forensic mental health.

Beverley is committed to delivering consistently high quality care to every person, every day and to do so supports the development of nursing practice and nurse leadership.

Qualifications: RMN, MA

Principle skills and expertise: mental health nursing practice, leadership, quality governance and professional development

Appointed: May 2023

Dr Kedar Kale, Executive Medical Director

Kedar is a consultant in General Adult Psychiatry and has over 28 years' experience in the field.

He trained in Mumbai, India and worked there as a Consultant Psychiatrist before moving to England. He retrained in Norwich and later Cambridge (where he also obtained his MPhil), before moving to the North East working within a community mental health setting for nearly 15 years as a Consultant Psychiatrist. He also held various leadership roles during this time.

His clinical practice has involved working with adult service users having long term mental illness, providing holistic care and focusing on recovery and reducing inequalities and more recently in Early Intervention services too.

He is passionate about continuous service improvement, coproduced with our service users and carers. He has led several improvement programmes over the years which brought significant change in practice and benefitted service users and staff.

He has enthusiastically trained postgraduate doctors for several years and is keen to ensure our Trust provides them with a high-quality training experience, and welcomes them as a place to work.

Qualifications: MBBS, DPM, MD, MPhil, FRCPsych.

Principal skills and expertise: General Psychiatric assessment and treatment, leadership, mentoring, teaching.

Appointed: June 2022

Liz Romaniak, Executive Director of Finance, Estates and Facilities

Liz joined the NHS in 1991 and gained extensive associate/deputy director and board-level experience from roles within commissioning and community and mental health provider organisations.

Liz's previous role was as Director of Finance, Contracting and Estates at Bradford District Care NHS Foundation Trust, where she led work in 2014 to 2015 to develop the organisation's long term financial plan and successfully navigate all financial aspects of the Trust's Monitor FT application and due diligence processes.

Liz also had responsibility for planning and performance and between 2017-2021, was Deputy Chief Executive, both roles affording opportunities to develop greater

operational and clinical perspectives. Liz has lobbied, including via NHS representative bodies, for parity of esteem (and resources) for mental health, including relating to capital developments. Liz is also a board member of the AuditOne NHS Audit consortium and a member of the HFMA's Governance and Audit Committee.

Qualifications: Qualified accountant, ACMA.

Principal skills and expertise: NHS finances (strategy, costing, financial accounting and management, commissioner and provider), financial strategy, planning and performance management.

Appointed: October 2020

Patrick Scott, Managing Director, Durham, Tees Valley and Forensics Care Group and Deputy Chief Executive

Having started out as a Health Care Assistant over 30 years ago, Patrick has extensive senior level NHS experience across both hospital and community services. Prior to his current role, he was the Chief Operating Officer at Bradford District Care NHS Foundation Trust and was previously the Director of Operations at TEWV before joining Bradford. He returned to the Trust in April 2022 as Managing director of Durham, Tees Valley, and Forensic Care Group.

Patrick has a strong track record of working with clinicians, service users and commissioners across health and social care to drive service transformation, continuous quality improvement, service developments and growth. He has also played a leading role in integrated care partnerships across the north east, working collaboratively with partners to jointly develop and deliver new services.

Qualifications: RMN; MSC distinction; Post Grad certification in Strategy, Policy and Leadership; Diploma in the Care and Management of Individuals Displaying Suicidal and Parasuicidal Behaviour.

Principal skills and expertise: Operational delivery; performance management; strategic planning and system working; quality improvement; governance.

Appointed: April 2022

Ann Bridges, Executive Director of Corporate Affairs and Involvement (non-voting)

Ann joined the Trust in September 2021 bringing extensive knowledge and expertise in strategic communications and engagement, having worked in local government and across the public sector at a senior level for over 20 years.

Originally from Edinburgh, Ann moved to the North East in 1999, leaving behind a career with Scottish Enterprise in regeneration and economic development marketing roles. Ann cut her teeth in local government having joined Newcastle City Council in 2000, progressing through the organisation and working closely with central Government in strategic leadership roles, and was laterally Head of Communications at Northumberland County Council before joining the Trust.

The corporate affairs and involvement department brings together our primary customer service teams including our patient and carer experience and complaints functions, our team leading the charge on embedding and facilitating co-creation in the Trust, plus the communications, stakeholder engagement and corporate affairs teams, as well working closely with our people and culture colleagues on staff experience and engagement.

Ann is a member of the Chartered Institute of Public Relations (CIPR) North East, and former committee member of the CIPR Local Public Services and CIPR Health Committees.

Qualifications: Professional Diploma from the Chartered Institute of Marketing (CIM), Chartered Institute of Public Relations (CIPR) Accredited Practitioner, SQA Advanced Diploma in Business Administration and Marketing.

Principal skills and expertise: Strategic communications, marketing and PR, public affairs, consultation and engagement, and coaching and mentoring.

Appointed: September 2021

Mike Brierley, Assistant Chief Executive (non-voting)

At a strategic level Mike has worked with both the public and private sector and assignments have ranged from leading a large Informatics service to implementing strategic planning frameworks and the development of organisation wide strategic plans.

Before joining the trust Mike spent 7 years as the Director lead for Mental Health Learning Disability and Autism commissioning across County Durham and Tees Valley and has strong leadership skills and stakeholder and relationship management experience; with an ability to achieve results in complex environments. He has led numerous large-scale change and redesign programmes, as well as short high intensity projects.

Mike holds an MBA and has extensive experience in change management, supporting teams and individuals to implement whole system redesign programmes.

Qualifications: Master of Business Administration (MBA).

Principal skills and expertise: Strategic planning, performance management, programme management, organisational change management, commissioning.

Appointed: July 2022

Dr Hannah Crawford, Director for Therapies (non-voting)

Hannah qualified as a Speech and Language Therapist in 1995, and has worked for Tees, Esk and Wear Valleys Trust (and its predecessor organisations) all her working life, achieving the position of Consultant Speech & Language Therapist in 2005. She mainly specialised clinically in working with adults with a learning disability, but also worked with working age and older adults. Between 2017 and 2019 Hannah also worked for NHS Improvement as the National Patient Safety Expert Adviser for adults with learning disabilities. She left this position at the end of 2019 to take up the role of Professional Head of Speech and Language Therapy within TEWV. Hannah achieved the role of Executive Director of Therapies in April 2022.

She currently holds a range of honorary positions including being a professional advisor for the Royal College of Speech & Language Therapists, an Honorary Lecturer at Teesside University and a Visiting Research Fellow at the University of York. Hannah has a PhD from the University of Edinburgh, which investigated the lived experience of family carers of adults with profound and multiple disabilities and dysphagia.

Qualifications: BA (Hons), Post Grad Diploma, MSc, PhD.

Principal skills and expertise: Clinical Speech & Language Therapy (dysphagia), ethics, patient and carer experience, leadership, coaching, research, teaching.

Appointed: April 2022

Dr Sarah Dexter-Smith, Director for People and Culture (non-voting)

As TEWV's Director for People and Culture, Sarah brings over 30 years of psychological training and practice in the health, education and social care sectors. Working as a clinical psychologist initially in older people's and dementia care, she then took on regional and national roles on behalf of the psychological professions more broadly, (including editing and contributing to national guidance) and medical management/ governance roles. She became one of the initial group of psychologists nationally to take on the Director of Therapies role in 2017 (leading allied health, social work, chaplaincy and psychological professions). Her extensive background in professional standards, leadership / coaching development and change management/effective team working, led her be appointed as the Trust's first Director for People and Culture. This signified a shift that has enabled TEWV to move beyond traditional approaches to employment and culture, ensuring our approaches are evidence based and compassionate, and clearly articulate the thread from our role as a large employer in tackling inequalities, through staff wellbeing to patient care.

Sarah maintains teaching, coaching and mentoring responsibilities across multiple organisations and chairs, or is a member of, strategic workforce groups in HNY and NENC ICBs as well as in the NEY region.

Qualifications: Doctorate Clinical Psychology, PhD Psychology, ILM 5 coaching, PGDips in Neuropsychology and Clinical Supervision

Principal skills and expertise: Leadership, coaching and mentoring, applied psychology, research, teaching.

Appointed: February 2021

*Note: *indicates that the individual has been reappointed as a Board member of the Foundation Trust.*

Statement on the Independence of each Non-Executive Director

The Trust confirms that each Non-Executive Director is considered independent taking into account the criteria set out in the Code of Governance.

Changes to the Board of Directors during 2023/24

Beverley Murphy joined the Board in May 2023 as the Chief Nurse

Elizabeth Moody, Director of Nursing and Governance, retired from the Board in April 2023

Patrick Scott became Deputy Chief Executive.

Prof Sir Pali Hungin, Non-Executive Director and Chair of the Mental Health Legislation Committee resigned from the Board in February 2024 having been appointed as a Non-Executive Director of the North East North Cumbria Integrated Care Board

Registers of Interests

Details of company directorships or other material interests in companies held by directors which might conflict with their responsibilities are included in the “Registers of Interests”. This document is available for inspection on our website www.tewv.nhs.uk.

Accounting Policies

The Trust prepared the financial statements in accordance with the NHS Group Accounting Manual (GAM) for 2023-24 as directed by NHS England, and fully

complies with accounting requirements as set out in International Financial Reporting Standards (IFRS).

The Trust's accounting policies are set out in the Annual Accounts and have been consistently applied over the comparative period. The implementation of IFRS 16 (leases) linked to PFI contracts was completed without restating prior year financial statements, as per the GAM.

Accounting Information

The accounts are independently audited by Mazars LLP as external auditors in accordance with the Health and Care Act 2022 and the National Audit Office Code of Audit Practice. As far as the directors are aware, all relevant audit information has been fully disclosed to the auditor and no relevant audit information has been withheld or made unavailable. Nor have any undisclosed post balance sheet events occurred.

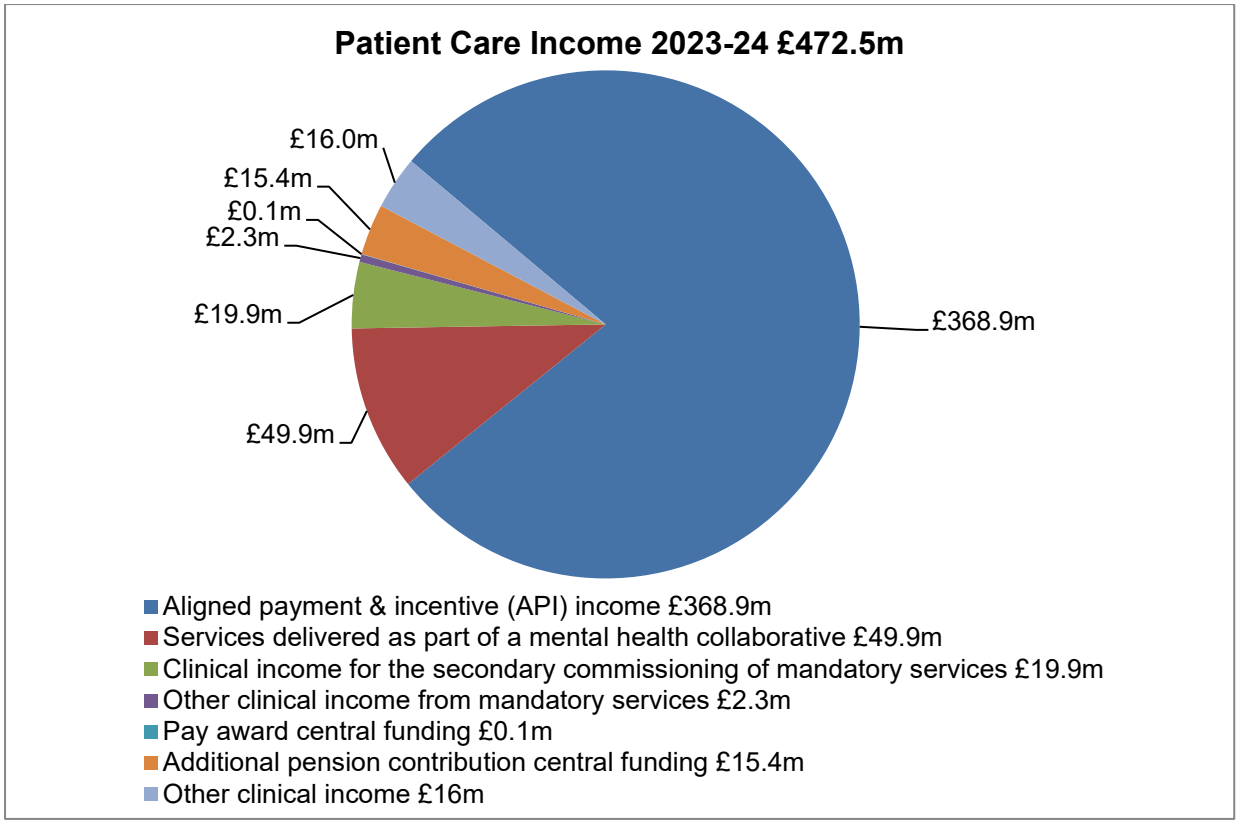
No political or charitable donations were made by the Trust during 2023-24.

Accounting policies for pensions and other retirement benefits are set out in the accounts, and details of senior managers remuneration can be found in the remuneration report.

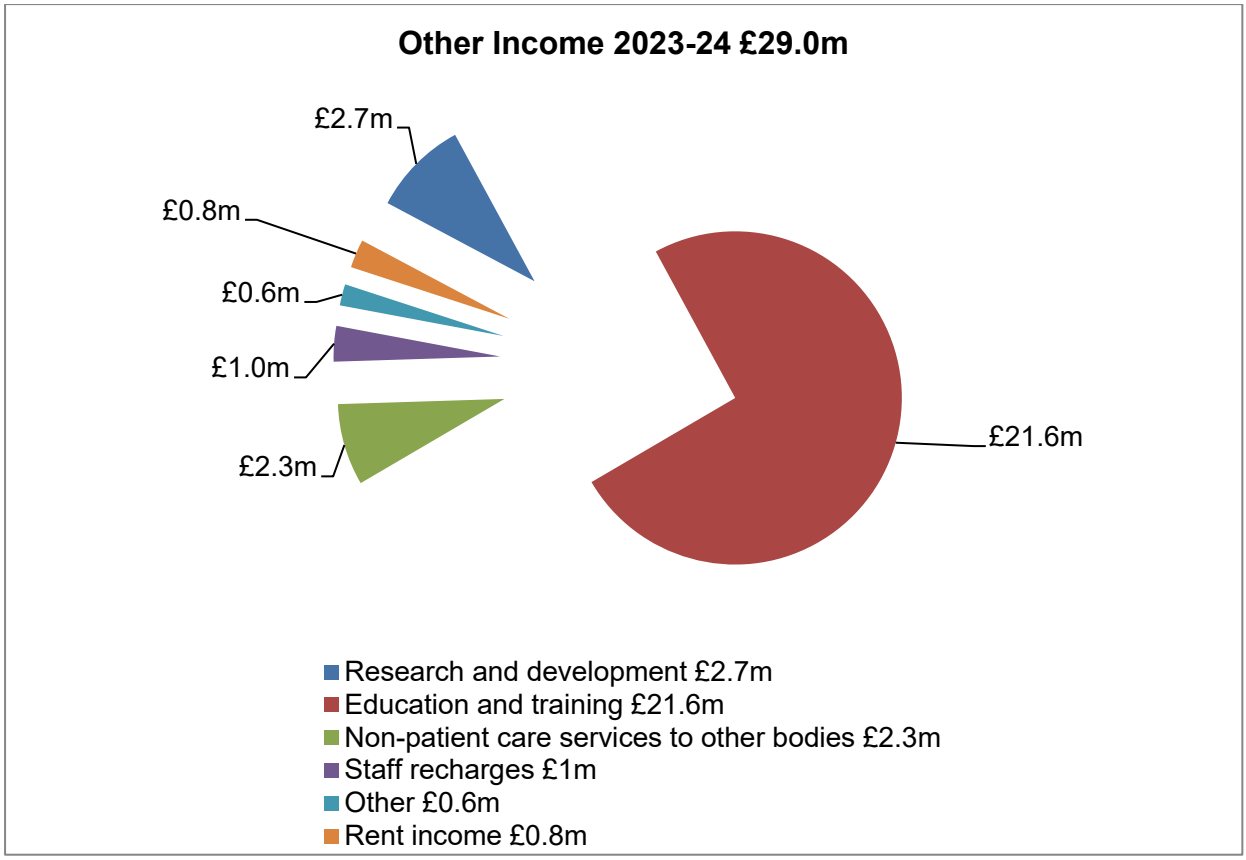
The Trust has complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector Information guidance.

Income Generation

During 2023-24, income generated was £501.6m from a range of activities; 94.2% being from direct patient care. Patient care income totalling £472.5m came from the following areas:



A further £29.0m was received in respect of education and training, research and development and other non-patient care services.



As shown above, the Trust's income from the provision of goods and services for the purposes of the health services in the UK was greater than its income from the provision of goods and services for any other purposes. The provision of goods and services for any other purposes had no negative impact on the provision of health services.

Better Payment Practice Code

The Better Payment Practice code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. Performance for the financial year 2023-24 was as follows:

	Number of Invoices	Value of invoices £000s
NHS Creditors		
Total bills paid	2,103	21,931
Total bills paid within target	2,037	21,059
Percentage of bills paid within target	96.9%	96.0%
Non-NHS Creditors		
Total bills paid	72,815	128,418
Total bills paid within target	68,706	121,757
Percentage of bills paid within target	94.4%	94.8%

It is Trust policy to pay all creditors as they fall due, unless extenuating circumstances are apparent, e.g. a dispute in the amount being charged, or the services or goods provided. Improving performance for non-NHS suppliers remains a key priority, including through the increased use of No Purchase Order No Payment procedures ('No PO, no Pay').

The total potential liability to pay interest on invoices paid after their due date during 2023-24 would be £3,435,402, an increase on 2022-23 amounts (£2,871,939). There have been minimal claims under this legislation, therefore the liability is only included within the accounts when a claim is received.

NHS England's 'well-led' Framework

In this section of the Annual Report we provide an overview of how we have had regard to NHS Improvement's well-led framework in arriving at our overall conclusions about the position of the organisation.

The eight domains of the well-led framework are as follows:

- Clarity of vision and a credible strategy
- Leadership capacity and capability
- Clarity of roles and systems of accountability
- The appropriateness and accuracy of information
- Engagement with service users and carers, the public, staff and external stakeholders
- Learning, continuous improvement and innovation
- Processes for managing risks, issues and performance
- Culture

In last year's annual report, we highlighted the improvements made to our leadership and governance arrangements which reflected the best practice described by the Good Governance Institute following independent development review of leadership and governance using NHS Improvement's 'Well led' framework.

These changes were designed to:

- Simplify the governance processes – giving nurses more time to care, enabling clinical teams to make decisions with the people they care for and making it easier for everyone to understand their role and responsibilities.
- Strengthen reporting from teams through our two care groups directly to our Trust Board.
- Improve the connectiveness of the tiers of governance and embed increased line of sight from ward to Board.

During 2022/24 we have reviewed, refined and embedded our new approach. Key developments included:

- The first year of the implementation of our five strategic journeys: Clinical, Quality and Safety, Co-creation, People and Infrastructure. These Strategic Journeys translate the high-level vision, mission, values and goals of Our Journey to Change into more concrete and specific ambitions and principles which are delivered through a series of programmes and workplans for the agreed priorities of our delivery plan.
- The delivery of improvements following a post-implementation review of our new arrangements. This was undertaken in two phases which focussed on:
    - Governance - improving the productivity of meetings, the flow of assurances in our structure and the timeliness and consistency of information

    - Organisational structure – addressing queries and concerns and improving clarity on roles and accountabilities
- The implementation of key new systems to support the delivery of Our Journey to Change including:
    - Cito, our clinical record system which enables clinical “pathways” to be designed so that staff are prompted to complete care plans and risk assessments (and other forms) at the appropriate point in the pathway that aligns with best practice.
    - InPhase, our risk and quality management system, which supports recording, reporting and learning across a number of areas, including patient safety incidents.
    - Workpal, our performance and appraisal platform

Overall, we consider that, taking into account the well-led domains, we have made significant progress. However, to provide independent assurance, we commissioned Deloitte LLP to undertake a further governance review. This highlighted a number of key themes and specific recommendations for further work.

The main themes were:

- Reviewing Our Journey to Change and related priorities and delivery planning.
- Reviewing our business planning approach.
- Getting a better understanding and responding to variations in our care group model and the differing governance approach being taken
- Reviewing and streamlining our executive level meeting structure.
- Further developing and embedding our Accountability Framework.
- Refining committee terms of reference, agendas and reporting – including performance reporting.
- Developing our approach to the use of data and its role in reporting.
- Leadership development programme.
- Reviewing executive portfolios
- Further developing and embedding our approach to risk, including the Board Assurance Framework.
- Embedding PSIRF, completing the complaints review and embedding the approach to mortality and morbidity reviews.
- Developing our Council of Governors further.
- Reviewing and advancing our co-creation work.
- Accelerating our developments in learning, innovation and quality improvement.

A number of these areas are already reflected in our proposed delivery plan for 2024/25, whilst others will require new workstreams. An action plan is being developed on these areas for consideration by the Board.

Further information on our governance framework and internal control arrangements is provided in the Annual Governance Statement.

The NHSI Well-led Framework is available at: www.england.nhs.uk/well-led-framework/

CQC inspection report

Our latest Care Quality Commission (CQC) trust-wide inspection was published in October 2023. Whilst our overall rating stayed at requires improvement, the CQC recognised that we're making progress. Seven out of 11 of our services are rated 'good' and four areas are rated as 'requires improvement'. This is an improvement since our last inspection in 2021. All services were rated 'good' for caring and nine out of 11 services were rated 'good' or 'outstanding' for effective.

The CQC acknowledging that we're making improvements, and that these positive changes have impacted on the quality of our care, is a really important step on Our Journey to Change. However, we know there's more to do and we're committed to continuous improvement.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Requires Improvement → ← Oct 2023	Requires Improvement → ← Oct 2023
Community-based mental health services of adults of working age	Requires Improvement ↓ Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Requires Improvement → ← Oct 2023	Good ↑ Oct 2023	Requires Improvement → ← Oct 2023
Wards for older people with mental health problems	Requires Improvement → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023
Long stay or rehabilitation mental health wards for working age adults	Requires improvement Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Community mental health services for people with a learning disability or autism	Requires Improvement ↓ Oct 2023	Good ↑ Oct 2023	Good ↓ Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023
Forensic inpatient or secure wards	Requires Improvement ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023
Specialist community mental health services for children and young people	Requires improvement Sep 2022	Good Dec 2021	Good Dec 2021	Requires improvement Dec 2021	Requires improvement Dec 2021	Requires improvement Sep 2022
Community-based mental health services for older people	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Wards for people with a learning disability or autism	Requires Improvement ↑ Oct 2023	Requires Improvement ↑ Oct 2023	Good ↑ Oct 2023	Requires Improvement → ← Oct 2023	Requires Improvement ↑ Oct 2023	Requires Improvement ↑ Oct 2023
Specialist eating disorders service	Requires improvement Mar 2020	Outstanding Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Mental health crisis services and health-based places of safety	Good Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021

Performance against key health care targets

Our Trust monitors a range of key health care targets which include those set internally by the Board of Directors, those set externally as part of the mental health contracts with commissioners and the national ones within the NHS Oversight Framework. This section will focus on the national ones within Oversight Framework, which is formally reported to the Board on a quarterly basis.

NHS Oversight Framework

There are 12 Oversight Framework measures for which standards are applied at Trust level. The Trust has consistently achieved the following 4 measures:

- National Patient Safety Alerts not completed by deadline.
- Proportion of staff in senior leadership roles who are women.
- Proportion of staff in senior leadership roles who are disabled staff.
- Agency spending: Agency spend compared to the agency ceiling.

In relation to the remaining 8 measures:

- We have not achieved our ambition to eliminate inappropriate OAP bed days for adults that are either 'internal' or 'external'. OAPs are intrinsically linked to the pressures on our inpatient services particularly within Durham and Tees. *(See commentary for 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider in the Quality section above.)*
- Consistency of reporting patient safety incidents was achieved in quarter 1; however national reporting has been paused pending the introduction of the new Learn from Patient Safety Events (LFPSE) service.
- Adult Acute Length of Stay Over 60 Days
  (*See commentary for 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider in the Quality section above.)*
- Older Adult Acute Length of Stay Over 60 *Days*
  (*See commentary for 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider in the Quality section above.*)
- Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BAME applicants: We have a robust Workforce Race Equality Standard action plan, which is focused on increasing the diversity of staff. A plan to increase diversity and hyperlocal recruitment is being developed and includes work to increase opportunities for under 18s, volunteer to career pathways, the development of academies, the coordination of recruitment activities in areas that will increase diversity, and community engagement activities. This will be promoted via links within the Black, Asian and Minority Ethnic (BAME) communities.
- Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants: As noted above we are

developing a plan to increase diversity, and this will be promoted via links within our partners who work with people with long term health conditions.

- Proportion of staff in senior leadership roles who are from a BAME background: A new Leadership Academy will be launched in 2024/25, which will provide a focus on career development for those in underrepresented groups including disabled colleagues, those from BAME backgrounds and women in senior leadership roles.
- Agency spending: Planned costs for 2023/24 were relatively in line with 2022/23 outturn representing a reduction in cost owing to the favourable plan variance year to date. However, the trust price cap compliance is 63%, which is behind the planned 100% compliance. Volume pressures and rate premia associated with agency expenditure are significantly impacting our financial plan.

There are 4 NHS Oversight Framework measures for which standards are applied at Integrated Care Board (ICB) level. The Trust has consistently achieved the following measure:

- Number of children and young people accessing mental health services as a % of population

In relation to the remaining 3 measures:

- Access rate for Talking Therapies services was not achieved. During 2023/24 the care groups have revised their Performance Improvement Plans. New actions within Durham & Tees Valley include the promotion of suitability criteria/referral routes, Therapy Support Workers contacting patients prior to their assessment and the formulation of Single Point of Access dashboard to track capacity and demand to maximise capacity. North Yorkshire and York Care Group are proactively contacting patients to remind them of upcoming appointments and are updating their attendance policy to include reasonable adjustments to improve patient choice.
- Access rates to community mental health services for adult and older adults with severe mental illness was achieved within the North East & North Cumbria ICB footprint, but was not within Humber & North Yorkshire ICB. The care group have identified that one of the main underlying issues in the reduction of contacts is the York and Selby Early Intervention in Psychosis team and recruitment is under way to improve staff capacity within that service.
- Women accessing specialist community perinatal mental health services was achieved within the North East & North Cumbria ICB footprint, but was not within Humber & North Yorkshire ICB. North Yorkshire and York Care Group have developed a Performance Improvement Plan and actions include recruiting to the vacant posts and developing standardised triage criteria to ensure all appropriate woman are accepted onto caseload.

Mental Health Priorities

There are 8 Operational Planning Requirements for delivery during 2023/24. Of these, 1 is monitored at Trust level, which we did not achieve the ambition for:

- Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider. (*Please see above narrative*)

Progress towards targets agreed with local commissioners

Priorities, Trajectories and Operational Planning Requirements

We provide regular performance information to commissioners as part of the mental health contract covering activity and key measures of quality. These are reported within our Integrated Performance Report and are aligned to the NHS Standard Contract.

Our commitment to contract performance management is evidenced through routine contract performance and quality meetings with commissioners, which are regularly attended and have full participation of senior staff.

These meetings/groups focus on areas such as service quality, service development and finance.

There were 8 National Quality Requirements for delivery during 2023/24, of which, for the financial year, we achieved:

- 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.
- 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 for all Sub-ICB Locations.

We did not achieve the national targets for the following measures:

- Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care for Vale of York Sub-ICB Location.
- Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care for Vale of York Sub-ICB Location.
- Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks (rolling 12 months) for County Durham, North Yorkshire and Vale of York Sub-ICB Locations.
- Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week (rolling 12

months) for County Durham, Tees Valley and Vale of York Sub-ICB Locations.

These measures have been impacted following the implementation of Cito and we are undertaking a comprehensive validation of the Quarter 4 data.

There are 2 further national quality requirements included within the 2023/24 mental health contract, which were:

- Number of episodes of mixed sex accommodation – sleeping
- Duty of Candour (failure to notify)

There are 7 Operational Planning Requirements for delivery during 2023/24 where we have agreed local plans for delivery or delivery of national standards with commissioners.

Of the agreed plans, for the financial year we achieved the following:

- Number of people who first receive Talking Therapies recognised advice and signposting or start a course of Talking Therapies psychological therapy for Tees Valley Sub-ICB Location.
- Talking Therapies: The proportion of people who are moving to recovery for all Sub-ICB Locations.
- Talking Therapies: Percentage of people who have waited more than 90 days between first and second appointments for North Yorkshire Sub-ICB Location.
- Number of CYP aged 0-17 supported through NHS funded mental health with at least one contact for all Sub-ICB Locations.
- Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services for adults and older adults with severe mental illnesses for County Durham, Tees Valley and North Yorkshire Sub-ICB Locations.
- Number of women accessing specialist community PMH services for County Durham and Tees Valley Sub-ICB Locations.

We did not achieve the plans we agreed in respect of the following measures:

- Total access to Talking Therapies services for County Durham, North Yorkshire and Vale of York Sub-ICB Locations.
- Talking Therapies: Percentage of people who have waited more than 90 days between first and second appointments for County Durham, Tees Valley and Vale of York Sub-ICB Locations.
- Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period for all Sub-ICB Locations.
- Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services for adults and older adults with severe mental illnesses for Vale of York Sub-ICB Location.

- Number of women accessing specialist community PMH services for North Yorkshire and Vale of York Sub-ICB Locations.

While the Trust has not achieved the plans set nationally for each individual Sub-ICB Location, work has been undertaken with partners to develop local trajectories where required as part of the 2024/25 operational planning round for mental health services. These have been submitted to the relevant Integrated Care Boards for agreement with NHS England. Our proposals, while achievable, are stretching to support progress towards the national ambitions.

The remuneration report

Annual Statement on remuneration

In July 2023 the 45th report of the Review Body on Senior Salaries (SSRB) outlined its conclusions on pay for very senior and executive managers (VSM/ EM) in the NHS.

The Nomination and Remuneration Committee approved the recommendations from the SSRB for a 5% uplift for all VSM staff backdated to April 2023 and a one off non-consolidated payment in line with the top of B9 salary for VSM staff, in line with the approach taken by neighbouring trusts.

It also approved the option to align any pay anomalies for VSM staff.

David Jennings

Chair of the Board's Nomination and Remuneration Committee

Policy Disclosures

Basic pay	The VSM Pay Framework is based on the national benchmarking for comparable providers and comparable roles. We have reviewed these when new appointments were made in line with the national benchmarks. The same committee reviews the objectives and appraisals of the executive directors to ensure: • Through these arrangements the Trust has satisfied itself that senior managers' remuneration is reasonable. • The basic pay arrangements support the short and long-term strategic objectives of the Trust by enabling the Trust to recruit and retain talented individuals who undertake key leadership roles using levels of remuneration that represent value for money and which are comparable to or lower than those of other similar organisations.

Performance related Components	There are no performance-related components
Recruitment and Retention Premia (RRP)	The Nomination and Remuneration Committee has the option of paying Recruitment and Retention Premia (RRP) but these should only be paid where there is clear evidence that the payments can be justified. No VSM staff were paid this during 2023/24.
Allowances	Car and on call allowances are included within basic pay.
Provisions for the recovery of sums paid to directors or for withholding payments of sums to senior managers	There is contractual provision for making appropriate deductions from notice period payments. Entitlement to pay progression, where applicable, is subject to confirmation from the individual's line manager that their performance over the preceding 12 months period has been rated as being good. The Nomination and Remuneration Committee of the Board of Directors agreed to the incorporation of an 'earn back' clause whereby up to 10% of salary is put at risk pending an annual review of performance against objectives set. This has not been applied to any VSM staff this year.
Remuneration above £150,000	A comparison is undertaken with the national benchmarking. All the VSM salaries are reported nationally through the national survey.
Arrangements specific to individual senior managers	Not applicable

- Service contracts obligations: none identified.
- Policy on payment for loss of office: a contractual entitlement to three months' notice, other than in the case of summary dismissal. Where eligible an entitlement to a redundancy payment in accordance with Section 16 of the National Terms and Conditions of Service.
- Diversity and inclusion: The Nomination and Remuneration Committee's approach to diversity and inclusion is based on the Trust's Human Rights, Equality and Diversity Policy. This policy, which is available on the Trust's website, lays down expected standards in relation to equality, diversity and human rights in employment and service delivery. This was actively considered in relation to the gender pay gap and the varying salaries amongst VSM colleagues. The standards in the policy are that we:
    - Respect and protect the human rights of all patients, colleagues and anyone else who has a relationship to the Trust.

- Take breaches of policy very seriously, particularly those that when breached have a harmful effect on other people. Victimisation, harassment, discrimination (or an attempt to do so) and bullying will not be tolerated and will, where substantiated, lead to disciplinary action.
- Colleagues who identify with protected groups have the right to be treated fairly and with dignity and respect and without the fear of unlawful discrimination, harassment, victimisation or bullying.
- Commit to the ongoing development of staff awareness and knowledge of equality, diversity and human rights. Staff development begins on employment and continues throughout an individual's career until they leave the Trust.
- Commit to monitoring, evaluating and reporting on issues of equality, diversity and human rights in employment and service provision.
- Work towards best practice standards of equality, diversity and human rights and not merely comply with legislation.
- Promote equality, foster good relations and take an anti-discriminatory approach in all areas of employment and service delivery.
- Ensure barriers to accessing services and employment are identified and removed so that no person is treated less favourably because they identify with a protected group/s.
- Recognise the importance of this policy in the employment relationship it has with its staff and in provision of services for patients, and will reflect this commitment in all Trust policies, procedures and practices.

The policy extends outside the workplace and Trust staff should be aware that workplace behaviour includes time when they are not physically at work but are participating in activities where work is a factor, for example, team nights out, shopping trips with colleagues etc.

This is because abusive, discriminatory and/or unethical behaviour outside of work could still affect the relationship between the Trust and its employees, particularly if it is deemed to be so serious that it would warrant disciplinary action or allegations of gross misconduct, as would be the case if the individual or group concerned were at work.

The policy supports the delivery of the Trust's Equality Strategy. Progress on the delivery of the equality objectives, included in the strategy, is monitored by the Equality, Diversity and Human Rights Steering Group.

Further information on equality and diversity is provided in the Accountability Report, while demographic information on the Trust's senior managers is provided in the Staff Report.

Statement of consideration of employment conditions elsewhere in the Foundation Trust

A combination of an independent job evaluation scheme, to establish respective job weights, and independently gathered and reported information about Very Senior Manager (VSM) remuneration levels in comparable Trusts were used to establish the original VSM Pay Framework.

Capita undertook the job evaluation exercise and provided information about remuneration levels of equivalent posts within comparable organisations. This information has been used by the Nomination and Remuneration Committee to establish and operate the VSM Pay Framework since 2014. This includes consideration of updated independent remuneration reports. Since then, the national benchmarking process, which we also contribute to, has been the foundation on which we have reviewed our own scales.

Non-Executive Director Remuneration

Basic Remuneration	The basic fees payable to the Chair and Non-Executive Directors have been set by the Council of Governors taking into account information provided by Capita on fees payable by other Foundation Trusts. Associate Non-Executive Directors receive the same level of remuneration as the Non-Executive Directors. The Non-Executive Directors have not received an increase in their remuneration since 2013/14.
Additional fees paid for other duties	Additional fees are payable to the Deputy Chair, the Chair of the Audit and Risk Committee and the Senior Independent Director.
Allowances	The Chairman and Non-Executive Directors are able to claim reimbursement of expenses (for example travel) in line with Trust policy.

Brent Kilmurray

Chief Executive

Senior managers' remuneration (subject to audit)

Name and Title	2023-24						2022-23					
	Salary	Other Remuneration **	Benefits in Kind *	Pension related benefits *****	Total Remuneration	Expenses Paid	Salary	Other Remuneration ***	Benefits in Kind *	Pension related benefits	Total Remuneration	Expenses Paid
	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £2500) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £2500) £000	(bands of £5000) £000	Rounded to the nearest £100
Mr Brent Kilmurray, Chief Executive	195 - 200	0 - 5	4,400	12.5 - 15.0	215 - 220	1,500	175 - 180	0 - 5	2,700	32.5 - 35.0	215 - 220	1,000
Mrs Zoe Campbell, Managing Director North Yorkshire and York Care Group (started 13 June 2022)	130 - 135	0 - 5	0	30.0 - 32.5	170 - 175	700	100 - 105	-	-	17.5 - 20.0	120 - 125	-
Mr Patrick Scott, Managing Director, Durham Tees Valley and Forensic Services	135 - 140	0 - 5	3,800	-	145 - 150	0	130 - 135	-	1,600	125.0 - 127.5	260 - 265	-
Mrs Liz Romaniak, Director of Finance, Information and Estates	145 - 150	0 - 5	0	-	150 - 155	300	140 - 145	0 - 5	-	37.5 - 40.0	175 - 180	-
Mrs Elizabeth Moody, Director of Nursing and Governance and Deputy Chief Executive (left 31 March 2023)	-	-	-	-	-	0	125 - 130	0 - 5	14,600	117.5 - 120.0	260 - 265	500
Mrs Beverley Murphy, Chief Nurse (started 01 May 2023)	120 - 125	0 - 5	800	-	125 - 130	0	-	-	-	-	-	-

Dr Stephen Wright, Medical Director (left 26 June 2022)	-	-	-	-	-	-	25 - 30	0 - 5	-	-	25 - 30	-
Dr Kedar Kale, Executive Medical Director (started 27 June 2022)	170 - 175	5 - 10	1,900	567.5 - 570.0	750 - 755	1,600	125 - 130	-	1,500	-	130 - 135	2,300
Dr Sarah Dexter-Smith, Director for People and Culture	130 - 135	0 - 5	0	-	135 - 140	1,600	120 - 125	0 - 5	-	52.5 - 55.0	170 - 175	1,700
Mrs Sharon Pickering, Assistant Chief Executive (left 18 July 2022)	-	-	-	-	-	-	40 - 45	0 - 5	-	-	40 - 45	300
Mr Mike Brierley, Assistant Chief Executive (started 1 July 2022)	120 - 125	0 - 5	1,300	-	125 - 130	400	85 - 90	-	1,000	72.5 - 75.0	160 - 165	-
Mrs Ann Bridges, Director of Corporate Affairs and Involvement	115 - 120	0 - 5	1,900	27.5 - 30.0	145 - 150	800	100 - 105	0 - 5	1,000	22.5 - 25.0	125 - 130	200
Dr Hannah Crawford, Director of Therapies	120 - 125	0 - 5	800	127.5 - 130.0	250 - 255	0	100 - 105	0 - 5	800	197.5 - 200.0	300 - 305	700
Mr David Jennings, Chairman (started 1 September 2022)	50 - 55	-	0	-	50 - 55	3,400	25 - 30	-	-	-	25 - 30	1,900
Mrs Shirley Richardson, Non-Executive Director, Senior Independent Director and Interim Deputy Chair (left 31 August 2022)	-	-	-	-	-	-	10 - 15	0 - 5	-	-	10 - 15	500
Mr Paul Murphy, Non-Executive Director, interim Chair (left 31 August 2022)	-	-	-	-	-	-	15 - 20	-	-	-	15 - 20	1,900

Prof. Pali Hungin, Non-Executive Director (left 28 February 2024)	10 - 15	-	0	-	10 - 15	400	10 - 15	-	-	-	10 - 15	300
Mrs Beverley Reilly, Non-Executive Director and Deputy Chair	20 - 25	-	0	-	20 - 25	900	15 - 20	-	-	-	15 - 20	200
Mr John Maddison, Non-Executive Director & Chairman of the Audit and Risk Committee	15 - 20	-	0	-	15 - 20	0	15 - 20	-	-	-	15 - 20	100
Dr Charlotte Carpenter, Non-Executive Director	10 - 15	-	0	-	10 - 15	0	10 - 15	-	-	-	10 - 15	-
Mrs Jillian Murray, Non-Executive Director	10 - 15	-	0	-	10 - 15	1,100	10 - 15	-	-	-	10 - 15	-
Mr Jules Preston, Associate Non-Executive Director	15 - 20	-	0	-	15 - 20	1,100	15 - 20	0 - 5	-	-	15 - 20	500
Mrs Roberta Barker, Associate Non-Executive Director	10 - 15	-	0	-	10 - 15	0	10 - 15	0 - 5	-	-	10 - 15	-

Fair pay disclosures (subject to audit)

Remuneration ranged from	10 - 15
Remuneration ranged to	750 - 755
Band of highest paid directors total remuneration (£000) #	195 - 200
Percentage increase from prior year of highest paid director salary #	11.3%

Percentage increase from prior year of median salary #	5.0%

Senior managers may be affected by Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

The above table shows the remuneration for time worked as a senior manager only. Where this was for part year (dates shown in table) the table reflects this.

* Benefits in kind are the provision of lease cars.

** Other remuneration includes a non-consolidated pay award made during the reported period, and a clinical excellence award for the medical director.

*** Other remuneration is for a £200 bonus paid to all employees in post 31 March 2022 unless otherwise specified.

**** An Executive deferred 2022/23 pay rises until 2023/24 other than standard cost of living increase. The Nomination and Remuneration Committee agreed a pay adjustment in 2023/24 to recognise both 2022/23 and 2023/24 uplifts.

***** The Medical Director rejoined the NHS Pension Scheme during the financial year, their increase in pension benefits is linked to both an increase in salary from when they were last a member, and the impact of the McCloud remedy.

Pension related benefits, other remuneration and benefit in kind have been excluded from this calculation, as they are not known for all staff.

Pension related benefits

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Senior managers' pension benefits (subject to audit)

Name and title	Real increase in pension at retirement age for time in post	Real increase in pension lump sum at retirement age for time in post	Total accrued pension at retirement age at 31 March 2024	Lump sum at retirement age related to accrued pension at 31 March 2024	Cash Equivalent Transfer Value at 31 March 2024	Cash Equivalent Transfer Value at 31 March 2023	Real Increase in Cash Equivalent Transfer Value for time in post less employee pension contributions
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000
Mr Brent Kilmurray, Chief Executive	-	45.0 - 47.5	65 - 70	185 - 190	1,557	1,246	284
Mrs Liz Romaniak, Director of Finance, Information and Estates	-	32.5 - 35.0	60 - 65	165 - 170	1,384	1,217	147
Dr Kedar Kale, Executive Medical Director	25.0 - 27.5	67.5 - 70.0	70 - 75	195 - 200	1,606	1,015	578
Dr Sarah Dexter-Smith, Director for People and Culture	-	30.0 - 32.5	40 - 45	105 - 110	866	679	170
Mr Mike Brierley, Assistant Chief Executive	-	25.0 - 27.5	35 - 40	95 - 100	860	760	83
Mrs Zoe Campbell, Managing Director North Yorkshire and York Care Group	2.5 - 5.0	-	0 - 5	-	73	29	25
Mr Patrick Scott, Managing Director, Durham Tees Valley and Forensic Care Group	-	37.5 - 40.0	75 - 80	210 - 215	1,778	1,481	279

Dr Hannah Crawford, Director of Therapies	5.0 - 7.5	35.0 - 37.5	40 - 45	110 - 115	920	642	262
Mrs Ann Bridges, Director of Corporate Affairs and Involvement	0.0 - 2.5	-	5 - 10	-	84	44	24

As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

Senior managers may be affected by Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Benefits and related CETVs do not include values for a future adjustment for eligible employees arising from the McCloud judgment.

Brent Kilmurray:

Chief Executive

Date: 25 June 2024

Expenses of Governors

At 31 March 2024 the Trust had 34 Governors (2022-23, 41), with 17 receiving reimbursement of expenses (2022-23, 15). The total amount reimbursed as expenses was £820, (£545 in 2022-23).

Pay Terms and Conditions

With the exception of directors, non-executives and medical staffing the workforce are covered by Agenda for Change. All inflationary uplifts for staff employed under national terms and conditions have been in accordance with nationally determined pay arrangements. All executive directors are on a permanent contract and have a notice period of 6 months.

The Nomination and Remuneration Committee is responsible for Executive Directors pay.

Brent Kilmurray:

Chief Executive

Date: 25 June 2024

In July 2023 the 45th report of the Review Body on Senior Salaries (SSRB) outlined its conclusions on pay for very senior and executive managers (VSM/ EM) in the NHS.

Nomination and Remuneration Committee approved the recommendations from the SSRB for a 5% uplift for all VSM staff backdated to April 2023 and a one off non-consolidated payment in line with the top of B9 salary for VSM staff, in line with the approach taken by neighbouring trusts. It also approved the option to align any pay anomalies for VSM staff.

Some Executives deferred 2022/23 pay rises until 2023/24 other than standard cost of living increase. Nomination and Remuneration Committee agreed pay adjustment in 2023/24 to recognise both 2022/23 and 2023/24 uplifts.

Senior managers may be affected by Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

Pension related benefits

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

2023-24	25th percentile	Median	75th percentile
Salary component of pay	24,336	34,581	42,618
Total pay and benefits excluding pension benefits	27,151	35,675	46,091
Pay and benefits excluding pension: pay ratio for highest paid director	7.3:1	5.5:1	4.3:1

2022-23	25th percentile	Median	75th percentile
Salary component of pay	23,177	32,934	40,588
Total pay and benefits excluding pension benefits	23,949	32,934	41,727
Pay and benefits excluding pension: pay ratio for highest paid director	7.4:1	5.4:1	4.3:1

The staff report

Staff costs (subject to audit)

Staff group	Permanent £000	Other £000	Total 2023/24 £000	Total 2022/23 £000
Salaries and wages	279,248	26,317	**305,565**	298,393
Social security costs	27,477	3,591	**31,068**	28,008
Apprenticeship levy	1,398	165	**1,563**	1,384
Employer's contributions to NHS pension scheme	45,247	5,376	**50,623**	47,546
Pension cost - other	71	9	**80**	131
Temporary staff	-	17,466	**17,466**	20,746
Total staff costs	**353,441**	**52,924**	**406,365**	**396,208**
Of which				
Costs capitalised as part of assets	2,423	297	**2,720**	532

Average number of employees (WTE basis) (subject to audit)

Staff group	Permanent Number	Other Number	2023/24 Total Number	2022/23 Total Number
Medical and dental	373	136	**509**	491
Administration and estates	1,204	110	**1,314**	1,332
Healthcare assistants and other support staff	449	4	**453**	405
Nursing, midwifery and health visiting staff	3,692	602	**4,294**	4,423
Scientific, therapeutic and technical staff	1,297	257	**1,554**	1,552

Healthcare science staff	4	-	**4**	4
Social care staff	86	-	**86**	50
Total average numbers	**7,104**	**1,109**	**8,213**	**8,257**
Of which:				
Number of employees (WTE) engaged on capital projects	33	6	**39**	9

Demographic information

As of the end of March 2024 there were 6509 female members of staff (79.5%) and 1675 male members of staff (20.5%).

The number of male and female staff in the following groups is as follows:

- Executive directors: six female and four male.
- Non executive directors: five female and two male
- Other senior managers: two female and five male

Sickness and Absence data

Our sickness levels continued to drop through 2023-24 with even the anticipated spike in January being significantly lower than the previous two January periods.

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

There has been increasingly joined up work through the people partners to ensure that staff are supported by both their line manager and the people and culture team. The Health and Wellbeing team has been strengthened and we have successfully gained the Better Health at Work Silver Award. The special leave policy has been renewed to ensure that types of leave the trust actively supports are made clear. Work has begun on implementing the Domestic Abuse and Sexual Violence Charter which the Trust has signed up to.

Occupational Health

The Trust's Occupational Health and physiotherapy services are provided by People Asset Management (PAM).

Provision includes a range of services including pre-employment screening, vaccination and immunisation, specialist occupational health employment advice, and musculoskeletal specialist services. We continue to work collaboratively to maintain and improve staff health and wellbeing.

Employee assistance/counselling services are provided via VIVUP with some additional services being available via the resilience hubs that the Trust is linked with; Humber and North Yorkshire Resilience Hub and North East and North Cumbria Resilience Hub. VIVUP also provide a range of staff benefits.

Staff policies and actions applied/taken during the year

We have a range of policies and procedures which support our commitment to being a good employer and providing equal opportunities to present and potential employees.

Our recruitment and selection procedure is followed for each recruitment episode.

The procedure has been equality impact assessed, ensuring application of the procedure does not impact negatively on people with disabilities.

We are signed up to the disability confident scheme and guarantee an interview to all applicants with a disability who meet the minimum essential criteria for a job vacancy. We make reasonable adjustments to support candidates through the recruitment process if this is required. We advise recruiting managers to check whether their new starter requires any reasonable adjustments to be put in place due to a disability/long-term health condition and encourage them to contact Access to Work at their earliest opportunity and direct them to our Reasonable Adjustments Team for support.

We provide a number of health and wellbeing support mechanisms to help staff throughout their employment. Specific advice can be gained from Occupational Health as to recommendations to support a staff member whilst at work. Reasonable adjustments will be made for staff with disabilities. We have a dedicated reasonable adjustment team which supports this process along with our workplace adjustments procedure. If a staff member can no longer work in the role they are employed, we will explore redeployment into another suitable alternative role.

We are fully committed to ensuring all colleagues with disabilities and long-term health conditions have a positive experience and equitable access to training, career development and promotion. To facilitate this, our reasonable adjustment team and workplace adjustments procedure provides for individual workplace adjustment plans detailing the adjustments that staff would need to undertake their job role, access training and career development and achieve promotion.

We regularly share information with colleagues on matters of concern to them, as employees, through our weekly staff briefing and on our staff intranet.

The CEO regularly hosts webinars for all staff, co-hosted with other directors or other staff members depending on the focus.

We hold regular “working together in our trust” coffee break type sessions for staff to talk with the Director for People and Culture and other leads about anything relating

to employment in the Trust. The Director for Corporate Affairs and Involvement also regularly attends these. This also allows an opportunity for People and Culture to share progress on workforce delivery plans, updates on our People Journey and other developments which impact our workforce.

The Director for People and Culture continues to meet with the chairs of the staff networks on a bi-monthly basis and each staff network is sponsored by an executive director ensuring that their concerns are heard and acted on.

Local consultative committees (LCC) take place bi-monthly within each care group and corporate services. A joint consultative committee (JCC) also takes place bi-monthly. Items affecting the workforce are discussed at both LCC and JCC, at which staff side representation are in attendance. A Pay and Workforce Group was fully embedded in 2023 and reports to JCC. This group negotiates on workforce related local agreements in a timely way submitting proposals to JCC for consideration.

For any formal changes affecting the workforce we follow the organisational change procedure. Consultation consists of group meetings and one to one meetings with staff (along with staff side representation). Staff have an opportunity to provide comments in relation to proposals prior to implementation.

Countering fraud and corruption

Our Trust has an established anti-fraud and corruption policy which aims to minimise the risk of fraud, bribery or corruption by detailing the key roles and responsibilities of employees and related parties as well as promoting an anti-fraud culture.

The policy and related materials are available on the Trust's intranet, and counter-fraud information is prominently displayed both on the Trust's intranet and throughout our premises.

Our Trust's Local Counter Fraud Specialist (LCFS) reports to the Audit and Risk Committee quarterly, and through an annual report, and performs a programme of work designed to provide assurance to the Board about fraud and corruption.

The LCFS provides regular fraud awareness sessions to staff, investigates concerns reported by staff and liaises with the police. If any issues are substantiated, we take appropriate criminal, civil or disciplinary measures.

Staff Turnover

Through 23-24 we addressed multiple factors and instigated an internal transfer scheme and an independent thinking about leaving process. Our leavers' rate has fallen month on month and we are now one of the higher performing Trusts nationally in terms of leaver rates.

NHS Workforce Statistics - December 2023 (Including selected provisional statistics for January 2024) - NHS England Digital

Annex 2 to Chapter 2: Staff survey report – template disclosure for NHS staff survey

Staff experience and engagement

The following principles describe how we will achieve our ambitions set out in our People Journey, More People, Working Differently, in a Compassionate and Inclusive Culture, and how we will work together:

- Co-creation
    - Ensuring everyone who works in TEWV has a voice – meaning that they are heard when they raise concerns or ideas, and they know that this has been listened to by colleagues and change is possible.
    - Working with service users and carers to understand how we can support our colleagues to provide a great experience of care.
    - Working with our partners, collaborating on regional priorities, working with education and training providers, social care and the voluntary sector so that our workforce is skilled, innovative and emotionally astute.
    - Working with our communities to build attractive and supportive routes into employment across the wide range of current and future roles that we embody.

- Value-based
    - Underpinned by our values of respect, compassion, and responsibility in the way we work, the way we behave, and the way the organisation is run.

- Centred around our Clinical Journey
    - Our future work will be prioritised and planned to support the ambitions of our Clinical Journey, to help to ensure patients and families have great experience of care.

NHS staff survey

The NHS staff survey is conducted annually. From 2021/22 the survey questions align to the seven elements of the NHS ‘People Promise’ and retains the two previous themes of engagement and morale. These replaced the ten indicator themes used in 2020/21 and earlier years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The response rate to the 2023/24 survey among trust staff was 48% (2022/23: 44 %).

Scores for each indicator together with that of the survey benchmarking group are presented below.

Indicators ('People Promise' elements and themes)	2023/24		2022/23	
People Promise:	**Trust Score**	**Benchmarking Group**	**Trust Score**	**Benchmarking Group**
We are compassionate and inclusive	7.49	7.93	7.4	7.5
We are recognised and rewarded	6.37	6.90	6.2	6.3
We each have a voice that counts	6.92	7.34	6.9	7.0
We are safe and healthy	6.37	6.70	6.2	6.2
We are always learning	5.77	6.45	5.6	5.7
We work flexibly	6.58	7.25	6.5	6.7
We are a team	7.00	7.47	6.9	7.1
Staff engagement	6.94	7.45	6.8	7.0
Morale	6.07	6.61	5.9	6.0

	2023/24	
	Trust score	**Benchmarking group score**
Equality, diversity	8.48	8.72

and inclusion	7.15	7.61
Health and wellbeing	59.99%	76.57%
Immediate manager works together with me to come to an understanding of problems	73.31%	80.98%
immediate manager is interested in listening to me when I describe challenges I face.	75.43 %	82.80%
immediate manager cares about my concerns.	74.67%	82.06%
immediate manager takes effective action to help me with any problems I face.	70.76%	78.70%
Quality of appraisals	4.80	5.86
Quality of care	55.41%	80.42%
Safe environment – violence Patients/service users	14.23%	7.25%
Staff engagement	6.94	- data not available

[Optional: NHS foundation trusts may wish to include additional information from their results, including their strongest and lowest scores against their benchmark group, or results showing greatest improvement or decline over time.]

- 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.
- 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.

Future priorities and targets

Trustwide priorities for 2023/24:

- Continued focus on quality of appraisals with the new appraisal system – TEWVision.
- Focus on Scope for Growth Career conversations, this will be to develop all managers to have these all-important conversations, which will support with Our Journey to Change and the strategic goals.
- There is a large piece of work underway to ensure all our systems are aligned so that future staff surveys accurately represent the directorates in the new structure (for information comms currently also reflects planning and performance, trust board reflects a series of Trustwide roles)
- Workforce planning across the Trust based on the NHS Long Term Workforce Plan which was released in June 2023.
- We have launched the first TEWV Leadership and Management Academy, where there will be a focus on developing our current and future leaders and managers.

Recording of Trade Union Facility Time (1st April 2023 – 31st March 2024)

Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
37	8213 FTE (calculated as per Regulations)

Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	27
1 – 50%	6

51-99%	0
100%	4

Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
Provide the total cost of facility time	£118,320 (calculated as per Regulations)
Provide the total pay bill	£403,645,000 (calculated as per Regulations)
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.029%

Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	4.1% (calculated as per Regulations)

Consultancy Costs

Expenditure on consultancy costs was £73k during 2023-24. No arrangements for 2023-24 required access to national NHS England approvals for management consultancy work of £50k or above.

Off payroll arrangements

Highly-paid off-payroll worker engagements as at 31 March 2024 earning £245 per day or greater:	Number
Number of existing engagements as of 31 March 2023	84
Of which:	
The number that have existed for less than 1 year at the time of reporting	25
The number that have existed for between 1 and 2 years at the time of reporting	46
The number that have existed for between 2 and 3 years at the time of reporting	8
The number that have existed for between 3 and 4 years at the time of reporting	0
The number that have existed for 4 or more years at the time of reporting	5

All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2024 earning £245 per day or greater	Number
Number of off-payroll workers engaged during the year ended 31 March 2023	216
Of which:	
Number not subject to off-payroll legislation	0
Subject to off-payroll legislation and determined as in-scope of IR35	216
Subject to off-payroll legislation and determined as out of scope of IR35	0

Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which, number of engagements that saw a change to IR35 status following review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024	Number
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	10

Ill Health Retirements

During 2023-24 8 Trust employees retired early on the grounds of ill health; the value of these early retirements (from NHS Pensions) was £0.7m.

Exit packages (subject to audit)

Reporting of compensation schemes - exit packages 2023/24

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
£50,001 - £100,000	1	-	1
>£200,000	-	1	1
Total number of exit packages by type	**1**	**1**	**2**
Total cost (£)	£98,000	£241,000	£339,000

Reporting of compensation schemes - exit packages 2022/23

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)			
<£10,000	-	-	-
£10,000 - £25,000	-	-	-
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**-**	**-**	**-**
Total resource cost (£)	£0	£0	£0

Exit packages: other (non-compulsory) departure payments	2023/24		2022/23	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Early retirements in the efficiency of the service contractual costs	1	241	-	-
Total	**1**	**241**	**-**	**-**
Of which:				

Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Gender pay gap

The latest gender pay gap report can be accessed via the Cabinet Office using the following link: https://gender-pay-gap.service.gov.uk/.

A copy of the report and previous reports are available on the Trust website which can be accessed via the following link:

https://www.tewv.nhs.uk/about/publications/gender-pay-gap-report-2023/

Governance including the Foundation Trust Code of Governance Disclosures

In this section we provide information on our corporate governance arrangements. We explain who sits on the Board of Directors, its committees, and Council of Governors and how they operate.

How the Trust is governed

As a public benefit corporation, the Trust is required to have the following governance arrangements:

- A legally binding constitution
- A Non-Executive Chair
- A Board of Directors comprising Non-Executive and Executive Directors
- A Council of Governors comprising elected public and staff Governors and Governors appointed by key stakeholder organisations
- A public and staff membership

The Trust's Constitution requires both the Board and the Council of Governors to

- Observe the Nolan principles of Public Life of selflessness, integrity, objectivity, accountability, openness, honesty and leadership
- Seek to comply, at all times, with the NHS Foundation Trust Code of Governance

Statement on the Application of the Code of Governance

The Foundation Trust Code of Governance, published by NHS Improvement, provides an overarching framework for corporate governance and complements the statutory and regulatory obligations placed on Foundation Trusts.

Tees, Esk and Wear Valleys NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis.

During 2023/24 the Trust complied with all the principles of the Code (April 2023 edition).

Under the Code of Governance the Trust is required to disclose the following information:

Code ref:	Summary of Disclosure Requirement	Page(s)
A 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based	11 – 15 Annual Governance

	partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Statement (132)
Disclose A 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	17
A 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	13
B 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties	48

	with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	
B 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	93
B 2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.	114 and 96
C 2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	96
C 2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	97 and 121
C 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	38
C 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led	96

	framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	
C 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.	101 and 121 *(Note: no appointments were made to the Board during 2023/24)*
C 5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	122
D 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	92
D 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe	Annual Governance Statement (132)

	associated disclosure requirements for the annual report.	
D 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	Annual Governance Statement (132)
D 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	15
E 2.3	Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings	Not applicable
Appendix B, para 2.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	115
Appendix B, para 2.14	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	94 & 125

Appendix B, para 2.15	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	94
Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	95

The Board of Directors

Our Board of Directors provides overall leadership and vision to the Trust and is ultimately and collectively responsible for all aspects of performance, including clinical and service quality, financial performance and governance.

The general statutory duty of our Board and each director, individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

Our Board of Directors:

- Has retained certain decisions to itself as set out in the reservation of powers and scheme of delegation (available on our website).
- Exercises certain functions in conjunction with our Council of Governors.

Any powers which the Board has not reserved to itself or delegated to a committee are exercised on its behalf by our Chief Executive.

Information on the Board Members as at 31st March 2024, including details of their qualifications, skills and expertise, is provided in the Accountability Report.

The Board considers that, as at 31st March 2024:

- Its composition meets the requirements of the National Health Service Act 2006 and the Constitution
- All its members are “fit and proper” persons to be Directors of the Trust in accordance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- There is an appropriate balance and breadth of skills, knowledge and experience amongst the Non-Executive Directors
- All the Non-Executive Directors meet the independence criteria set out in the Foundation Trust Code of Governance

Statement on the Directors’ responsibility for preparing the Annual Report and Accounts

The Directors are required under the National Health Service Act 2006, and as directed by NHS Improvement, to prepare accounts for each financial year.

NHS England, with the approval of HM Treasury, directs that these accounts shall show, and give a true and fair view of the NHS foundation trust's gains and losses, cash flow and financial state at the end of the financial year. NHS England further directs that the accounts shall meet the accounting requirements of the Department of Health Group Accounting Manual that is in force for the relevant financial year, which shall be agreed with HM Treasury.

In preparing these accounts, the Directors are required to apply on a consistent basis for all items considered material in relation to the accounts, accounting policies contained in the Department of Health Group Accounting Manual; make judgements and estimates which are reasonable and prudent; and ensure the application of all relevant accounting standards and adherence to UK generally accepted accounting practice for companies, to the extent that they are meaningful and appropriate to the NHS, subject to any material departures being disclosed and explained in the accounts.

The Directors are responsible for keeping proper accounting records which disclose, with reasonable accuracy, at any time the financial position of the Trust. This is to ensure proper financial procedures are followed, and that accounting records are maintained in a form suited to the requirements of effective management, as well as in the form prescribed for the published accounts.

The Directors are also responsible for safeguarding all the assets of the Trust, including taking reasonable steps for the prevention and detection of fraud and other irregularities.

Each of the Directors, holding office on 31st March 2024, confirms that the annual report and accounts, taken as a whole, are fair, balanced and reasonable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust’s performance, business model and strategy.

Attendance at Board meetings

The following table provides details of the attendance at the 12 meetings of the Board of Directors held during 2023/24:

Board Member	Position	No. of board meetings attended
David Jennings	Chair of the Trust	11
Brent Kilmurray	Chief Executive and Accounting Officer	12
Bev Reilly	Non-Executive Director Deputy Chair Chair of Quality Assurance Committee	11
Roberta Barker	Non-Executive Director Freedom to Speak up NED Champion	11
Ann Bridges	Executive Director for Corporate Affairs and Involvement	11
Mike Brierley	Assistant Chief Executive	12
Zoe Campbell	Managing Director North Yorkshire and York Care Group	11
Charlotte Carpenter	Non-Executive Director Chair of Strategy & Resources Committee	6
Hannah Crawford	Executive Director of Therapies	12
Sarah Dexter-Smith	Executive Director for People and Culture	12
Pali Hungin	Non-Executive Director Chair of Mental Health Legislation Committee	11 (11)
Kedar Kale	Executive Medical Director	9
John Maddison	Non-Executive Director Chair of Audit and Risk Committee	11

	Chair of Commissioning Committee Digital/Cyber NED Champion	
Elizabeth Moody	Director of Nursing and Governance	1 (1)
Beverley Murphy	Executive Chief Nurse	11 (11)
Jill Murray	Non-Executive Director Chair of People, Culture and Diversity Committee Wellbeing NED Champion	10
Jules Preston	Non-Executive Director Senior Independent Director	12
Liz Romaniak	Executive Director for Finance, Information and Estates	11
Patrick Scott	Managing Director, Durham Tees Valley and Forensic Care Group Assistant Chief Executive	12

(Note: The maximum number of meetings to be attended by those Board Members who held office during part of the year is shown in brackets)

Keeping informed of the views of Governors and members

The following arrangements were maintained during the year to ensure the Board was kept informed of the views of Governors and members:

- Regular meetings between the involving the Chair, the Managing Directors and the Director of Corporate Affairs and involvement and Governors in their Care Group areas.
- Attendance by Board Members at meetings of the Council of Governors.
- The provision of reports on the outcome of consultations with Governors, for example on the Our Journey To Change Delivery Plan.
- Governors encouraged to observe public Board meetings.
- Regular liaison between the Chair and the Lead Governor.
- Feedback from Governors on briefings circulated to them.

Jules Preston, as the Senior Independent Director, was also available to Governors if they had concerns regarding any issues which had not been addressed by the Chair, Chief Executive or other usual business arrangements.

In general, with regard to attendance at meetings of the Council of Governors:

- The Chair, as the chair of the Council, attends all meetings.
- There is a standing invitation for the Non-Executive Directors to attend meetings.
- Executive Directors attend meetings, if required, for example to deliver reports, or as observers.

The Council of Governors has powers to require attendance of a director at any of its meetings, under paragraph 26 (2) (aa) of Schedule 7 of the National Health Service Act 2006, for the purpose of obtaining information on the Foundation Trust's performance of its functions or the Directors' performance of their duties. The Council of Governors did not exercise these powers during 2022/23.

In total the Council of Governors held six formal meetings, including the Annual General Meeting (AGM), during 2023/24. Board Member attendance at these meetings was as follows:

Board member	No. of meetings attended (including AGM)
David Jennings	6
Brent Kilmurray	6
Roberta Barker	5
Ann Bridges	4
Mike Brierley	2
Zoe Campbell	4
Charlotte Carpenter	4
Hannah Crawford	3
Sarah Dexter-Smith	5
Pali Hungin	2(5)
Kedar Kale	3
John Maddison	4
Beverley Murphy	5
Jill Murray	4
Jules Preston	4

Board member	No. of meetings attended (including AGM)
Liz Romaniak	5
Bev Reilly	6
Patrick Scott	4

(The maximum number of meetings to be attended by those Board Members who held office during part of the year is shown in brackets)

Resolution of Disputes with the Council of Governors

A process has been established for the resolution of disputes between the Board and the Council of Governors.

Led by the Chairman or Deputy Chairman and supported by the Senior Independent Director, the process is based on discrete steps by which the matters in dispute are formally stated, considered and responded to.

If resolution cannot be achieved the view of the Board will prevail unless the issue falls within the Council of Governors' statutory powers.

Nothing within the process restricts the Council of Governors from informing NHS Improvement or the Care Quality Commission of relevant concerns.

The dispute resolution procedure was not invoked during the year.

Further details on the dispute resolution procedure are Provided in Annex 9 of our Constitution.

Evaluating Board Performance

The evaluation of the performance of the Board was undertaken:

- As part of the well-led review undertaken by Deloitte LLP during 2023/24. This included a Board Members survey, interviews with Board Members, focus groups involving a selection of senior staff and Governors and observations of a range of meetings.
- Through surveys of Board members on compliance with the terms of reference and effectiveness of the Board's committees.

Deloitte LLP had no other connection with the Trust or with any individual directors.

Appointments to the Board, terms of office and how appointments can be terminated

Appointments to the Board of Directors are made through open competition. They are overseen by the Nomination and Remuneration Committees of the Board and Council of Governors.

Formal, rigorous and transparent procedures are in place to ensure that all appointments:

- Are made solely in the public interest, with decisions based on integrity, merit, openness and fairness.
- Comply with CQC standards, NHS Employer standards, statutory requirements and the Code of Governance.
- Are made against objective criteria and, within this context, promote diversity of gender, social and ethnic backgrounds, disability, and cognitive and personal strengths.
- Promote service user and carer involvement and reflect our values and those of the broader NHS.

The terms of office of the Chair and Non-Executive Directors are usually for three years. They will be appointed for further terms, to a maximum of nine years, without the need for external competition, unless they fail to meet performance, independence or regulatory requirements or the skills and experience required on the Board have changed since their initial appointment. They may also be appointed to serve for more than nine years (three, three-year terms) if it is in the Trust's interest for them to do so, they remain independent and the reasons for the extension are approved by the Council of Governors.

The terms of office of Executive directors are not time limited.

Appointments can be terminated for the following reasons:

- By resignation
- By ceasing to be a public member of the Trust
- Upon becoming a Governor of the Trust
- Upon being disqualified by the Independent Regulator
- Upon being disqualified from holding the position of a director of a company
- Upon being adjudged bankrupt
- Upon making a composition or arrangement with, or granting a Trust deed for, his/her creditors
- Upon being convicted of any offence and a sentence of imprisonment being imposed (whether suspended or not) for a period of not less than three months (without the option of a fine)
- Upon removal by the Council of Governors at a general meeting
- If they cease to be a fit and proper person to be a director of the Trust in accordance with the Licence, the Constitution or the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The Board's Committees

As of 31st March 2024 there were six standing committees of the Board: the Audit and Risk Committee; the Mental Health Legislation Committee; the People, Culture and Diversity Committee; the Quality Assurance Committee; the Strategy and Resources Committee; the Nomination and Remuneration Committee.

The importance of the Board's committees in the delivery of our risk and control framework is described in the Annual Governance Statement.

The roles, functions and membership of the Committee are set out in their reports together with relevant disclosure required by the Code of Governance.

The terms of reference for each of the committees can be found at our website (www.tewv.nhs.uk).

The Audit and Risk Committee

The Committee remains responsible for providing the Board with advice and recommendations on matters which include the effectiveness of the framework of controls in the Trust, the adequacy of the arrangements for managing risk and how they are implemented and embedded, the adequacy of the plans of our auditors and how they perform against them, the impact of changes in accounting policy and the Committee's review of the Annual Accounts.

The Committee ensured a focus on the effectiveness of arrangements in place for counter fraud, anti-bribery and corruption to ensure that these met the NHS Counter Fraud Authority's requirements standards.

The Committee met its responsibilities during 2023/24 by:

- Reviewing the Board Assurance Framework.
- Reviewing risk and internal control-related disclosures, such as the Annual Governance Statement.
- Reviewing the work and findings of Internal Audit, including the Internal Audit annual plan.
- Reviewing the work and findings of External Audit, Mazars LLP.
- Reviewing the work and findings of the Local Counter Fraud Officer.
- Reviewing the process by which clinical audit is undertaken in the organisation.
- Receiving assurance that the organisation is compliant with the NHS England EPRR core standards and has an effective business continuity process in place.
- Reviewing the 2023/24 Financial Statements and Annual Report, prior to submission to the Board and NHS England
- Seeking assurance that the financial statements have been appropriately compiled on a going concern basis.

- Reviewing and approving the Trust's Standing Financial Instructions and Scheme of Delegation.
- Approving the Register of Interests for the Trust Board of Directors
- Seeking assurance in relation to the Trust's compliance with regulatory changes.
- Reviewing the schedule of losses and compensations, the annual fraud report and provided assurance to the Board following each of its meetings.
- Providing assurance to the Board on the effectiveness and robustness of the Trust's risk management arrangements and controls environment.
- Reviewing the adequacy of all risk and control related statements (e.g. the Annual Governance Statement) prior to endorsement by the Board.
- Reviewing the Assurance Framework, prior to its presentation to the Board.
- Monitoring progress with the embeddedness of the risk management framework and the CQC Improvement Plan in response to recommendations made in 2023.

In the review of internal audit and management assurance reports, Audit & Risk Committee identified three High, 13 Medium and ten Low risk rated findings to improve weaknesses in the design of controls and/or operating effectiveness.

The membership of the Audit and Risk Committee consists of at least three independent Non-Executive Directors. The Board should satisfy itself that the membership of the committee has sufficient skills to discharge its responsibilities effectively and ensure that at least one member of the committee has recent and relevant financial experience. The committee is chaired by Mr John Maddison who has been performing this role since 1 September 2020.

There were four meetings held during 2023/24. Meetings were held virtually.

Board member	No. of meetings attended
John Maddison (Chair)	4
Charlotte Carpenter	1
Jules Preston	3
Bev Reilly	4

The External Auditors

Mazars LLP have been the Trust's external auditors since 2013. Since that time the appointment has been subject to two competitive procurement exercises.

The cost of providing external audit services during 2023/24 was £96k excluding VAT. This includes the cost of the statutory audit, the independent review of the accounts of the charitable funds and the whole Government accounting return.

These services have been provided under the contract between the Trust and the firm entered into in 2023.

Details of the external audit fees, split between the statutory audit fees and other auditor remuneration, are provided in notes 7.1 and 7.2 to the accounts.

The Internal Auditors

Internal audit services are provided by AuditOne; a not-for-profit provider of internal audit, technology risk assurance and courter fraud services to the public sector in the North of England.

Preetha Kumar, Associate Director of Internal Audit (Digital), at AuditOne, is the Trust's Head of Internal Audit.

Each year the Audit and Risk Committee agrees an internal audit plan which sets out the reviews to be undertaken during the year which is aligned to the principal strategic risks identified by the Trust.

Progress reports are provided by the internal auditors to each meeting of the committee and contribute to the Head of Internal Audit's annual opinion on the Trust's system of internal control, which is used to inform the Annual Governance Statement.

Safeguarding auditor independence

The Audit and Risk Committee has agreed a policy to ensure that auditor objectivity and independence is safeguarded if the firm providing external audit services is commissioned to provide services outside of the external auditor's responsibilities. This policy stipulates that only the Chief Executive, Finance Director and Trust Secretary may commission the external audit firm for non-audit services and the appointment must be approved by the Chair of the Audit and Risk Committee.

Safeguards are required that:

- External audit does not audit its own firm's work.
- External audit does not make management decisions for the Trust.
- No joint interest between the Trust and external audit is created.
- The external auditor is not put in the role of advocate for the Trust.
- The external audit firm does not undertake certain functions including: preparation of accounting records and financial statements, advising on the selection, implementation or running of IS/IT systems, staff secondments, employee remuneration or selection and recruitment and finance or transaction services work within the Trust.

- The external auditor must ensure that the provision of non-audit services meets its own ethical standards and internal operational policies.

The Nomination and Remuneration Committee of the Board

The Nomination and Remuneration Committee is responsible for overseeing the appointment of executive directors and directors who report directly to the Chief Executive, including succession planning, and is responsible for deciding their terms and conditions of service (where they are not determined nationally).

The Committee is also responsible for:

- Authorising applications to NHS Improvement and HM Treasury for permission to make special severance payments to an employee or former employee.
- The agreement of locally determined terms and conditions of service for all TEWV staff employed on national medical terms and conditions and all staff paid at, or above, Agenda for Change Band 8.

The membership of the Committee comprises the Chair of the Trust and all the Non-Executive Directors. The Chief Executive is an ex-officio member of the Committee in relation to all matters pertaining to the appointment to those director positions (excluding the role of the Chief Executive) which fall within its remit.

Board member	No. of meetings attended
David Jennings (Chair)	1
Charlotte Carpenter	0
Jill Murray	1
Pali Hungin	1
John Maddison	1
Bev Reilly	1
Jules Preston	1
Roberta Barker	0

Advice and/or services were provided to the Committee by:

- Brent Kilmurray, Chief Executive
- Sarah Dexter-Smith, Director of People and Culture
- Phil Bellas, Company Secretary

Information of the work of the Committee is provided in the Chair's Statement as part of the Remuneration Report.

The Mental Health Legislation Committee (MHLC)

The Committee remains responsible for providing the Board with oversight and assurance to the Board on the Trust's compliance with the Mental Health Act 1983 (as amended); the Mental Capacity Act 2005, the Deprivation of Liberty Standards/Liberty Protection Standards and any statutory Codes of Practice.

It provides to the Board advice and recommendations on matters which include gaining assurance that mental health legislation is applied to each individual patient and that practice is compliant with statutory and regulatory requirements.

It also looks to identify themes arising from the findings of the Care Quality Commission following visits to Trust services and to gain assurance that appropriate learning and action is being undertaken in relation to them.

During 2023/24 the Committee:

- Received good assurance that the legislative requirements for patients held in the Trust on section 136 are being met, however there is work ongoing to address the growing numbers of people being detained in a 136-suite due to a lack of beds.
- Received substantial assurance that for **Discharges from Detention** the number of times detained patients are discharged by the Tribunal or Hospital Managers is very low and within normal range.
- Received substantial assurance relating to **Section 132b** that patients are being given their rights when first detained and a robust escalation process is in place for any patients who have not had their rights within three days of detention. Significant progress has been made over the last year with the process and next steps include working with NY Fundamental Standards lead to improve the flow of information on rights between the MHL department to clinicians, with the aim to be able to look at live data.
- There is reasonable assurance on the use of **Section 5 MHA 1983 Holding Powers**. Improvements are being made to increase awareness and oversight of the process by including information on Section 5 in the Trust's Fundamental Standards groups. Data quality is good.
- Received progress on establishing the **internal MHL operational groups and the inter-agency operational groups** with partners. These groups will

provide the governance link for internal operational matters and externally with key stakeholders like the Police and Local Authorities.

- Received good assurance on the **Scrutiny of MHA documentation (annual report)** that the administrative and medical scrutiny processes take place.
- Received substantial assurance that the CQC have been notified of every instance of **absence without leave (AWOL)**, 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.
- Received reasonable assurance that the Trust is meeting its requirements under the **Mental Capacity Act/Deprivation of Liberty Standards** and that the use and reporting of Deprivation of Liberty Standards is being carried out as required.
- **Received reasonable assurance related to Section 17 leave** 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 certain wards that haven't performed well and learning from the ones that have.
- Received 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.
- Considered the **Positive and Safe Improvement Plan.**
- Received substantial assurance that the CQC were notified of every instance of **absence without leave**, that the trust is required to notify them of.
- Received the outcome of an independent audit by Audit One on the rights and discharge information reported to the Mental Health Legislation Committee the outcome was that "governance, risk management and control arrangements provide substantial assurance that the risks identified are managed effectively. Compliance with the control framework was found to be taking place".
    - Noted that work is being undertaken to look at strengthening the processes to ensure patients have access to **the independent mental health advocacy service (IMHAR)**. The Trust operates an "opt out" system, where patients should be automatically referred unless they decide not to access the service.
    - Agreed, following consideration by Executive Directors to a small uplift to the recompense for panel members and the Chair at **Hospital Managers meetings**.

The membership of the mental health legislation committee consists of two independent Non-Executive Directors.

The Board should satisfy itself that the membership of the committee has sufficient skills to discharge its responsibilities effectively and ensure that at least one member of the committee has relevant experience in mental health legislation.

Membership of the committee during 2023/24 comprised:

- Pali Hungin, Non-Executive Director (Chair of the Committee) (left February 2024). Roberta Barker, Non-Executive Director replaced on 1 May 2024.
- Jules Preston, Non-Executive Director/Senior Independent Director (SID)
- Kadar Kale, Executive Medical Director
- Beverley Murphy, Executive Chief Nurse
- Zoe Campbell, Managing Director of North Yorkshire & York Care Group
- Patrick Scott, Managing Director of Durham, Tees Valley & Forensics Care Group

There were four meetings held during 2023/24. Meetings were held face to face, with the opportunity for attendees or observers joining on Teams.

Board member	No. of meetings attended
Pali Hungin (Chair)	4
Kedar Kale	2
Beverley Murphy	3
Jules Preston	3
Patrick Scott	4
Zoe Campbell	3

The People Culture and Diversity Committee

The People Culture and Diversity Committee is the principal provider of oversight and assurance to the Board on the delivery of the Trust's Strategic Goal "To co-create a great experience for our colleagues".

Its functions include:

- To gain assurance that the Trust understands its strategic workforce needs (including wellbeing, culture, recruitment, retention, development of people, and organisational capacity) and to oversee the development and monitoring of plans to progress their delivery.

- To review and gain assurance that:
    (a) The Trust's values and standards of behaviour are being practiced within all services and at all levels of the organisation.
    (b) The Trust is compliant with its statutory, regulatory and contractual obligations as an employer.
    (c) The Trust is compliant with the Equality Act 2010 including the Public Sector Equality Duty.

(d) The health and wellbeing of staff is being effectively promoted and supported.
(e) Arrangements for raising concerns, including the functions of the Freedom to Speak Up Guardian, meet national expectations and have the confidence of staff.
(f) Appropriate action is taken to support the transformation of services and teams where issues are identified.
(g) Effective and inclusive arrangements, which reflect best practice, are in place to communicate with and involve staff.
(h) Appropriate arrangements are in place to support and maintain good relations with employees including through their recognised trade unions and professional bodies.

- To keep abreast of changes in employment law and regulation; to draw the Board's attention to any significant risks and implications arising from them; and to obtain assurance on the appropriateness of mitigating actions proposed by management.
- To assess the delivery of its purpose though the establishment and monitoring of a range of workforce, cultural and behavioural metrics.
- Taking into account agreed risk appetite and tolerances, to identify and escalate any significant risks related to the Committee's purpose and functions to the Board of Directors.
- To review the scope, impact and management of risks contained within the Board Assurance Framework and the Corporate Risk Register, as relevant to its purpose and functions, and to gain assurance on the delivery and effectiveness of mitigation plans.
- To review and make recommendations to the Board on:
    (a) Changes to the staffing establishment, including financial and staffing implications, arising from strategic staffing reviews, major service changes or where quality or workforce concerns are identified which could impact on the delivery of Our Journey to Change or the Trust's statutory and regulatory obligations.
    (b) The appropriateness of the findings of external staffing reviews, including culture reviews, and management's response to them. In doing so the Committee shall take advice from the Quality Assurance Committee where quality issues/concerns are identified.
    (c) The efficacy of actions proposed by management to tackle NHS workforce equality and diversity issues including, but not limited to, the delivery of improvements on:
    (d) Pay gaps
    (e) National equality and diversity standards (WRES, WDES, SOWES)
    (f) The implementation of the Equality Delivery System of the NHS.

The Committee considered a wide range of topics during 2023/2024, brief highlights of some set out below.

The colleague stories during the year included an important reminder for the Committee to ensure that the Trust creates the conditions where Autistic strengths

are embraced in the workplace - a world which is designed by and for Neuro-typical people. In addition, the Committee supported exploring options such as **the Menopause Pledge or independent accreditation as an 'Menopause Friendly Employer'** due learning about the impact of the menopause on women's working lives. The Committee acknowledged the excellent work of individual volunteers and the Voluntary Services Team which supports 150-200 volunteers and services including therapy dogs, driving, delivering Covid items, the 'Check and Chat' service, volunteering on Inpatient Wards and even providing music sessions. The Team won 'Non-clinical Team of the Year' at the Positive Practice Awards.

Throughout the year there was considerable emphasis on the Workforce Delivery Plan, welcoming the overall growth in posts and the approval of the business case for future international recruitment to medical and nursing posts. In addition to recruitment, there was a focus on retention with the staff-led Health and Well-being (HWB) Council evaluating the impact of the Trust's HWB offers as they worked towards achieving the Silver Accreditation for the Better Health at Work Awards and providing a route for staff to decide how to spend charitable funds and raise further resources. A Trust-wide 'Thinking of Leaving' process and a 'transfer scheme' had been established to support staff who were uncertain about their current roles but would like to explore other options with the Trust.

Considerable work was undertaken on reducing violence and aggression towards staff. The new Freedom to Speak Up Policy (Whistleblowing/Raising Concerns) was agreed, based on the National Guardian's Office policy template as developed with NHS England/Improvement. The new partnership agreement with staff-side has been concluded and led to the establishment of a Corporate Local Consultative Council, mirroring those in the care groups and estates. Performance improvement plans were developed with metrics for safe staffing. The new people standards were agreed and the Board Integrated Performance Dashboard. The staff survey was undertaken with a 49% response rate.

The Committee continued to escalate concerns throughout the year in relation to the Corporate Risk Register, particularly about the further refinements needed to ensure the structure of the report to Committee effectively enabled the movement of risks between quarters to be tracked and provided explicit risk assurance (evidence) of risk management and mitigation, in relation to PCDC owned risks. The introduction of the 'Inphase' system from mid-late September 2023, following data transfer did not provide the anticipated mitigation. The Chair of the Committee continued to highlight the need for the report to include an 'at a glance' 'RAG' rating and a clear audit trail to record the risk mitigation (progress, stagnation or regress) and the reason for the changes to the risk score at the conclusion of the year. The other significant issue which was tracked throughout the year was review compliance which was 70% in May 2023 (a 10% drop) and at its lowest was 56% in December 2023. However, once staff had completed their 'InPhase' training, compliance had increased to 80%, by February 2024.

The Committee recommended to the Board that it published the Equality Delivery System 2022 for 2023 on the Trust website and confirmed the scoring process for

the selected services as ‘Developing’. At the Committee’s ‘Time Out’ session in January it explored the links between the Equality Delivery System and the work being undertaken on health inequalities. Areas for further consideration included engaging with communities and violence prevention and reduction work. The Committee confirmed it had good assurance throughout the year in relation to the work undertaken by the staff networks: BAME; Armed Forces; Neuro-diverse; Working Carers; and Long-Term Health Conditions. In addition, it noted the work of the Menopause Café. The Committee confirmed it had good assurance in relation to the work on gender and ethnicity pay gap reports and for following a robust process in analysing its staff data by protected group (the WRES, WDES, SOWES frameworks) and recommended approval of the publication of staff equality information on the Trust website.

In addition, throughout the year, the Committee received reports on its responsibilities in relation to the Trust’s apprenticeship workforce and the levy funding. It confirmed good assurance in relation to working with 24 providers and seeking to address health inequalities where possible through this.

As at 31 March 2024, the membership of the Committee comprised:

- Jill Murray, Non-Executive Director (Chair of the Committee)
- Roberta Barker, Non-Executive Director
- Sarah Dexter-Smith, Executive Director for People and Culture
- Ann Bridges, Executive Director of Corporate Affairs and Involvement
- Patrick Scott, Managing Director for Durham, Tees Valley Care Group/Deputy Chief Executive
- Zoe Campbell, Managing Director for North Yorkshire and York Care Group.

The Committee was established in September 2021, and four Committee meetings were held during the 2023/2024 year, plus one Committee development half-day meeting. Attendance at meetings was as follows:

Board member	No. of meetings attended
Jill Murray (Chair)	4
Roberta Barker	3
Sarah Dexter-Smith	4
Ann Bridges	3
Patrick Scott	4

Zoe Campbell	3

The Quality Assurance Committee

The Committee is responsible for providing assurance to the Board of Directors on the quality, safety and effectiveness of the Trust's clinical and operational services. It provides assurance to the Board that the Trust is discharging its duty of quality and safety in compliance with the Health and Social Care Act 2008 and ensures that standards of quality and safety as set out in the Fundamental Standards prescribed in the Health and Social Care Act (Regulated Activities) Regulations 2014 are being met.

The committee in gaining and providing assurance to the Board of Directors, monitors regulatory requirements and activities across each location, which enables the trust to maintain registration with the Care Quality Commission.

The committee has oversight and monitors other statutory and regulatory requirements and national guidance relating to quality and safety including but not limited to:

- Safe Staffing
- Infection Prevention and Control
- Safeguarding
- Medical Devices
- Medicines Management
- Mortality Reviews including Learning Disabilities Mortality Review (LeDeR)
- Health and Safety
- The Duty of Candour
- Complaints
- Serious Incidents

The Committee met its responsibilities during 2023/24 by:

- Reviewing the Board Assurance Framework.
- Reviewing the Corporate Risk Register.
- Receiving assurance from the Executive Review of Quality Group.
- Receiving the trust quality and learning report.
- Receiving reports on PALS/Complaints and Patient Carer Experience
- Reviewing the draft Quality Account.
- Receiving updates on Medicines Management
- Receiving progress on implementation of the recommendations following the CQC inspection in 2023.
- Reviewing the End of Life Trust Plan.
- Receiving progress reports on compliance with Infection, Prevention and Control.

- Receiving assurance from Safeguarding reports.
- Receiving progress reports on positive and safe and the reduction of restrictive interventions.
- Receiving progress reports on the implementation of PSIRF.
- Receiving progress on compliance with Duty of Candour.
- Physical healthcare was considered.
- Reviewing the Quality Assurance Programme
- Monitoring sexual safety and receiving the annual statement of compliance.

To provide assurance to the Board on those matters linked to the strategic risks of the trust the following escalated quality risks were reported to committee:

Feeling safe, serious incident recovery plan, waiting times, community transformation, impact of short staffing, performance with answering calls to the crisis lines, NICHE recommendations and environmental risks.

The Committee also received an internal audit report from AuditOne, on 'complaints review'.

The impact of the recommendations in the Edenfield Review were also considered and any actions the trust might need to take.

The membership of the quality assurance committee consists of three independent Non-Executive Directors.

There is currently a vacancy for a third Non-Executive Director on the committee following the resignation of Sir Pali Hungin as Non-Executive Director in February 2024.

The Board should satisfy itself that the membership of the committee has sufficient skills to discharge its responsibilities effectively and ensure that at least one member of the committee has clinical/medical experience.

The committee is chaired by Bev Reilly, who has been performing this role since 2020.

There were eight meetings held during 2023/24. Meetings were held face to face and virtually.

Board member	No. of meetings attended
Bev Reilly (Chair)	8
Zoe Campbell	6
Pali Hungin	7 (7)

Kedar Kale	5
Beverley Murphy	8
Patrick Scott	6
Hannah Crawford	5
Elizabeth Moody *	1 (1)

*Elizabeth Moody, former Director of Nursing and Governance resigned from post in May 2023. Beverley Murphy took up the role of Chief Nurse and executive lead for the committee from May 2023.

Following every meeting the Chair of the Committee reports to the next meeting of the Board of Directors, to advise of the business transacted and to escalate any material matters of concern or risks, which may require a response from the Board, or which might impact on the functions of another Board Committee.

The Committee undertook a review of its terms of reference in May 2023.

The Strategy & Resources Committee

The purpose of the Strategy and Resources Committee is to oversee the stewardship of the Trust's finances, investments, sustainability, reputation and physical and digital infrastructure on behalf of the Board of Directors. It also provides assurance to the Board of Directors

on delivery of the Trust's Vision and Strategy as articulated in "Our Journey to Change" and acts as lead Committee providing oversight and assurance on delivery of the Trust's Strategic Goal "To be a great partner".

The Committee's principal functions include:

- Leading the agreement of processes to develop and update the Trust Strategy and Business Plan, including related financial planning activities.
- Identifying and, where necessary, escalating any significant risks relating to the Committee's purpose to the Board, including in relation to financial performance.
- Providing assurance that the priorities identified in the Business Plan are aligned to, and will effectively deliver, the Trust Strategy.
- Gaining assurance that the non-staffing resources are appropriate and sufficient to deliver its Business Plan and are deployed effectively.

- Monitoring delivery of the Business Plan approved by the Board of Directors and assuring itself that any changes proposed by management will not impact materially on the delivery of Our Journey to Change.
- Gaining assurance that the priorities identified in the Business Plan are aligned to those of strategic partners.
- Reviewing the scope, impact and management of risks contained within the Board Assurance Framework and the Corporate Risk Register, as relevant to the Committee's purpose and functions, and gaining assurance on the delivery and effectiveness of mitigation plans.
- Receiving system updates and considering their alignment to the Trust Strategy, and drawing any opportunities, implications or risks to the attention of the Board.
- Overseeing investments and business cases for strategic projects and any statutory consultations on major service changes.

As at 1 April 2023 the membership of the Committee comprised:

- Charlotte Carpenter, Non-Executive Director (Chair of the Committee)
- John Maddison, Non-Executive Director
- Roberta Barker, Non-Executive Director
- Liz Romaniak, Director of Finance, Estates and Facilities
- Mike Brierley, Assistant Chief Executive
- Ann Bridges, Director of Corporate Affairs and Involvement

The Committee held six meetings during 2023/24 and the Chair of the Committee reported alerts, assurances, advisory and escalation issues to the Board of Directors. Attendance during the year was as follows:

	No. of meetings attended
Charlotte Carpenter (Chair)	6
Roberta Barker	5
Ann Bridges	5
Mike Brierley	5
John Maddison	6
Liz Romaniak	5

The Committee agreed:

- Outputs from a significant mid-year reforecast of the position for 2023/24 in November 2023 and associated assumptions, risks and mitigation/opportunities and a recommendation that the Trust continue to forecast a break even position for 2023/24.
- Arrangements for developing the 2024/25 Delivery Plan.
- To recommend a Sensor Door Business Case for approval by Board of Directors.
- A procurement approach and financial envelope for the procurement of Secure Patient Transport which would help to reduce recurrent costs.
- Proposed arrangements to transition to an alternative Food Supplier, considering NHS Supply Chain advice and permitted Framework options to ensure continuity of provision.

The Committee considered:

- An update on the Trust's underlying financial position.
- The 2023/24 draft financial plan and detailed associated assumptions at an extraordinary meeting before approval of plans by the Board.
- That several technical issues would impact the Trust's annual accounting statements for 2023/24, including a re-evaluation of right of use assets (leased).
- Risks from non-recurrent mitigation of the under delivery of recurrent efficiencies and impact on the forward financial position.
- Progress to develop the Trust's 2024/25 financial plan.
- Strategic and Corporate risks assigned to it by the Board at each meeting, including in relation to Infrastructure, Cyber Security, Financial Sustainability and EPR.
- Committee Metrics within the Board Integrated Performance Dashboard and a deep dive on Unique Caseload.
- Receipt of EPR programme updates including on the critical path to complete all essential work, revised arrangements for the detailed oversight of the project and for the Project Board, with oversight via the NHSE Digital team as part of their Frontline Digitisation work.
- Updates on partnership work including developing a NENC Medium Term Financial Plan and on Humber and North Yorkshire Mental Health Collaborative Developments.
- An update on the Estates Master Plan and related workstreams.

The Committee received assurance:

- That the approach to cash management demonstrated strong financial governance.
- From Finance Reports at each meeting, about the effectiveness of actions to identify, develop and progress mitigations that addressed projected risks to delivery of break even and deliver 'Control Totals' approved through the mid-year reforecast.
- From actions to identify additional recurrent efficiencies, including: from LED lighting installation at several sites, from significant reductions in agency

Whole Time Equivalents and following discharge of some patients with complex care packages.

- Through 3 quarter end Delivery Plan updates, on progress or challenges in delivering against agreed milestones.
- On processes to ensure an accurate national cost collection submission and approved the submission.
- That proposed changes to the Safe Staffing Group and its workstreams for routine annual inpatient establishment reviews were appropriate to support consideration of financial impacts.
- On processes to complete and submit National ERIC, PLACE and PAM submissions and develop, deliver and oversee annual improvement plans.
- From the Green Plan update, where progress was limited, due to recruitment challenges following retirement of the Trust's specialist.

The Council of Governors

The statutory duties of our Council of Governors are:

- To hold the Non-Executive Directors individually and collectively to account for the performance of the Board
- To represent the interests of the members of the Trust as a whole and the interests of the public

It has specific responsibilities which it exercises by itself or in conjunction with the Board of Directors. These include:

- To develop our membership and represent their interests
- To assist with the development of the Trust's strategy
- To appoint or remove the Chairman and the Non-Executive Directors and to determine their remuneration and other terms and conditions of service
- To approve the appointment of the Chief Executive
- To receive the annual accounts and annual report
- To appoint or remove the Trust's external auditor
- To determine proposals to increase the proportion of the Trust's income earned from non-NHS sources by 5% or more in any financial year
- To determine (in conjunction with the Board of Directors) any proposed changes to the Trust's Constitution
- To determine (in conjunction with the Board of Directors) any questions on mergers, acquisitions or separation of the Trust or whether it should be dissolved
- To determine any significant transactions (as defined in the Constitution) proposed by the Board of Directors
- To consider any matters raised by the Care Quality Commission or NHS Improvement which might affect the Trust's compliance with the terms of its Licence or its registration of services

The Composition of the Council of Governors as at 31st March 2024

(54 seats)

(Note: The composition of the Council has been amended. Details are provided in the Trust's Constitution)

The Lead Governor

In accordance with the Code of Governance, the Lead governor has a role in facilitating direct communication between NHS England and the NHS foundation trust's Council of Governors (CoG). This is in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the chair or the company secretary.

For 2023/24 the Lead Governor was Ann McCoy.

Membership of the Council of Governors during 2023/24

Information on the Governors who held office during 2023/24, including their attendance at the six meetings of the Council, is presented below.

Public Governors

Constituency / Class / Organisation	Name	Term of Office (From – To)	CoG meeting attendance incl. AGM (No. of eligible meetings)
Darlington	Joan Kirkbride	01/07/2023 - 30/06/2026	4 (6)
Darlington	Audrey Lax	01/09/2020 - 30/06/2023	0 (1)
Middlesbrough	Mary Booth	01/07/2023 - 30/06/2026	5 (6)
Middlesbrough	Alicia Painter	01/07/2022 - 30/06/2025	5 (6)
Scarborough and Ryedale	Keith Marsden	01/09/2020 - 30/06/2023	0 (1)
Scarborough and Ryedale	Judith Webster	01/07/2023 - 30/06/2026	5 (6)
Scarborough and Ryedale	Lisa Holden	01/07/2022 - 30/06/2025	0 (0)
Redcar and Cleveland	Alan Williams	01/07/2022 – 10/09/2023	0 (3)
Stockton-on-Tees	Gillian Restall	01/07/2023 - 30/06/2026	6 (6)
Stockton-on-Tees	Megan Harrison	01/07/2022 - 30/06/2023	0 (1)
Stockton-on-Tees	Dr Judy Hurst	01/07/2022 - 30/06/2025	3 (6)
Stockton-on-Tees	Gary Emerson	01/07/2023 - 30/06/2026	4 (5)
Durham	Jill Wardle	01/07/2023 - 30/06/2026	5 (6)

Durham	Pamela Coombs	01/07/2023 - 30/06/2025	2 (5)
Durham	Dominic Haney	01/07/2023 – 02/01/2024	3 (5)
Durham	Graham Robinson	01/07/2022 - 30/06/2025	3 (6)
Durham	Joan Aynsley	01/07/2023 - 30/06/2026	5 (6)
Durham	Mac Williams JP	01/07/2023 – 23/02/2024	3 (4)
Durham	David Moore	01/07/2023 – 14/09/2023	0 (2)
Durham	Jacci McNulty	01/09/2020 – 30/06/2023	0 (1)
Durham	Lynne Ackland	01/07/2022 – 25/04/2023	0 (0)
Hartlepool	Zoe Sherry	01/09/2023 - 30/06/2026	5 (6)
Hartlepool	Jean Rayment	01/07/2022 - 30/06/2025	4 (6)
Hambleton and Richmondshire	John Yorke	01/07/2023 – 08/04/2024	5 (5)
Hambleton and Richmondshire	Stanley Stevenson	01/09/2020 - 30/06/2023	0 (1)
Hambleton and Richmondshire	Roger Tuckett	01/07/2022 – 07/09/2023	1 (1)
Harrogate and Wetherby	Hazel Griffiths	01/07/2022 - 30/06/2025	6 (6)
Harrogate and Wetherby	John Green	01/07/2022 - 30/06/2025	3 (6)
York	Christine Hodgson	01/07/2021 - 30/06/2024	5 (6)
York	Dr Martin Combs	01/07/2021 - 30/06/2024	4 (6)

York	Susan Croft	01/07/2022 - 30/06/2024	1 (6)
Selby	Gemma Birchwood	01/09/2023 - 30/06/2026	4 (6)
Selby	John Venable	01/09/2020 - 30/06/2023	0 (1)

Staff Governors

Constituency / Class / Organisation	Name	Term of Office (From – To)	CoG meeting attendance incl. AGM (No. of eligible meetings)
Corporate Directorates	Cheryl Ing	01/07/2023 - 30/06/2024	4 (5)
Durham, Tees Valley and Forensics Care Group	Jane King	01/07/2021 - 30/06/2024	1 (6)
Durham, Tees Valley and Forensics Care Group	Clive Mackin	01/07/2023 – 30/06/2024	3 (5)
Durham, Tees Valley and Forensics Care Group	Emmanuel Chan	01/09/2020 - 30/06/2023	0 (1)
Durham, Tees Valley and Forensics Care Group	Heather Leeming	01/07/2023 - 30/06/2024	3 (6)
North Yorkshire and York Care Group	Sarah Blackamore	01/07/2022 - 30/06/2023	0 (1)

Appointed Governors

Constituency / Class / Organisation	Name	Term of Office (From – To)	CoG meeting attendance incl. AGM

			(No. of eligible meetings)
University of Sunderland	Catherine Lee-Cowan	Appointed 27/10/2022	3 (6)
University of York	Rob Allison	Appointed 01/04/2022	2 (6)
Stockton Borough Council	Cllr Ann McCoy	Appointed 08/07/2014	5 (6)
Darlington Borough Council	Kevin Kelly	Appointed 13/08/2015	0 (6)
Durham County Council	Lee Alexander	Appointed 03/01/2017	0 (6)
North Yorkshire County Council	Cllr Roberta Swiers	Appointed 20/03/2023	5 (6)
City of York Council	Cllr Claire Douglas	Appointed 04/08/2023	2 (4)
City of York Council	Cllr Derek Wann	26/06/2019 – 26/05/2023	0 (0)
City of York Council	Cllr Nigel Ayre	26/05/2023 – 04/08/2023	1 (2)
Hartlepool Borough Council	Cllr Moss Boddy	Appointed 07/11/2022	3 (6)
Redcar and Cleveland Borough Council	Cllr Mary Ovens	03/11/2022 – 02/08/2023	0 (2)
Redcar and Cleveland Borough Council	Cllr Lisa Belshaw	Appointed 02/08/2023	1 (4)

Note: The maximum number of meetings to be attended for those Governors who held office during part of the year is shown in brackets

Details of company directorships or other material interests in companies held by Governors where those companies or related parties are likely to do business, or are possibly seeking to do business with the Trust, are included in the “Register of Interests of the Council of Governors”. This document is available for inspection on our website.

Elections held during 2023/24

Public Governors

Constituency Name	Date of Election	No of Seats	No. of candidates	No. of Votes cast	No. of eligible voters	Turnout (%)
Darlington	30/06/23	2	1	-	-	-
Durham	30/06/23	6	7	99	2063	5%
Hartlepool	30/06/23	1	1	-	-	-
Hambleton and Richmondshire	30/06/23	1	2	23	458	5%
Harrogate and Wetherby	30/06/23	1	0	-	-	-
Middlesbrough	30/06/23	1	3	49	1033	5%
Redcar and Cleveland	30/06/23	1	0	-	-	-
Rest of England	30/06/23	1	0	-	-	-
Selby	30/06/23	2	1	-	-	-
Stockton-on-Tees	30/06/23	2	2	-	-	-
Scarborough and Ryedale	30/06/23	2	1	-	-	-

Staff governors

Constituency Name	Date of Election	No of Seats	No. of candidates	No. of Votes cast	No. of eligible voters	Turnout (%)
Corporate Directorates	30/06/23	1	1	-	-	-
Durham, Tees Valley and Forensics Care Group	30/06/23	2	3	330	4709	7%
North Yorkshire and York Care Group	30/06/23	1	0	-	-	-

All elections to the Council of Governors have been administered and overseen by Civica Election Services to ensure independence and compliance with the election rules contained within the Trust's Constitution.

Report of the Council of Governors' Nomination and Remuneration Committee

Chaired by the Chair of the Trust, the Nomination and Remuneration Committee supports the Council of Governors undertake its duties regarding the appointment and setting the remuneration and terms of service of the Chairman and Non-Executive Directors.

The Committee met three times during 2023/24. The business transacted by the Committee was as follows:

- To consider the outcome of the Chair's appraisal.
- To receive an update on the appraisals of the Non-Executive Directors.
- To review and make recommendations on the re-appointment of a Non-Executive Director to the Council of Governors.
- To consider a report from the Senior Independent Director on compliance with the Fit and Proper Persons Test.
- To consider the arrangements for the appointment of a new Non-Executive Director.

The membership of the Committee during 2023/24 and attendance at this meeting was as follows:

Name	Position	No. of meetings attended
David Jennings	Chair	1
Mary Booth	Public Governor	2
Graham Robinson	Public Governor	2
Jill Wardle	Public Governor	3
Jules Preston	Senior Independent Director	2

Notes:

- *The maximum number of meetings to be attended by Members of the Committee is shown in brackets*
- *The Senior Independent Director is an ex officio member of the Committee when matters relating to the appointment and appraisal of the Chair of the Trust are being considered)*
- *Bev Reilly (Deputy Chair) attended and chaired a meeting of the Committee in February 2024 in the absence of Mr Jennings*

The terms of reference of the Committee are available on the Trust's website.

Training and Development

Under the National Health Service Act 2006 the Trust has a duty to equip Governors with the skills and knowledge they require to undertake their role.

Mandatory training is offered via NHS Providers (including Governwell), NHS England and the CQC, and all Governors are encouraged to participate on an ongoing basis. Non-statutory training is available to all Governors, and specific training is available for those Governors with key responsibilities.

Governor training and development is very important to the Trust, and our Governors continue to be involved in co-creating their training and development needs and requirements, as well as future priorities.

Governor participation in the development of the Operational and Business Plan

Governors were involved in the development of TEWV's Delivery Plan in two main ways. The first was through formal meetings of the Council of Governors. A working draft was considered at the March meeting of Council of Governors and the final draft of the plan was considered at their June meeting. Both of these meetings were in advance of the Board of Directors' consideration of the document and so governor comments were fed into the Board's discussion.

Governors were also invited to the Trust's stakeholder planning workshops which took place in November 2023 and May 2024. This allowed governors to engage with lead clinicians, senior managers, partners and members of the Trust's lived experience planning reference group around the Trust's priorities and plans.

Governors who are also service users or carers were also eligible to join the lived experience planning reference group and some did so, making a valuable contribution to the planning process including feeding into the Trust's assessment of strengths and weaknesses which is featured in the plan.

Membership report

The first way Membership is important in helping to make us more accountable to the people we serve, to raise awareness of mental health and learning disability issues and assists us to work in partnership with our local communities.

Public membership

Anyone (unless eligible to join the staff constituency) aged 14 or over who lives in the area covered by the public constituencies (as described in the constitution) may become a public member of the Trust.

Staff membership

All staff employed by the Trust (including those on a temporary or fixed term contract of 12 months or more) are eligible to become members of the staff constituency

Members of staff are "opted in" upon commencement of employment and given the choice to "opt out" of membership in writing

As at 31st March 2023 the Trust's membership was as follows:

- Public members – 8,863
- Staff members – 7,774

The following table provides an analysis of our public membership compared to the population covered by the Trust:

Public constituency	Number of members	Eligible membership
Age (years):		
0-16	2	381,785

17-21	108	117,417
22+	8,326	1,550,539
Ethnicity:		
White	8,083	1,897,919
Mixed	55	17,513
Asian or Asian British	152	40,256
Black or Black British	75	7,935
Other	23	5,452
Socio-economic groupings*:		
AB	1,937	167,186
C1	2,443	260,198
C2	2,015	204,836
DE	2,422	262,895
Gender analysis		
Male	2,951	1,008,556
Female	5,849	1,041,183
Other	4	-

Notes:

The above analysis excludes:

- *427 public members did not provide a date of birth*
- *475 members did not state their ethnicity*
- *63 members with no gender*

Member Engagement

The focus of the Trust is to grow a representative membership to ensure accountability through engaging with its members.

The Trust has levels of membership (support, informed, active and involved member) from which members can choose, so that their engagement with the Trust is aligned to their aspirations.

Membership activities continued throughout 2023/24 including:

- Emails sent to new members welcoming them to the Trust.
- Governor elections were held.
- Personal invitations were sent for the Annual General and Members' meeting.
- Targeted invitations were sent to members in the Stockton area for a 'meet the governors' event held in the area.
- The Trust continued its use of social media to encourage attendance at meeting of the Board and Council of Governors.
- Members, who were also registered as involvement members, participated in a wide range of involvement and engagement activities.
- A membership email newsletter was launched.

Members wishing to contact Governors and/or Directors of the Trust can do so via the Corporate Affairs and Involvement Directorate on 01325 552068, email tewv.ftmembership@nhs.net or via our website www.tewv.nhs.uk/get-involved/membership/

Applications for membership should be sent to the Company Secretary's Department at West Park Hospital or submitted using the online form on the Trust's website.

NHS system oversight framework

The NHS System Oversight Framework outlines NHS England's approach to NHS oversight, providing the framework for overseeing systems including providers and identifying potential support needs. The framework looks at five national themes:

- Quality of care, access and outcomes
- Leadership and capability
- People
- Preventing ill health and reducing inequalities
- Finance and use of resources, and a sixth theme focusses on local strategic priorities

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

Our Trust has been placed in segment 3.

This segmentation information is the Trust's position as at 31 March 2024. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England and NHS Improvement website:

https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/.

Modern Slavery Act statement

Commitment

This statement has been published in accordance with the requirements of Section 54 (1) Modern Slavery Act 2015. It sets out the steps taken by Tees, Esk and Wear Valleys NHS Foundation Trust during the financial year ended 31 March 2024 to ensure modern slavey and human trafficking is not taking place in any part of our business or any of our supply chains. The Trust has a zero tolerance approach to modern slavery within our organisation and supply chains. We are committed to improving our practices to enable us to ensure slavery and human trafficking is not taking place in any of our supply chains, and in any part of our business.

Organisation Structure and supply chains

Whether we are providing education, prevention, crisis or specialist care, we are committed to working in partnership with our patients, communities and partners to help the people of our region feel safe, understood, and cared for. We have restructured our organisation to ensure that we work closely with communities and partners in each of our local places.

The trust has two wholly owned subsidiary companies "Positive Individualised Proactive Support Limited", and "TEWV Estates and Facilities Management Limited". "TEWV Estates and Facilities Management Limited" was made dormant during 2019/20. Positive Individualised Proactive Support Limited have a Moden Slavery Policy as required for a business with a turnover of less than £32million. They undertake risk assessments and staff training.

Policies in relation to slavery and human trafficking

The Trust has a number of polices which support our commitment to preventing modern slavery and human trafficking as well as providing a framework for staff to identify and raise concerns where necessary. These policies are reviewed regularly.

Freedom to Speak up and whistleblowing policy.

This policy provides employees with the means to raise genuine concerns about malpractice, patient safety, financial impropriety, bribery, corruption, criminal offences or any other serious risks without fear. This policy has been reviewed this year in line with national guidance.

Human Rights, Equality Diversity and Inclusion Policy

As a major employer and provider of services, we are committed to advancing equality of opportunity and providing fair access and treatment in employment and

when delivering or procuring services or working in partnership. Our Human Rights, Equality, Diversity and Inclusion Policy make clear the Trust's responsibilities under the Equality Act and Human Rights Act. We are committed to equality, diversity and inclusion and have a range of equality network groups, all of which are sponsored by an executive and therefore have a voice at Board.

Recruitment and selection procedure

We undertake our own recruitment activity through in-house functions. Robust processes are in place to ensure that the policy is adhered to and all staff with a responsibility for recruitment and selection must be aware of their legal obligations under existing employment legislation. Agency worker appointments are subject to the same rigour as staff appointed by the Trust, for example, Disclosure and Barring Service (DBS) checks (where applicable); proof of eligibility to work in the UK; any gaps in employment history. We work closely with our counter fraud team to ensure we act on any concern or advice they raise and have run a series of events for staff to raise awareness of fraudulent activity including at the recruitment stage.

Safeguarding

Our Safeguarding adult and safeguarding children policies support the Trust's commitment to preventing modern slavery and human trafficking and provide staff with clear routes to raising any concerns they may have about this issue. It is included in safeguarding training and advice about modern slavery and human trafficking is available to staff through the safeguarding team.

Procurement and our supply chain

The Trust understands the vital role procurement plays in preventing acts of modern slavery within both its business and supply chain. In line with this commitment, the Trust imposes those high standards on its suppliers.

The Trust uses the services of County Durham and Darlington Foundation Trust for its procurement processes. When undertaking procurement processes bidding suppliers are asked to confirm if they are a commercial organisation as defined in Section 54 ("Transparency in supply chains etc.") of the Modern Slavery Act 2015 ("the Act"). If they answer yes to this question they are asked if they are compliant with the annual reporting requirements contained within Section 54 of the Act. Such self-declarations are endorsed within the Public Contracts Regulations (PCR) 2015. Should there be any concerns with their self-declaration the responsible procurement officer will investigate accordingly. In addition, the Procurement team works with suppliers to identify and minimise ethical issues in supply chains by investigating abnormally low bids in line with the PCR 2015 and challenging the status quo,

including but not limited to; modern slavery, corruption, bribery, and human trafficking.

Through our procurement processes we seek assurance that our Agency worker supplier is complying with its duties under the Act. The Trust uses the National Framework for the Provision of Clinical and Healthcare staffing which contains clauses obliging suppliers to comply with the Modern Slavery Act and include clauses in their contracts with subcontractors anti- slavery and human trafficking.

Risk assessment and management

The Trust's risk management process is used to ensure risks are identified and mitigated with appropriate controls. Concerns raised through any route (e.g., incident report, Freedom to Speak Up/ Whistleblowing concerns, safeguarding concern or line manager) are investigated.

Priorities for 2024/25

The Trust will continue to work with partner organisations to identify any risks around modern slavery and will continue to engage in further training as it becomes available.

Accounting Officer statement

Statement of the chief executive's responsibilities as the accounting officer of Tees, Esk and Wear Valleys NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England has given Accounts Directions which require Tees Esk and Wear Valleys NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Tees Esk and Wear Valleys NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the accounting officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed

Brent Kilmurray

Chief Executive

Date: 25 June 2024

Annual Governance Statement 2023/24

Scope of responsibility

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Tees Esk and Wear Valleys NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Tees Esk and Wear Valleys NHS Foundation Trust for the year ended 31 March 2024 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust's governance arrangements, including its internal control and risk management processes, are designed to support, and provide continual assurance on, the delivery of Our Journey to Change.

The risk and control framework is overseen by the Board of Directors which has also retained responsibility for the approval of risk management policies; setting the organisation's risk appetite and risk tolerances; and establishing the tone and culture for risk management in the Trust.

A dynamic Board Assurance Framework and operational risk management arrangements are maintained through which the Board, and its committees, can monitor and gain assurance that a satisfactory level of internal control is being achieved.

The Audit and Risk Committee provides independent assurance to the Board on risk management and internal control. As set out in the Annual Report, membership of this Committee is limited to independent Non-Executive Directors.

Other Board committees have responsibility for scrutinising and monitoring relevant risks, both strategic and operational, and providing assurance to the Board that they are being managed and mitigated effectively.

Risk management groups are established and embedded in both the executive and care group levels of the organisation. These support the flow of assurance through the care group boards, the Executive Directors Group, the Board's committees to, ultimately, the Board ensuring that risks of all types are identified and, where practicable, controlled to an acceptable level.

As the Chief Executive I have responsibility and accountability for maintaining a sound system of internal control, assurance and risk management that supports the achievement of the organisation's objectives.

I discharge these duties through the Executive Directors with the clear designation of accountability to individuals, in line with their portfolios, to support me in this role.

The arrangements are subject to ongoing development and refinement based on learning from good practice. This has been provided though:

- a range of governance reviews including those commissioned externally from the Good Governance Institute and Deloitte LLP and undertaken internally to provide assurance on the implementation of the new structures introduced during 2022/23;
- guidance received from NHS England's Intensive Support Team particularly on quality governance; and
- the findings of, and recommendations arising from, external inspections and investigations.

The Trust's risk management arrangements are supported by an accountability framework which provides for a devolved, high-trust and more empowered way of working and governs the relationships between the Board, the Executive Directors Group, the care group boards and other corporate structures. It frames how individual teams and the various levels of our structure operate and provides clarity around roles, responsibilities and the expectations of each part of the leadership and governance arrangements.

Within clinical, operational and corporate services, senior managers are responsible for ensuring they, and their staff, fulfil their responsibility for risk management by operating in accordance with the Trust's systems, policies and procedures and ensuring that risks are identified and escalated appropriately within the Trust's governance structures.

All staff (including contractors and agency staff) are required to be familiar and comply with the Trust's risk-related policies and relevant professional guidelines and standards. They are expected to have an awareness of risk in the performance of their day-to-day duties and to escalate situations which present risk.

Capacity to handle risk has been enhanced with the appointment of a dedicated and qualified Head of Risk Management whose responsibilities include supporting the day-to-day management of the Trust's risk registers; the review, development and embedding of the Trust's Organisational Risk Management Policy; and designing and implementing the provision of training on risk management across the organisation.

Risk management training, aligned to ISO 31000 guidelines, continues to be delivered to agreed levels of staff across the organisation. One to one and team-based sessions are also undertaken to supplement and support the formal training.

Basic risk management awareness and training are incorporated into the national patient safety training.

The implementation of a new incident and risk management system, "Inphase", during 2023/24 has improved risk management through increased visibility, triangulation and compliance, and enhanced our overall learning culture.

The risk and control framework

The key elements of the Trust's risk management arrangements, including how risks are identified, evaluated and controlled, are detailed in the Organisational Risk Management Policy.

Risk appetites, the amount and type of risk that an organisation is willing to accept in order to meet its objectives, have been defined using a matrix developed by the Good Governance Institute. These are reviewed annually by the Board based on an assessment of the Trust's overall risk profile.

Risk tolerances, the maximum amount of risk the Trust is willing to accept, have also been established for each type of risk.

Risks, or changes in risk, are identified from a number of sources, both internal and external to the organisation, for example:

Internal - though risk assessments; the development of the business plan; consultations with staff and patients; internal inspections and audits; and complaints, incidents and claims.

External – through assessments by regulators; environmental appraisals; intelligence from regional partnerships/developing system arrangements and information disseminated by national bodies; consultation with external stakeholders; and benchmarking.

A standardised approach to risk assessment, scoring and grading is used. This includes the assignment of initial, current and target scores. These scores are

based on a 5 x 5 matrix for consequence and likelihood supported by descriptors of severity levels for each type of risk.

Controls in place to manage risk and related sources of assurance, positive assurance, gaps in control and assurance and mitigation plans are identified for each risk.

A key part of the risk and control framework is the Board Assurance Framework (BAF). This provides a method for seeking assurance over the management of the principal strategic risks to meeting the Trust's strategic objectives as set out in "Our Journey to Change".

The format of the BAF has been improved in response to recommendations from the Care Quality Commission and the Trust's Internal Auditors and feedback from the Board's committees. Alignment with other key processes, for example, the integrated performance assurance approach, has been strengthened.

During 2023/24 the Board reviewed and revised the risks included in the BAF reflecting changes in the Trust's external environment and the development of the new strategic journeys.

As at 31st March 2024 the following strategic risks were included in the Board Assurance Framework:

Ref	Strategic Goals			Risk Name and Description	Risk Grade	Oversight Committee
	To co-create a great experience for our patients, carers and families	To co-create a great experience for our Colleagues	To be a great partner			
1	✓	✓		**Safe Staffing** There is a risk that some teams are unable to safely and consistently staff their services caused by factors affecting both number and skill profile of the team. This could result in an unacceptable variance in the quality of the care we provide, a negative impact on the wellbeing and morale of staff, and potential regulatory action and a lack of confidence in the standard of care.	High	People Culture and Diversity Committee
2	✓			**Demand** There is a risk that people will experience unacceptable waits to access services in the community and for an inpatient bed caused by increasing demand for services, commissioning issues and a lack of flow through services resulting in a poor experience and potential avoidable harm.	High	Quality Assurance Committee

3	✓			**Co-creation** There is a risk that if we do not fully embed co-creation caused by issues related to structure, time, approaches to co-creation and power resulting in fragmented approaches to involvement and a missed opportunity to fully achieve OJTC	Moderate	Quality Assurance Committee
4	✓	✓	✓	**Quality of Care** There is a risk that we will be unable to embed improvements in the quality of care consistently and at the pace required across all services to comply with the fundamental standards of care; caused by short staffing, the unrelenting demands on clinical teams and the lead in time for significant estates actions resulting in a variance in experience and a risk of harm to people in our care and a breach in the Health and Social Care Act.	High	Quality Assurance Committee
5	✓	✓	✓	**Digital** There is a risk that failure to implement appropriate, cost effective and innovative approaches to digital infrastructure, caused by lack of resources, infrastructure challenges and digital expertise resulting in limited delivery of OJTC goals today and for the future.	Scope of risk subject to review	Strategy and Resources Committee
6	✓	✓	✓	**Estate / Physical Infrastructure** There is a risk of delayed or reduced essential investment caused by constrained capital resources resulting in an inability to adequately maintain, enhance or transform our inpatient and community estate, adversely impacting patient and colleague outcomes/experience.	Moderate	Strategy and Resources Committee
7	✓	✓	✓	**Cyber Security** There is a risk of a successful cyber-attack or breach, caused by global threats, digital and data security and literacy, resulting in compromised patient safety, business continuity, systems and information integrity and loss of confidence in the organisation.	Scope of risk subject to review	Strategy and Resources Committee
8	✓	✓	✓	**Quality Governance** There is a risk that our floor to Board quality governance does not provide thorough insights into quality risks caused by the need to further develop and embed our governance and reporting including triangulating a range of quality and performance information resulting in inconsistent understanding of key risks and mitigating actions, leading to variance in standards.	Moderate	Quality Assurance Committee
9			✓	**Partnerships and System Working** There is a risk that failure to take a proactive role and engage effectively with partners caused by capacity challenges including spanning 2 ICSs and multiple local authorities limits our ability to influence service transformation and improve the health of the communities we serve.	Moderate	Strategy and Resources Committee

10			✓	**Regulatory compliance** There is a risk that failure to comply with our regulatory duties and obligations, at all times, could result in enforcement action and financial penalties and damage our reputation	Moderate	Board
11	✓	✓	✓	**Roseberry Park** There is a risk that the necessary Programme of rectification works at Roseberry Park, limited access to capital funding, and associated PFI termination legal case could adversely affect our service quality, safety, financial, and regulatory standing.	High	Board
12	✓	✓	✓	**Financial Sustainability** There is a risk that constraints in real terms funding growth caused by government budget constraints and underlying financial pressures could adversely impact on the sustainability of our services and/or our service quality/safety and financial, and regulatory standing	High	Strategy and Resources Committee
13	✓	✓	✓	**Public confidence** There is a risk that ongoing external scrutiny and adverse publicity could lead to low public and stakeholder perception and confidence in the services we provide	High	Board

Operational risks are managed, monitored and escalated within the Trust's governance structure based on their current score. Two risk registers are in place for high risks (those with a score of 15+) differentiated by those risks having cross organisational significance (the Corporate Risk Register) and those impacting on discrete services.

Our broader governance structures and processes help to ensure that there are effective controls and escalation mechanisms in place to support decision-making and risk management.

All the Board's committees have responsibility for providing assurance to the Board on the management of risks; the effectiveness of controls; and for identifying and escalating new risks that could impact on the Trust's ability to deliver Our Journey to Change.

The Audit and Risk Committee has specific responsibilities for:

- Providing assurance to the Board on the effectiveness and robustness of the Trust's risk management arrangements and controls environment.
- Reviewing the adequacy of all risk and control related statements (e.g. the Annual Governance Statement) prior to endorsement by the Board.
- Reviewing the Assurance Framework, prior to its presentation to the Board, to provide assurance on its coverage and comprehensiveness and the appropriateness and effectiveness of the mitigations for each principal risk.

The Committee utilises reports from management, including from the Executive Risk Group, and Internal Audit, in assessing the effectiveness of the Board Assurance Framework and risk management as components of the internal control framework.

A monitoring and assurance flow is in place through the care group boards, and their individual risk groups, through the Executive Risk Group to the Executive Directors Group.

At an executive level, the Executive Directors Group gains assurance that organisational risks are being appropriately managed, assurance/mitigations are correctly identified and actioned. The Executive Risk Group has a crucial role supporting the Executive Directors Group by scrutinising, challenging and reviewing high level risks and holding care groups/corporate divisions to account for the timely and appropriate management of risk.

The care group boards are responsible for the management of risks within their services and the timely escalation of operational risks within the governance structure.

The Trust's quality governance arrangements are focussed on the Quality Assurance Committee of the Board. It has responsibility for overseeing the Trust's compliance with the fundamental standards for quality and safety. It also considers statutory and regulatory compliance in regard to relevant matters including health and safety; safeguarding; and medicines management; clinical audit; and research and development.

During the year the Committee received assurance by way of:

- Reports from the Executive Review of Quality which highlight the assurances taken about quality of care and which provide advice to the Committee on performance as well as identifying risks to quality and safety matters. The work of the group is supported by flows of reporting from the care group clinical leaders and subject matter experts on a range of quality issues.
- The Integrated Performance Report to ensure triangulation of quality and safety matters.
- Reports on the management of relevant risks included in the Board Assurance Framework (BAF) and the Corporate Risk Register.
- Regular reporting on the operation of key quality controls including infection prevention and control, clinical audit and research and development
- Assurance reports on the delivery of quality improvements e.g. the delivery of action plans in response to recommendations made by the Care Quality Commission, independent investigations;. etc
- Reports by exception where gaps in control and assurance have been identified.

Underpinning the governance structure are key corporate processes which support the oversight of risk and internal control. These include:

- Items for consideration by the Board being grouped in accordance with relevant Board Assurance Framework risks.
- Summary reports on the Board Assurance Framework being provided to each Board and committee meeting to support the consideration of strategic risks and the operation of controls during their discussions.
- The business cycles of the Board and its committees being aligned to providing assurance on the management of the risks, and the operation of related controls, included in the Board Assurance Framework.
- A standard reporting template focussing on the Board Assurance Framework risks. For assurance reports, the Lead Executive is expected to define the level of assurance they believe to be in place, providing relevant supporting evidence, so that it can be tested and additional information can be provided where there are considered to be further gaps.
- Reports from the Board's committees summarise those issues where they have gained assurance or wish to alert or advise the Board of significant issues. They also are used to draw the Board's attention to new material risks.
- The alignment of the key performance metrics in the integrated performance assurance dashboards with the Board Assurance Framework risks.
- The introduction of performance improvement plans (PIPS) to remedy areas of underperformance which also act as mitigations for closing gaps in control and assurance.
- The alignment of Internal Audit and Counter Fraud Plans with the Trust's principal strategic risks.

In accordance with the provider licence, the Trust must apply those principles, systems and standards of good corporate governance as appropriate for a provider of health care services to the NHS.

As stated earlier in the annual report, the Board has demonstrated due regard to well-led principles and the well-led framework throughout the year.

Potential control weaknesses and opportunities for improvement are identified from a range of sources such as through feedback provided by Governors and external partners; the findings of key assurance processes (e.g. the integrated performance assurance approach, internal audit, counter fraud, clinical audit and quality governance processes); and other key areas of learning e.g. the national staff and patient surveys.

In addition to these, during 2023/24 the Board has given specific consideration to internal control issues highlighted in:

- "A system-wide independent investigation into concerns and issues raised relating to the safety and quality of CAMHS provision at West Lane Hospital, Tees Esk and Wear Valley NHS Foundation Trust" prepared NICHE (March 2023).
- The report of the Care Quality Commission following its inspection of the Trust in 2023 and, in particular the rating of "requires improvement" for the well-led domain.

- The findings and recommendations arising from the governance review undertaken by Deloitte LLP during the year.
- Post-implementation reviews of the Trust's governance and leadership structure.
- Variation from plan in the delivery of major projects e.g. the implementation of Cito.

Action plans are agreed to address any internal control issues identified which are monitored, on behalf of the Board, by relevant committees based on assurances provided by the Executive Directors.

Risk is embedded in the activities of the organisation in the following ways:

- Equality impact assessments (EIAs) are carried out on all policies and procedures and a dedicated team review all EIAs to ensure a consistent process. In addition, staff are trained in how to complete an EIA.
- Quality Impact Assessments (QIA), requiring consideration by the Executive Medical Director and Chief Nurse, for all Cash Releasing Efficiency Savings (CRES) schemes to assess the impact they will have on clinical performance, and ultimately, the quality of patient care.
- An open reporting culture which encourages staff to report all incidents through its internal reporting system. During this year a new reporting system has been introduced to improve the local ownership of incident reporting and a better understanding of our performance and learning.
- The arrangements, as set out in the Trust's Incident Policy CORP 0043, by which all incidents are openly reported within the Trust (and, as necessary, externally) and are systematically reviewed and analysed to prevent/minimise their repetition. These include the involvement of patients and families from the beginning of the incident where appropriate.
- During the year the learning from all serious incidents has been reviewed to ensure that the themes of learning are understood and acted upon on across all services. This makes it easier to reduce the burden of bureaucracy and focus energy on improvements in practice.
- Incidents marked as racist etc on the incident reporting system are sent to the Equality, Diversity and Inclusion (EDI)) team and are reported to the Equality, Diversity and Human Rights (EDHR) steering group. The patient safety and CQC teams also send any EDI related incidents to the EDHR steering group.
- Members of the Equality, Diversity and Inclusion (EDI) team also sit on preliminary employee relations panels where there are indications that the concern may be related to a protected characteristic.
- Business case approval processes through which investment requirements are articulated, risk assessed, costed and refined to ensure value for money.

The Trust involves public stakeholders in identifying and managing risks to its strategic objectives in a number of ways. These include:

- Feedback from Governors on concerns raised by their Members.
- Patient satisfaction surveys including the “Friends and Family Test”.
- Feedback from the Trust’s complaints process to inform actionable learning.
- The involvement of patients and the public in the development and evaluation of services.
- Feedback received from patients, staff and the public through CQC enquiries and Mental Health Act complaints.
- Our commitment to co-creation involving multiple stakeholders
- Close links with Local Authorities, the Integrated Care Boards, voluntary sector partners and others to ensure the delivery of integrated care and treatment.

The Trust progressed well with the People Journey this year with the subgroups of the Executive People Culture and Diversity Group making good progress on key issues such as roster oversight, agency reduction, training and supervision.

International recruitment continued for both medical and nursing staff continued successfully with more staff joining us from both professions and an award for pastoral care for nursing staff.

A workforce planner joined the Trust and has started work in earnest on developing workforce plans for key areas of the Trust. This aligned with the new professional reference groups is ensuring that, across all staff groups, we understand and can act on medium to long term need as well as meeting any immediate issues.

We moved on from the restructure and progressed through the first module of the leadership and management training for all operational, clinical and corporate leaders from service management level and up alongside quarterly sessions discussing key emergent issues.

Work has been underway through the year on building the Trust-wide People and Culture Dashboard in the Integrated Information Centre (IIC) and as the year came to an end this was launched ready to be utilised consistently through 2024/25. This work has moved the Trust on significantly in developing a shared data set that can be tracked for statistical change at different levels and sections of the organisation.

The review of the Board Assurance Framework came at a meaningful time for the People Journey and reflected our transition from working on issues that affected the whole of the trust to being able; to focus on remaining areas of concern in a more targeted way.

The staffing establishment review process and report has been refreshed through 2023/24 and, reflecting the work on the Board Assurance Framework, now provides board with more nuanced information reflecting the widespread improvements in place and our ability to track more local issues in real time. Roster rules and oversight have also strengthened across the Trust.

The monthly workforce reports to Executive Directors Group, improved staffing establishment analysis, shared dashboard and local tracking of roster use mean that the oversight of staffing and any issues continues to be strengthened.

In addition to the Executive People Culture and Diversity Subgroup, a new Executive Workforce and Resourced Group meets bimonthly to consider those issues that affect staffing, finance, estates, quality etc. All executives are part of this meeting and focus on key issues such as agency reduction, financial and workforce mitigations whilst maintaining safe care, and vacancy control.

Throughout the year our use of apprentices has grown to the point that we are now at capacity with our levy. This is providing routes through from entry level posts to registered roles across the organisation. In addition we have introduced a range of developmental frameworks to enable applicants to safely develop from one band to another, learning in role, and being signed off as competent to move to the more senior post. This is enabling us to retain staff and also oversee their development in the process.

We have also reintroduced the internal transfer scheme so that people can move to the same role in other teams rather than leave the organisation. There is a new independent process for staff to talk to someone about thinking about leaving the trust so that we can identify areas of concern more quickly and support the person to find ways of staying.

The speak up group continues to share early information about concerns in services enabling us to provide support or enquiry in some instances before any member of staff has taken the step to speak up themselves.

All of this has resulted in a significant shift in key metrics such as retention (leavers' rate fell month on month), sickness has continued to improve, training and supervision compliance have also increased significantly

Each establishment review is considered and signed off by the Board in accordance with NQB guidelines and the process is in line with Developing Workforce Standards (NHS, 2018) which states that Trusts are required to use evidence-based tools including a professional judgement approach to support the achievement of the correct staffing establishments based upon acuity and dependency of patients.

The establishment review reports consider and triangulate professional judgement with workforce data and outcomes alongside the assessment of acuity and dependency via the mental health optimal staffing tool (MHOST). Risks to safety and quality, financial areas, performance and staff and patient experience are described in the reviews. Benchmarking data for Care Hours Per Patient Day (CHPPD) and skill mix is used to support decision making including peer review. The NHS Improvement Model Hospital (Model System) provides national and peer values which are used to support benchmark values of CHPPD for peer trusts and are used to support the identification of any potential gaps in our budgeted establishments to that of these benchmark values. Monthly assurances are also provided by the Quality Assurance Committee to the Trust Board. Quality impact assessments are

undertaken for any required changes to the roster demand templates and the budgeted establishments, taking into consideration staffing numbers and skill mix.

The Trust has actioned specific processes to address areas where staffing risks remain despite mitigations and has established and implemented responsive business continuity plans to maintain safety and care quality. These actions have included full and partial closure of wards, reduced bed provision, commissioning of independent sector bed capacity and realignment of teams to support quality and safety requirements. The Trust is aware that we are not always able to meet our planned skill mix on a daily basis and therefore have a range of risk mitigations in place including daily operational processes that include robust daily management systems to ensure safe staffing across all of our inpatient areas. Where sudden shortages of staff arise, there are staffing escalation procedures to be followed for both community and inpatient areas within and out of office hours. Acuity-dependency based rostering is completed daily for inpatient wards to support daily staffing discussions and is underpinned by the staffing escalation process for any red flags as part of a dynamic staffing risk assessment.

Concerns about staffing are escalated to Executive Directors and either managed in local services or escalated to the Executive Directors Group depending on the acuity of risk or the breadth of issue. The focus is on whether the service is safe today and over the next week and then how to build the service back to a sustainable level of workforce provision that can be maintained.

Whilst the focus is on staffing establishments, the Trusts has also implemented a number of “invest to improve” initiatives to ensure safer and more effective care can be provided and free up clinical time to care. These include:

- **Zonal models of Care** - the introduction of zonal models of care and engagement has been shown to reduce the number of falls in our older persons unit, physical interventions related to violence and aggression and a reduction in the harm caused by sexual safety incidents on Psychiatric Intensive Care Units.
- **Acuity based rostering (Safe Care)** - The introduction of the SafeCare tool to all inpatient areas which is now linked into the staffing escalation procedure. SafeCare enables the input of a daily acuity dependency assessment of the current cohort of patients on the ward which is then inputs into an algorithm to provide a picture of the staffing requirements to meet the dynamic need of the current patient group. As part of the work of the Safe Staffing Group will include assurances regarding compliance with the requirements of the tool
- **Digital care assistant (Oxehealth)** - this technology is designed to assist staff by supporting physical health monitoring and risk management, observation, and oversight of our patients particularly during night shift
- **Ward Clerk Review** - the introduction of 7 day a week admin support to wards to support the provision of an increase in the clinical time available to clinical staff. The impact of these developments has increased the quality of care and patient safety within the Trust and aims to improve upon staff well-being and staff retention.

To mitigate the risk to data security, the Trust issues monthly cyber security eLearning to all staff. All new staff complete mandatory Data Security and Protection Training, and phishing simulations are performed with the findings and learning shared Trustwide.

Cyber is one of the risks on the Board Assurance Framework (BAF) and is regularly reviewed through the Executive Strategy and Resource Group and by the Strategy and Resources Committee.

The Trust employs cyber defences within its estate and is about to embark on the delivery of a comprehensive Cyber strategy from 2023-2025 in line with the National Cyber strategy to further strengthen its cyber position and to keep pace with emerging threats. Cyber security assurance is considered good within the Trust, and this is reflected in a number of audits, that have been consistently carried out year on year.

The Trust performs supplier assurance in line with the NHS Digital Technology Assessment Criteria (DTAC) process when new software, systems and suppliers are being considered for use within the organisation. This constitutes verifying privacy statements, certification and cyber approach with prospective suppliers in addition to data protection and technology best practice areas. Clinical safety assessments are also undertaken on products which impact or influence direct patient care. This provides assurance that products or systems comply with the Health and Social Care Act 2012 by having DCB0160 Accreditation.

These checks include verifying any security certifications they may have (ISO 27001, CE, CE+, SOC2). Privacy statements are checked focussing on where the information is held, how it is stored and what security is applied to safeguard it.

This allows assurance to be gained that the supplier is aware of and compliant with GDPR/DPA 2018 and that the Trust follows ‘privacy by design’ principles from procurement to implementation. Data and cyber security are a core and essential part of maintaining quality patient care within the Trust and our efforts reflect this.

The principal risks to compliance with licence condition 4 of the (foundation trust governance) are included in the Board Assurance Framework.

The assessment of these risks has taken into account:

- The implementation of the revised governance and leadership arrangements mentioned above.
- The completion of a six-month post implementation review of the new arrangements.
- Feedback on the findings and recommendations following inspections by the Care Quality Commission and assurance on the delivery of action plans developed in response.
- An annual review of precautions taken by the Trust to maintain compliance with its provider licence conditions.

- The preparation and agreement of assurance statements in regard to recommendations made on governance arising from an independent investigation commissioned by NHS England.

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the *Managing Conflicts of Interest in the NHS* guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has duly considered risks relating to the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Trust has agreed processes to ensure that resources are used economically, efficiently and effectively that involve:

- Agreeing an annual financial plan aligning operational, workforce and financial requirements.
- A rigorous process of setting annual budgets and a detailed cash releasing efficiency savings (CRES) programme.
- Periodic review of Standing Financial Instructions and Scheme of Delegation (last reviewed April 2022).
- Robust financial performance management arrangements, including monthly re-forecasting and consideration of necessary recovery actions.
- Support to Care Groups and Directorates to better understand and manage their respective income and expenditure, including the agreement of internal control totals to plan and oversee the mitigation of in-year pressures and support delivery of the agreed financial plan.
- Breaking down the Trust's overall national cost collection indicator to support benchmarking of costs.

- Leveraging efficiencies through internal and collaborative procurement initiatives.
- Using benchmarking and nationally published performance metrics to inform plans for improved inpatient and community service efficiency.
- Developing workstreams to progress the Estates Master Plan and aim to rationalise and / or better utilising the estate footprint and make progress on sustainability targets.
- Improving workforce productivity, including through innovation and technology and hybrid working.
- Benchmarking costs of corporate functions, including reference to national tools including Model System.
- Utilising annualised Business Planning and Care Group engagement to generate ideas for cost reductions (workshop in September 2023).
- Embedding the Quality Improvement (QI) methodology to review how the Trust operates, maximising efficiency and minimising waste.
- Working with partners to improve the overall local health economy in terms of quality and efficiency, including developing non-Trust pathways and assuming commissioning functions to improve cost effectiveness and outcomes. The Trust has strategic partnerships with ICBs in both North East and North Cumbria, and Humber and North Yorkshire; works collaboratively with NHS England and with CNTW and others in Provider Collaboratives for specialist services and develops new services for people with Learning Disability using Positive Independent Proactive Support ltd.
- Robust capital planning function locally adopting the NHS England business case approvals process guidance, coordination of prioritisation processes to ensure transparent agreement of relative priorities and impact assessments where resource constraints limit Trust ambitions.

The Board plays an active role by:

- Determining the level of financial performance it requires and the consequent implications (including ensuring QIA).
- Reviewing in detail at each meeting the Trust's year to date and forecast financial performance, financial risk and mitigations and delivery against planned CRES, supplemented by more detailed discussion at Strategy and Resources Committee.
- Allocating oversight for key relevant strategic risks to the Trust's Strategy and Resources Committee.
- Agreeing the integrated Annual financial and business Plan submitted to NHS England.
- Considering plans for all major revenue and capital investment (and disinvestment).

The Trust's Audit and Risk Committee has a key role on behalf of the Board in reviewing assurance through its audit programme on the effective use of resources. The Trust also gains assurance from:

- Internal audit reports and Local Counter Fraud Specialist findings in relation to fraud.
- External audit reports on specific areas of interest.
- The Care Quality Commission reports.

Information governance

There were 23 incidents reported in the Data Security and Protection Toolkit during the period 1st April 2023 to 31st March 2024, 13 of which were responded to as not required to report. Of the remaining 10 reported incidents:

- All incidents were confidentiality breaches with a variety of causes.
- All incidents were investigated by the appropriate Trust team.
- No cases resulted in regulatory action by the Information Commissioners Office.

Data Security and Protection Toolkit 2023-24 is required to be submitted 30th June 2024. Of the 108 mandatory evidence items and 35 assertions, it is anticipated that the Toolkit will be published with all evidence items provided and achieving a status of 'Standards Met'.

Data quality and governance

The following steps have been put in place to ensure that appropriate controls are in place to ensure the accuracy of data:

Who	What	When	Why
Digital Performance and Assurance Group	To monitor and oversee the data quality within the organisation, which covers all information systems managed by Digital and Data Services	Monthly	Provide strategic leadership, direction, and oversight
Data Quality Working Group (DQWG)	To monitor Trustwide data quality issues and develop action plans to take remedial action. The group will also take a proactive role in ensuring that existing systems are used to record information in line with	Monthly	Develop action plans to improve the data quality of the organisation. Monitor improvements and report progress, escalating any areas of concern.

	agreed trust and national standards and use systems to proactively view, monitor and improve data quality on an ongoing basis.		Monitor nationally available data quality metrics. Raise any business/clinical processes that are leading to poor data quality.
NHS England	Assesses the completeness of data to make assessments for specific outcomes (i.e., employment) using MHSDS (Mental Health Services Data Set)	Monthly	For monitoring compliance by NHS Foundation Trusts with their terms of Authorisation

The Trust has been subject to several audits in which data quality has been measured and targets established to improve the quality of the data captured on information systems.

The Data Quality Assessment Tool (DQAT) is a fundamental part of our “assurance” to the Board, providing confidence that:

- We have clearly defined measures/key performance indicators which are robust and fit for purpose.
- Our testing processes ensure that the measures remain accurate and up to date.

The tool provides assurance on the quality of data being reported as part of our Integrated Performance Dashboard, focussing on our quality and confidence in:

- The source of the data.
- The accuracy and consistency of the data.
- The measure construction.
- The assurance/audit testing undertaken.

The results (scores) from the data quality assessment are reported to the Board within our Integrated Performance Report and are overseen by the Data Quality Working Group to ensure that all improvement actions identified as part of the assessment are completed.

Strategic improvements in the monitoring and oversight of data quality are described and implemented within the Digital and Data Journey for Change.

In the most recent NHS Digital published results (January 2024) TEWV gained a score of 97.3 for the Data Quality Maturity Index which is a measurement of data quality in the NHS.

The Trust has the following policies linked to data quality:

- IT-0030 Data Management Policy
- CORP-0026: Records Management Policy
- CORP-0026-007: Records Management and Safe Haven procedure
- CORP-0026-005: Moving records and other sensitive information
- CORP-0026-002: Minimum standards for clinical record keeping
- CORP-0006: Information Governance Policy
- IT-0011: Registration Authority Policy
- IT-004: Network User Access Procedure
- IT-0031: Access to Information Systems Policy
- IT-0010: Information Security and Risk Policy
- IT-0014: NHS Number Procedure
- CLIN-0066: Clinical Coding Procedure
- [Multiple]: System Specific Policies of those trust systems containing patient information

The policies incorporate national standards where available and are regularly reviewed. All the policies are held on the intranet. When policies have been reviewed (or new ones published) staff are informed through all-staff email, team brief and other cascade mechanisms.

Training is provided to support staff using the electronic patient record (PARIS/Cito). Training is provided where issues around data quality have been identified.

- As part of performance reporting to the Board, real-time data is used to forecast future positions thus improving the decision-making process. Trust dashboards are available via the Integrated Information Centre (IIC) to support and enhance decision making.
- All data returns are submitted in line with agreed timescales.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the

system of internal control by the Board, the Audit and Risk Committee and the Quality Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review has specifically taken into account:

- The delivery of recommendations made by the External Auditors in 2022/23 in regard to embedding and sustaining actions put in place Trustwide to address the patient care issues identified by the Care Quality Commission and the consequent improvements to the arrangements for securing economy, efficiency and effectiveness in the use of resources.
- The findings and recommendations arising from the fourth report (governance), into the deaths of three young women in 2019 and the assurances, accepted by the Board, on the improvements to structures, systems and processes since that time.
- The findings and regulatory improvements required by the Care Quality Commission following its Trustwide inspection during 2023/24 and the progress made in delivering actions to address the internal control issues identified.
- Whilst the overall and “well-led” ratings remained as “requires improvement” the regulator found clear evidence of improvements in all services since the last inspection.
- The findings of the post implementation reviews of the new structures which have provided assurance on their overall appropriateness and embeddedness.
- The findings and recommendations of the governance review undertaken by Deloitte LLP which focussed on flow within in the governance structure.
- The Trust’s position against NHS England’s Oversight Framework (segment 3) and the feedback received from the region on the actions for improvement.
- The timely action taken to address the internal control issues identified with the implementation of Cito.
- The conclusions of the annual opinion of the Head of Internal Audit and the overall improvement from “reasonable” to “good” assurance provided.
- The findings of individual internal audit assignments both those where the Trust has been successful in improving internal control (e.g., BAF and Risk Management) and those where mitigating risk has proved more challenging (e.g., the management of patient property and monies).
- Improvements to the arrangements for the management of risk within the Trust as detailed above.
- The assurances provided to the External Auditors by the Audit and Risk Committee on the controls in place to manage fraud and the application of laws and regulations.

Conclusion

In conclusion, the Trust has continued to strengthen its governance, risk management and internal controls arrangements to support the delivery of Our Journey to Change.

Progress has been made on embedding and refining the key changes made to our organisational and governance structures introduced in 2022/23. This work has been supported by the independent assessments and assurances received from regulators, inspections and reviews commissioned by the Trust.

Whilst some control issues were identified during the year, none of them are considered to be significant and timely action has been taken to address them.

Brent Kilmurray

Chief Executive

25 June 2024

Independent auditor's report to the Council of Governors of Tees, Esk and Wear Valleys NHS Foundation Trust

To be inserted

The accounts 2022/23

The accounts, for the year ended 31 March 2024, have been prepared by Tees, Esk and Wear Valleys NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 to the NHS Act 2006.

Brent Kilmurray

Chief Executive

25 June 2024

Statement of Comprehensive Income

	Note	2023/24 £000	2022/23 *restated £000
Operating income from patient care activities	3	472,534	459,542
Other operating income	4	29,032	24,923
Operating expenses	7, 9	(510,800)	(507,579)
Operating deficit from continuing operations		**(9,234)**	**(23,114)**
Finance income	11	3,787	1,678
Finance expenses	12	(3,573)	(1,411)
PDC dividends payable		(2,588)	(2,935)
Net finance costs		**(2,374)**	**(2,668)**
Other gains	13	-	3,945
Deficit for the year		**(11,608)**	**(21,837)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Net Impairments	8	(1,851)	362
Revaluations	16.1	166	1,386
Other reserve movements		-	(3)
Total comprehensive expense for the period		**(13,293)**	**(20,092)**

* Restated 2022/23 impairments included in operating expenditure following independent valuation of right of use assets, which resulted in material impairment.

Statement of Financial Position

	Note	31 March 2024 £000	31 March 2023 * £000
Non-current assets			
Intangible assets	15	2,531	16
Property, plant and equipment	16	144,082	143,158
Right of use assets	18	6,085	7,065
Receivables	23	406	558
Total non-current assets		**153,104**	**150,797**
Current assets			
Inventories	22	1,286	856
Receivables	23	16,505	35,633
Cash and cash equivalents	26	60,198	75,171
Total current assets		**77,989**	**111,660**
Current liabilities			
Trade and other payables	27	(50,342)	(68,245)
Borrowings	29	(3,471)	(2,572)
Provisions	31	(3,173)	(5,227)
Other liabilities	28	(519)	(946)
Total current liabilities		**(57,505)**	**(76,990)**
Total assets less current liabilities		**173,588**	**185,467**
Non-current liabilities			
Borrowings	29	(32,497)	(25,859)
Provisions	31	(2,974)	(5,154)
Total non-current liabilities		**(35,471)**	**(31,013)**
Total assets employed		**138,117**	**154,454**
Financed by			
Public dividend capital		162,964	160,212
Revaluation reserve		6,005	7,690
Income and expenditure reserve		(30,852)	(13,448)
Total taxpayers' equity		**138,117**	**154,454**

* Restated right of use assets and income and expenditure reserve following independent valuation which resulted in material impairment.

The notes on pages 8 to 53 form part of these accounts.

Name Brent Kilmurray

Position Chief Executive
Date 25 June 2024

Statement of Changes in Equity for the year ended 31 March 2024

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**160,212**	**7,690**	**(13,448)**	**154,454**
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	(5,796)	**(5,796)**
Surplus/(deficit) for the year	-	-	(11,608)	**(11,608)**
Impairments	-	(1,851)	-	**(1,851)**
Revaluations	-	166	-	**166**
Public dividend capital received	2,752	-	-	**2,752**
Taxpayers' and others' equity at 31 March 2024	**162,964**	**6,005**	**(30,852)**	**138,117**

Statement of Changes in Equity for the year ended 31 March 2023

	Public dividend capital	Revaluation reserve	Income and expenditure reserve *restated	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2022 - brought forward	**155,468**	**5,942**	**6,004**	**167,414**
Implementation of IFRS 16 on 1 April 2022	-	-	2,388	**2,388**
Surplus/(deficit) for the year	-	-	(21,837)	**(21,837)**
Impairments	-	362	-	**362**
Revaluations	-	1,386	-	**1,386**
Public dividend capital received	4,744	-	-	**4,744**
Other reserve movements	-	-	(3)	**(3)**
Taxpayers' and others' equity at 31 March 2023	**160,212**	**7,690**	**(13,448)**	**154,454**

* Restated income and expenditure reserve following independent valuation of right of use assets which resulted in material impairment.

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised, in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2023/24 £000	2022/23 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(9,234)	(23,114)
Non-cash income and expense:			
Depreciation and amortisation	7.1	5,293	8,064
Net impairments	8	9,725	22,641
(Increase) / decrease in receivables and other assets		19,608	(19,766)
(Increase) / decrease in inventories		(430)	(27)
Increase / (decrease) in payables and other liabilities		(16,506)	14,689
Increase / (decrease) in provisions		(4,279)	(1,572)
Net cash flows from / (used in) operating activities		**4,177**	**915**
Cash flows from investing activities			
Interest received		3,787	1,678
Purchase of intangible assets		(2,522)	-
Purchase of PPE and investment property		(16,631)	(10,685)
Sales of PPE and investment property		11	300
Net cash flows from / (used in) investing activities		**(15,355)**	**(8,707)**
Cash flows from financing activities			
Public dividend capital received		2,752	4,744
Movement on other loans		-	(238)
Capital element of finance lease rental payments		(2,110)	(2,013)
Capital element of PFI, LIFT and other service concession payments		(652)	(657)
Interest paid on finance lease liabilities		(228)	(180)
Interest paid on PFI, LIFT and other service concession obligations		(919)	(1,188)
PDC dividend (paid) / refunded		(2,909)	(2,882)
Cash flows from (used in) other financing activities		1	3,641
Net cash flows from / (used in) financing activities		**(4,065)**	**1,227**
Increase / (decrease) in cash and cash equivalents		**(15,243)**	**(6,565)**
Cash and cash equivalents at 1 April - brought forward		**75,171**	**81,736**
Cash and cash equivalents at 31 March	26.1	**59,928**	**75,171**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2023/24 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Interests in other entities

Joint operations
Joint operations are arrangements in which the trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The trust includes within its financial statements its share of the assets, liabilities, income and expenses.

The trust is trustee for the "Tees Esk and Wear Valleys NHS Trust General Charitable Fund", the balances of which are not consolidated with the trust's accounts on the grounds of materiality.

The trust has two wholly owned subsidiary companies "Positive Individualised Proactive Support Limited", and "TEWV Estates and Facilities Management Limited", however the trust has not consolidated either within the trust's accounts on the grounds of materiality. "TEWV Estates and Facilities Management Limited" was made dormant during 2019/20.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under International Financial reporting Standard (IFRS) 15. The GAM expands the definition of a contract to include legislation and regulations which enable an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer, and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the trust accrues income relating to performance obligations satisfied in that year. Where the trust's entitlement to consideration for those goods or services is unconditional, a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The majority of the trust's revenue from contracts with customers is received from annual contracts with NHS commissioners. Cash is received monthly in twelfths, and performance criteria are met as the contracted services are provided.

Revenue from NHS contracts

The main source of income for the trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1 April 2023. The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned Payment and Incentive (API) contracts form the main payment mechanism under the NHSPS. In 2023/24 API contracts contained both a fixed and variable element. Under the variable element, acute providers earned income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element included income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

In 2022/23 fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts.

The trust also receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular Integrated Care Board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income from mandatory services' in these accounts.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of a multi-year contract. In these cases it is assessed that the trust's interim performance does not create an asset with alternative use for the trust, and the trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

Note 1.5 Other forms of income

Grants and donations
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes (the scheme). Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme, except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that, they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services, or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has a cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such an item will flow to the enterprise, and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement
Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus, with no plan to bring them back into use, are measured at fair value where there are no restrictions on sale at the reporting date, and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity, and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust’s Private Finance Initiative (PFI) scheme, where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with International Accounting Standard (IAS) 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

A desktop MEA valuation was carried out on the trust's land and buildings at 31 March 2024, and the assets have been treated as prescribed in the Group Accounting Manual. All of the trust's MEA valuations at 31 March 2024 have been completed by Cushman and Wakefield Inc. (independent qualified valuer).

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the International Financial Reporting Interpretations Committee (IFRIC) 12 definition of a service concession, as interpreted in HM Treasury's Financial reporting Manual (*FReM)* , are accounted for as 'on-Statement of Financial Position' by the trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services, and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets, as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

PFI Lifecycle Replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Initial application of IFRS 16 liability measurement principles to PFI

IFRS 16 liability measurement principles have been applied to PFI and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis has been applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

Comparatives for PFI and other service concession arrangement liabilities have not been restated on an IFRS 16 basis, as required by the DHSC Group Accounting Manual. Under IAS 17 measurement principles which applied in 2022/23 and earlier, movements in the liability were limited to repayments of the liability and the annual finance cost arising from application of the implicit interest rate. The cumulative impact of indexation on payments for the asset was charged to finance costs as contingent rent as incurred.

Useful lives of property, plant and equipment
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	90
Plant & machinery	1	15
Information technology	1	7

Note 1.9 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business, or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus, with no plan to bring it back into use, is valued at fair value where there are no restrictions on sale at the reporting date, and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is reflective of expected life, this can be linked to a contract, a nominal expected life, or, if licenses are to be held in perpetuity, they do not have a maximum life.

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

The Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial assets and financial liabilities

Recognition
Financial assets and financial liabilities arise where the trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive, or a legal obligation to pay, cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs, except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured at amortised cost.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows, and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements, and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost, using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts, through the expected life of the financial asset or financial liability, to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the trust recognises an allowance for expected credit losses.

The trust adopts the simplified approach to impairments for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are calculated for non government funded organisations only, based on the level of risk attached to individual transactions.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired, or the trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.13 Leases

A lease is a contract, or part of a contract, that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of IFRS 16 Leases (previously IAS 17) by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases, where consideration paid is nil or nominal (significantly below market value) but which in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease with reference to the non-cancellable period, and any options to extend or terminate the lease which the trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost, comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments include fixed lease payments, variable lease payments dependent on an index or rate, and amounts payable under residual value guarantees. Lease payments also include amounts payable for purchase options and termination penalties, where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 3.51% applied to new leases commencing in 2023 and 4.72% to new leases commencing in 2024.

The trust does not apply the above recognition requirements to leases with a term of 12 months or less, or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT, or where a total group right of use asset value is not material. Lease payments associated with these leases are expensed on a straight-line basis over the lease term, or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The trust subsequently measures the lease liability by increasing the carrying amount for interest arising, which is also charged to expenditure as a finance cost, and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications, or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The trust as a lessor
The trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line, or another systematic, basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset, and recognised as an expense on a straight-line basis over the lease term.

Initial application of IFRS 16 in 2022/23
IFRS 16 Leases, as adapted and interpreted for the public sector by HM Treasury, was applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaced *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations.

The standard was applied using a modified retrospective approach, with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 were only applied to existing contracts where they were previously deemed to be a lease, or to contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or to contain a lease, these assessments were not revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability, hindsight was used in determining the lease term where lease arrangements contained options for extension or earlier termination.

No adjustments were made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022, or for leases where the underlying assets had a value below £5,000. No adjustments were made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the trust was lessor were unaffected by initial application of IFRS 16.

Note 1.14 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2024:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.26%	3.27%
Medium-term	After 5 years up to 10 years	4.03%	3.20%
Long-term	After 10 years up to 40 years	4.72%	3.51%
Very long-term	Exceeding 40 years	4.40%	3.00%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting, using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2024:

	Inflation rate	Prior year rate
Year 1	3.60%	7.40%
Year 2	1.80%	0.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.45% in real terms (prior year: 1.70%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 31.2 but is not recognised in the trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution, and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses when the liability arises.

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 32 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 32, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events, whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events, but for which it is not probable that a transfer of economic benefits will arise, or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply, and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category, or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Corporation tax

Foundation trusts are exempt from corporation tax on their principle health care income under section 519A Income and Corporation Taxes Act 1988. In determining whether other income may be taxable, a full review of the trust's activities has been carried out in accordance with guidance published by HM Revenue and Customs to establish any activities that are subject to Corporation Tax. Based on this review there is no corporation tax liability in the period ended 31st March 2024.

Note 1.19 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.20 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Note 1.21 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.24 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2023/24.

Note 1.25 Standards, amendments and interpretations in issue but not yet effective or adopted
The following standards and updates have been published by the International Accounting Standards Board as adopted but are not required to be followed until after the current reporting period:

IFRS 14 Regulatory Deferral Accounts has not been endorsed by the UK and is not applicable to DHSC bodies.
IFRS 17 Insurance Contracts is planned to be adopted from the 2024/25 financial year.
IFRS 18 Presentation and Disclosure in Financial Statements was issued in April 2024, and is applicable from 2027/28.

Note 1.26 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below), that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:
The trust has identified the valuation of the trust's estate and the valuation of provisions as critical accounting judgements and key sources of uncertainty. Cushman and Wakefield Inc. provide third party assurance of the value of the estate, completing a full modern equivalent valuation exercise every 3 to 5 years.

Provisions are, in the main, injury benefits provisions (which are valued using actuarial tables), public liability claims, creditor provisions and annual leave pay provisions following the Flowers legal case (informed by national negotiations).

On the grounds of materiality, as per guidance within the GAM, the trust has not consolidated its Charitable Fund, its subsidiaries for the provision of Positive Individual Proactive Support (PIPS) services, or TEWV Estates and Facilities Management (TEWV EFM) services, (now dormant) service within the main accounts.

Note 1.27 Sources of estimation uncertainty
The trust has made no assumptions about the future and has no other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.
Valuations are undertaken by an independent external valuer. These values will therefore be subject to changes in market conditions and market values. The asset lives are also estimated by the independent valuer and are subject to professional judgement.

Note 2 Operating Segments

The trust has no elements that require segmental analysis for the period ended 31 March 2024. The chief operating decision maker has been identified as the Chief Executive, an Executive Director post within the trust; and on this basis the trust has identified healthcare as the single operating segment.

Note 2.1 Performance against planned financial position

For the year ending 31st March 2024, the performance of NHS organisations is measured against delivery of their agreed planned financial position. Certain exceptional and technical revenue streams are excluded from the calculation of 'performance' to ensure true operational performance is measured.

The trust's planned operational performance, as confirmed formally through national plan submissions for 2023/24, and excluding technical adjustments, was to breakeven (i.e. no reported surplus or deficit). The trust reported an adjusted financial surplus position (excluding Annually Managed Expenditure (AME) impairments and Statement of Comprehensive Income impact of peppercorn leases) of £4k, which was £4k ahead of plan i.e. target achieved. Inclusive of technical adjustments, the accounts show an unadjusted deficit of £11,608k.

A reconciliation of the trust's performance against agreed financial plans is shown below:

	2023/24	2022/23 *restated
	£000	£000
Deficit for the year from SoCI	(11,608)	(8,590)
Add back net impairments *	9,725	9,394
Remove I&E impact of peppercorn lease	20	404
Remove actual IFRIC 12 scheme finance costs	3,300	-
Add back forecast IFRIC 12 scheme interest on an IAS 17 basis	(533)	-
Add back forecast IFRIC 12 scheme contingent rent on an IAS 17 basis	(660)	-
Remove PDC dividend benefit arising from PFI liability remeasurement	(240)	-
Actual surplus for performance assessment	**4**	**1,208**
Required / planned surplus	-	1,160
Performance ahead of required level	**4**	**48**

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2023/24	2022/23
	£000	£000
Mental health services		
Income from commissioners under API contracts*	368,884	355,246
Services delivered under a mental health collaborative	49,884	48,068
Clinical income for the secondary commissioning of mandatory services	19,942	10,947
Other clinical income from mandatory services	2,320	2,381
All services		
National pay award central funding**	116	15,452
Additional pension contribution central funding***	15,388	14,449
Other clinical income	16,000	12,999
Total income from activities	**472,534**	**459,542**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.

https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

** Additional funding was made available by NHS England in each of 2023/24 and 2022/23 for implementing the backdated element of pay awards where government offers were made at the end of the financial year.

2023/24: In March 2024, the government announced a revised pay offer for consultants, reforming consultant pay scales with an effective date of 1 March 2024. Trade Unions representing consultant doctors accepted the offer in April 2024.

2022/23: In March 2023, the government made a pay offer for staff on Agenda for Change terms and conditions which was later confirmed in May 2023. The additional pay for 2022/23 was based on individuals in employment as at 31 March 2023.

*** The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts through equivalent increases to both income and expenditure.

Note 3.2 Income from patient care activities (by source)

	2023/24	2022/23
Income from patient care activities received from:	**£000**	**£000**
NHS England	24,388	36,606
Clinical commissioning groups*	-	82,917
Integrated care boards*	379,942	276,571
Other NHS providers	52,204	50,256
NHS other	8	193
Local authorities	2,781	2,187
Non NHS: other	13,211	10,812
Total income from activities	**472,534**	**459,542**
Of which:		
Related to continuing operations	472,534	459,542

* Clinical Commissioning Groups were disestablished during 2022/23 and their functions transferred into newly established Integrated Care Boards with effect from 1 July 2022.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

The trust had no income relating to overseas visitors (non-reciprocal, chargeable to the patient) (2022/23 £nil).

Note 4 Other operating income			**2023/24**			**2022/23**
	Contract income	**Non-contract income**	**Total**	**Contract income**	**Non-contract income**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Research and development	2,663	-	**2,663**	2,627	-	**2,627**
Education and training	19,931	1,662	**21,593**	17,177	1,273	**18,450**
Non-patient care services to other bodies	2,338		**2,338**	1,540		**1,540**
Income in respect of employee benefits accounted on a gross basis	1,029		**1,029**	923		**923**
Charitable and other contributions to expenditure		16	**16**		94	**94**
Revenue from operating leases		846	**846**		946	**946**
Other income*	547	-	**547**	343	-	**343**
Total other operating income	**26,508**	**2,524**	**29,032**	**22,610**	**2,313**	**24,923**
Of which:						
Related to continuing operations			29,032			24,923

*The largest source of other income was £229k relating to catering (£164k in 2022/23).

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2023/24	2022/23
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	946	1,061

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2024 £000	31 March 2023 £000
within one year	519	946
Total revenue allocated to remaining performance obligations	**519**	**946**

Note 5.3 Income from activities arising from commissioner requested services

The trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2023/24	2022/23
	£000	£000
Income from services designated as commissioner requested services	472,534	459,542
Income from services not designated as commissioner requested services	29,032	24,923
Total	**501,566**	**484,465**

Note 5.4 Profits and losses on disposal of property, plant and equipment

The trust received a payment of £11k during 2023/24 linked to the sale of land. This land had a net book value of £11k, so no profit on disposal was realised. (2022/23 £300k).

Note 5.5 Fees and charges

The trust received no income from fees and charges - aggregate of all schemes that, individually, have a cost exceeding £1m (2022/23 £nil).

Note 6 Operating leases - Tees, Esk and Wear Valleys NHS Foundation Trust as lessor
This note discloses income generated in operating lease agreements where Tees, Esk and Wear Valleys NHS Foundation Trust is the lessor.

The trust has 4 leases, all for the rent of property and the lessees are 3 NHS organisations and Thirteen Housing Group Ltd. Due to this there is minimal risk associated with contract default.

Note 6.1 Operating lease income

	2023/24	2022/23
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	846	946
Total in-year operating lease income	**846**	**946**

Note 6.2 Future lease receipts

	31 March 2024	31 March 2023 restated*
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	837	946
- later than one year and not later than two years	105	105
- later than two years and not later than three years	105	105
- later than three years and not later than four years	105	105
- later than four years and not later than five years	105	105
- later than five years	1,957	1,852
Total	**3,214**	**3,218**

*prior year receipts have been restated to reflect contracts in place at 31 March 2023.

Note 7.1 Operating expenses

	2023/24 £000	2022/23 restated £000
Purchase of healthcare from NHS and DHSC bodies	2,048	1,239
Purchase of healthcare from non-NHS and non-DHSC bodies	17,894	17,341
Staff and executive directors costs*	398,270	391,073
Remuneration of non-executive directors	191	203
Supplies and services - clinical (excluding drugs costs)**	3,576	3,680
Supplies and services - general	6,643	6,997
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	5,315	5,368
Consultancy costs	73	80
Establishment	4,726	4,320
Premises	25,508	22,427
Transport (including patient travel)	9,720	8,602
Depreciation on property, plant and equipment	5,277	6,526
Amortisation on intangible assets***	16	1,538
Net impairments *****	9,725	22,641
Movement in credit loss allowance: contract receivables / contract assets	25	71
Increase/(decrease) in other provisions	-	(17)
Change in provisions discount rate(s)	(217)	(689)
Fees payable to the external auditor		
Audit services- statutory audit	96	90
Internal audit costs	261	264
Clinical negligence	1,597	1,319
Legal fees	5,010	2,626
Insurance	406	332
Research and development	2,937	2,663
Education and training	8,112	7,154
Expenditure on short term leases	-	17
Early retirements	242	-
Redundancy	100	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	746	651
Hospitality	90	71
Losses, ex gratia & special payments	15	9
Other services, eg external payroll	72	-
Other****	2,326	983
Total	**510,800**	**507,579**
Of which:		
Related to continuing operations	510,800	507,579

*2022/23 staff and executive director costs include an accrual for the impact of the (then proposed) non-consolidated pay award of £15,904k.

**Includes £16k of DHSC procured consumables, the majority being personal protective equipment (PPE) or domestic items (£94k in 2022/23).

***Amortisation of system licences held in perpetuity that are end of life due to a move to Cloud based systems.

**** Other includes £2,085k for construction experts and Kings Counsel professional services associated with a now settled legal case (£nil in 2022-23)

***** Restated 2022/23 impairments following independent valuation of right of use assets, which resulted in material impairment.

Note 7.2 Other auditor remuneration

The trust has not paid its auditors any additional remuneration for the period to 31 March 2024 (31 March 2023, £nil). Auditor's remuneration for statutory audit is shown in note 7.1.

Note 7.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2023/24 or 2022/23.

Note 8 Impairment of assets

	2023/24	2022/23 *restated
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	9,725	22,641
Total net impairments charged to operating deficit	**9,725**	**22,641**
Impairments charged to the revaluation reserve	1,851	(362)
Total net impairments	**11,576**	**22,279**

The trust realised impairments totalling £11.576k during 2023/24 following a modern equivalent asset valuation of its sites and right of use assets (£22,279k in 2022/23).

* 2022/23 impairment values have been restated following independent valuation of right of use assets, which resulted in material impairment.

Note 9 Employee benefits

	2023/24 Total £000	2022/23 Total £000
Salaries and wages	305,565	298,393
Social security costs	31,068	28,008
Apprenticeship levy	1,563	1,384
Employer's contributions to NHS pensions	50,623	47,546
Pension cost - other	80	131
Temporary staff (including agency)	17,466	20,746
Total staff costs	**406,365**	**396,208**
Of which		
Costs capitalised as part of assets	2,720	532

Note 9.1 Retirements due to ill-health

During 2023/24 there were 8 early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2023). The estimated additional pension liabilities of these ill-health retirements is £717k (£293k in 2022/23).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as at 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury, have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of the valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% of pensionable pay from 1 April 2024 (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

Auto-enrolment

The trust opts all employess into the NHS pension scheme on its auto enrolment date (next exercise April 2025). In previous years some staff were ineligible to be enrolled in the NHS pension scheme, so the trust set up a scheme with the National Employment Savings Trust (NEST). If staff choose to, they can still become a member of NEST, but the NHS pension scheme is the default enrolment offering. The NEST pension scheme is a defined contribution scheme, and as such the cost to the NHS Body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2023/24	2022/23
	£000	£000
Interest on bank accounts	3,787	1,678
Total finance income	**3,787**	**1,678**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2023/24	2022/23
	£000	£000
Interest expense:		
Interest on lease obligations	228	179
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	919	561
Contingent finance costs*	-	627
Remeasurement of the liability resulting from change in index or rate*	2,381	-
Total interest expense	**3,528**	**1,367**
Unwinding of discount on provisions	45	44
Total finance costs	**3,573**	**1,411**

* From 1 April 2023, IFRS 16 liability measurement principles are applied to PFI, LIFT and other service concession liabilities. Increases to imputed lease payments arising from inflationary uplifts are now included in the liability, and contingent rent no longer arises. More information is provided in Note 37.

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

The trust did not pay any interest payable arising from claims or pay compensation to cover debt recovery costs under this legislation (2022/23, £nil).

Note 13 Other gains

	2023/24	2022/23
	£000	£000
Gains on disposal of assets	-	300
Total gains on disposal of assets	**-**	**300**
Fair value gains on financial liabilities*	-	3,645
Total other gains	**-**	**3,945**

*Fair value gains were realised in 2022/23 following the cancellation of a contract, and subsequent unwinding of associated liabilities.

Note 14 Discontinued operations

The trust had no discontinued operations at 31 March 2024 (31 March 2023, £nil).

Note 15 Intangible assets

The trust's intangible assets are bespoke software systems that have been created. Asset balances as at 31 March 2024 were £2,531k (31 March 2023, £16k).

Note 16.1 Property, plant and equipment - 2023/24

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2023 - brought forward	**11,941**	**119,061**	**4,691**	**2,731**	**-**	**9,008**	**-**	**147,432**
Additions	-	8,740	3,987	514	-	1,550	-	**14,791**
Impairments	(371)	(16,466)	-	-	-	-	-	**(16,837)**
Reversals of impairments	7	7,272	-	-	-	-	-	**7,279**
Revaluations	56	(2,919)	-	-	-	-	-	**(2,863)**
Reclassifications	-	4,691	(4,691)	-	-	-	-	**-**
Disposals / derecognition	(11)	-	-	-	-	-	-	**(11)**
Valuation/gross cost at 31 March 2024	**11,622**	**120,379**	**3,987**	**3,245**	**-**	**10,558**	**-**	**149,791**
Accumulated depreciation at 1 April 2023 - brought forward	**-**	**-**	**-**	**1,345**	**-**	**2,929**	**-**	**4,274**
Provided during the year	-	3,029	-	232	-	1,203	-	**4,464**
Revaluations	-	(3,029)	-	-	-	-	-	**(3,029)**
Accumulated depreciation at 31 March 2024	**-**	**-**	**-**	**1,577**	**-**	**4,132**	**-**	**5,709**
Net book value at 31 March 2024	**11,622**	**120,379**	**3,987**	**1,668**	**-**	**6,426**	**-**	**144,082**
Net book value at 1 April 2023	**11,941**	**119,061**	**4,691**	**1,386**	**-**	**6,079**	**-**	**143,158**

Note 16.2 Property, plant and equipment - 2022/23

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022 - as previously stated	**12,136**	**123,815**	**1,835**	**2,388**	**84**	**6,926**	**1,347**	**148,531**
Additions	-	8,625	3,440	343	-	2,082	-	**14,490**
Impairments	(237)	(11,139)	-	-	-	-	-	**(11,376)**
Reversals of impairments	42	2,302	-	-	-	-	-	**2,344**
Revaluations	-	(5,126)	-	-	(84)	-	(1,347)	**(6,557)**
Reclassifications	-	584	(584)	-	-	-	-	**-**
Valuation/gross cost at 31 March 2023	**11,941**	**119,061**	**4,691**	**2,731**	**-**	**9,008**	**-**	**147,432**
Accumulated depreciation at 1 April 2022 - as previously stated	**-**	**2,270**	**-**	**1,130**	**84**	**1,973**	**1,347**	**6,804**
Provided during the year	-	2,856	-	215	-	956	-	**4,027**
Revaluations	-	(5,126)	-	-	(84)	-	(1,347)	**(6,557)**
Accumulated depreciation at 31 March 2023	**-**	**-**	**-**	**1,345**	**-**	**2,929**	**-**	**4,274**
Net book value at 31 March 2023	**11,941**	**119,061**	**4,691**	**1,386**	**-**	**6,079**	**-**	**143,158**
Net book value at 1 April 2022	**12,136**	**121,545**	**1,835**	**1,258**	**-**	**4,953**	**-**	**141,727**

Note 16.3 Property, plant and equipment financing - 31 March 2024

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Owned - purchased	11,622	114,323	3,987	1,668	6,426	**138,026**
On-SoFP PFI contracts and other service concession arrangements	-	6,056	-	-	-	**6,056**
Total net book value at 31 March 2024	**11,622**	**120,379**	**3,987**	**1,668**	**6,426**	**144,082**

Note 16.4 Property, plant and equipment financing - 31 March 2023

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Owned - purchased	11,941	112,941	4,691	1,386	6,079	**137,038**
On-SoFP PFI contracts and other service concession arrangements	-	6,120	-	-	-	**6,120**
Total net book value at 31 March 2023	**11,941**	**119,061**	**4,691**	**1,386**	**6,079**	**143,158**

Note 16.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Subject to an operating lease	236	3,594	-	-	-	**3,830**
Not subject to an operating lease	11,386	116,785	3,987	1,668	6,426	**140,252**
Total net book value at 31 March 2024	**11,622**	**120,379**	**3,987**	**1,668**	**6,426**	**144,082**

Note 16.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2023

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Subject to an operating lease	236	3,951	-	-	-	**4,187**
Not subject to an operating lease	11,705	115,110	4,691	1,386	6,079	**138,971**
Total net book value at 31 March 2023	**11,941**	**119,061**	**4,691**	**1,386**	**6,079**	**143,158**

Note 17 Donations of property, plant and equipment

The trust did not receive any donations of property, plant and equipment during the year (2022/23, £nil).

Note 18 Leases - Tees, Esk and Wear Valleys NHS Foundation Trust as a lessee

The trust has 35 property leases included within its IFRS 16 accounting at 31 March 2024, all of which existed at 31 March 2023. One lease has been extended in 2023/24, this is reflected in the liability increase in note 29.1.

Note 18.1 Right of use assets - 2023/24

	Property (land and buildings)	Total	Of which: leased from DHSC group bodies
	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**9,564**	**9,564**	**2,737**
Additions*	1,919	**1,919**	-
Impairments	(2,035)	**(2,035)**	(12)
Reversal of impairments	17	**17**	5
Revaluations	-	**-**	-
Disposals / derecognition*	(68)	**(68)**	-
Valuation/gross cost at 31 March 2024	**9,397**	**9,397**	**2,730**
Accumulated depreciation at 1 April 2023 - brought forward	**2,499**	**2,499**	**883**
Provided during the year	813	**813**	233
Accumulated depreciation at 31 March 2024	**3,312**	**3,312**	**1,116**

*Additions and disposals related to the same lease as a new lease was entered into before the end date of the original lease

Net book value at 31 March 2024	**6,085**	**6,085**	**1,614**
Net book value at 1 April 2023	**7,065**	**7,065**	**1,854**
Net book value of right of use assets leased from other NHS providers			45
Net book value of right of use assets leased from other DHSC group bodies			1,569

Note 18.2 Right of use assets - 2022/23 *restated

	Property (land and buildings)	Total	Of which: leased from DHSC group bodies
	£000	£000	£000
IFRS 16 implementation - adjustments for existing operating leases / subleases	21,425	**21,425**	9,050
Impairments	(13,247)	**(13,247)**	(6,320)
Revaluations	1,386	**1,386**	7
Valuation/gross cost at 31 March 2023	**9,564**	**9,564**	**2,737**
Provided during the year	2,499	**2,499**	883
Accumulated depreciation at 31 March 2023	**2,499**	**2,499**	**883**
Net book value at 31 March 2023	**7,065**	**7,065**	**1,854**
Net book value of right of use assets leased from other NHS providers			50
Net book value of right of use assets leased from other DHSC group bodies			1,804

* 2022/23 right of use asset values have been restated following an independent valuation, which resulted in material impairment.

Note 18.3 Revaluations of right of use assets

From 1 April 2023 the trust has measured Right of Use (ROU) assets by applying the revaluation model in IAS 16. ROU assets were subject to a full MEA valuation as at 1 April 2023 and an indexation review at 31 March 2024. All of the trust's MEA valuations received in the year have been completed by Cushman and Wakefield Inc. (independent qualified valuer).

Due to the materiality of impairments resulting from the 1 April 2023 valuation the prior year comparative ROU asset values have been restated.

Note 18.4 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the Statement of Financial Position. A breakdown of borrowings is disclosed in note 29.1.

	2023/24	2022/23
	£000	£000
Carrying value at 31 March	**17,022**	**-**
IFRS 16 implementation - adjustments for existing operating leases		19,036
Lease additions*	1,919	-
Interest charge arising in year	228	179
Early terminations*	(68)	-
Lease payments (cash outflows)	(2,338)	(2,193)
Carrying value at 31 March	**16,763**	**17,022**

*Additions and disposals related to the same lease as a new lease was entered into before the end date of the original lease

Lease payments for short term leases, leases of low value underlying assets, and variable lease payments not dependent on an index or rate, are recognised in operating expenditure.

These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 18.5 Maturity analysis of future lease payments

	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2024	31 March 2024	31 March 2023	31 March 2023
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	2,262	929	2,193	929
- later than one year and not later than five years;	8,330	3,527	8,122	3,603
- later than five years.	7,443	3,251	7,458	4,063
Total gross future lease payments	**18,035**	**7,707**	**17,773**	**8,595**
Finance charges allocated to future periods	(1,271)	(351)	(750)	(390)
Net lease liabilities at 31 March 2024	**16,764**	**7,356**	**17,022**	**8,206**
Of which:				
Leased from other NHS providers		121		135
Leased from other DHSC group bodies		7,235		8,071

Note 19 Investment Property

The trust has no investment property (2022/23, £nil).

Note 20 Investments in associates and joint ventures

The trust has no investments in associates or jointly controlled operations consolidated in these accounts as at 31 March 2024 (31 March 2023, £nil) on the basis of materiality (as disclosed in note 1).

Note 21 Other investments / financial assets (non-current)

The trust has no other investments or financial assets (non-current) at 31 March 2024, (2022/23, £nil).

Note 21.1 Other investments / financial assets (current)

The trust has no other investments or financial assets (current) at 31 March 2024, (2022/23, £nil).

Note 22 Inventories

	31 March 2024	31 March 2023
	£000	£000
Drugs	287	206
Consumables*	999	650
Total inventories	**1,286**	**856**

*Consumables inventory increased linked to a new food supplier and associated food inventory requirements.
Inventories recognised in expenses for the year were £872k (2022/23: £923k). Write-down of inventories recognised as expenses for the year were £0k (2022/23: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £16k of items purchased by DHSC (2022/23: £94k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 23.1 Receivables

	31 March 2024 £000	31 March 2023 £000
Current		
Contract receivables*	7,597	33,628
Allowance for impaired contract receivables / assets	(212)	(6,232)
Prepayments (non-PFI)	7,010	6,766
PFI lifecycle prepayments	477	470
PDC dividend receivable	400	79
VAT receivable	1,225	918
Other receivables	8	4
Total current receivables	**16,505**	**35,633**
Non-current		
Other receivables	406	558
Total non-current receivables	**406**	**558**
Of which receivable from NHS and DHSC group bodies:		
Current	4,325	22,173
Non-current	381	530

*Contract receivables at 31 March 2023 included accrued income to support the (then proposed) 2022/23 non-consolidated Agenda for Change pay award (£15,452k). Values were advised by NHS England.

Impaired contract receivables have reduced as debt was written off for a supplier that entered liquidation. A corresponding reduction has been realised in contract receivables.

Note 23.2 Allowances for credit losses

	2023/24 Contract receivables and contract assets £000	2022/23 Contract receivables and contract assets £000
Allowances as at 1 April - brought forward	**6,232**	**6,161**
New allowances arising	25	71
Utilisation of allowances (write offs)*	(6,045)	-
Allowances as at 31 Mar 2024	**212**	**6,232**

*Allowance for credit losses has reduced as debt was written off for a supplier that entered liquidation. A corresponding reduction has been realised in contract receivables.

Note 23.3 Exposure to credit risk

	2023/24 Contract receivables and contract assets £000	2022/23 Contract receivables and contract assets £000
Non-impaired receivables past their due date by:		
0 - 30 days	2,198	3,039
30-60 Days	202	538
60-90 days	142	160
90- 180 days	424	181
over 180 days	732	806
Total	**3,698**	**4,724**

Note 24 Other assets

The trust had no other assets as at 31 March 2024 (31 March 2023, £nil).

Note 25.1 Non-current assets held for sale and assets in disposal groups

The trust had no non-current assets held for sale as at 31 March 2024 (31 March 2023 £nil).

Note 25.2 Liabilities in disposal groups

The trust had no liabilities in disposal groups as at 31 March 2024 (31 March 2023, £nil).

Note 26.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2023/24	2022/23
	£000	£000
At 1 April	**75,171**	**81,736**
Net change in year	(14,973)	(6,565)
At 31 March	**60,198**	**75,171**
Broken down into:		
Cash at commercial banks and in hand	94	127
Cash with the Government Banking Service	39,604	75,044
Deposits with the National Loan Fund	20,500	-
Total cash and cash equivalents as in SoFP	**60,198**	**75,171**
Bank overdrafts (GBS and commercial banks)	(270)	-
Total cash and cash equivalents as in SoCF	**59,928**	**75,171**

Note 26.2 Third party assets held by the trust

Tees, Esk and Wear Valleys NHS Foundation Trust held cash and cash equivalents which relate to monies held by the trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2024	31 March 2023
	£000	£000
Bank balances	755	710
Total third party assets	**755**	**710**

Note 27.1 Trade and other payables

	31 March 2024	31 March 2023
	£000	£000
Current		
Trade payables	5,106	5,995
Capital payables	4,268	6,092
Accruals*	27,850	42,630
Social security costs	4,160	4,061
VAT payables	99	1,225
Other taxes payable	3,928	3,580
Pension contributions payable	4,931	4,662
Total current trade and other payables	**50,342**	**68,245**
Of which payables from NHS and DHSC group bodies:		
Current	3,291	5,778

*2023/24 accruals include a legally informed estimate for a fine, the value of which was determined during April and after the Trust's financial position had been confirmed.

2022/23 accruals included £15,904k for the impact of the (then proposed) Agenda for Change non-consolidated pay award.

The trust had no non current trade and other payables (31 March 2023, £nil).

The Directors consider that the carrying amount of trade payables approximates to their fair value.

Note 27.2 Early retirements in NHS payables above

There were no early retirement costs in the NHS payables balance as at 31 March 2024 (2022/23, £nil).

Note 28 Other liabilities

	31 March 2024 £000	31 March 2023 £000
Current		
Deferred income: contract liabilities	519	946
Total other current liabilities	**519**	**946**

Note 29.1 Borrowings

	31 March 2024 £000	31 March 2023 £000
Current		
Bank overdrafts	270	-
Lease liabilities	2,262	2,193
Obligations under PFI, LIFT or other service concession contracts	939	379
Total current borrowings	**3,471**	**2,572**
Non-current		
Lease liabilities	14,502	14,829
Obligations under PFI, LIFT or other service concession contracts	17,995	11,030
Total non-current borrowings	**32,497**	**25,859**

Note 29.2 Reconciliation of liabilities arising from financing activities

	Other loans	Lease Liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2023	**-**	**17,022**	**11,409**	**28,431**
Cash movements:				
Financing cash flows - payments and receipts of principal	-	(2,110)	(652)	**(2,762)**
Financing cash flows - payments of interest	-	(228)	(919)	**(1,147)**
Non-cash movements:				
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023			5,796	**5,796**
Additions	-	1,919	-	**1,919**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	2,381	**2,381**
Application of effective interest rate	-	228	919	**1,147**
Early terminations	-	(68)	-	**(68)**
Carrying value at 31 March 2024	**-**	**16,763**	**18,934**	**35,697**

	Other loans	Lease Liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2022	**238**	**-**	**12,066**	**12,304**
Cash movements:				
Financing cash flows - payments and receipts of principal	(238)	(2,013)	(657)	**(2,908)**
Financing cash flows - payments of interest	-	(180)	(561)	**(741)**
Non-cash movements:				
Impact of implementing IFRS 16 on 1 April 2022		19,036		**19,036**
Application of effective interest rate	-	179	561	**740**
Carrying value at 31 March 2023	**-**	**17,022**	**11,409**	**28,431**

Note 30 Other financial liabilities

The trust had no other financial liabilities as at 31 March 2024 (31 March 2023, £nil).

Note 31.1 Provisions for liabilities and charges

	Pensions: injury benefits	Legal claims *	Other **	Total
	£000	£000	£000	£000
At 1 April 2023	**1,995**	**115**	**8,271**	**10,381**
Change in the discount rate	(217)	-	(84)	**(301)**
Arising during the year	315	71	814	**1,200**
Utilised during the year	(158)	(29)	(1,812)	**(1,999)**
Reversed unused	-	(39)	(3,166)	**(3,205)**
Unwinding of discount	45	-	26	**71**
At 31 March 2024	**1,980**	**118**	**4,049**	**6,147**
Expected timing of cash flows:				
- not later than one year;	159	118	2,896	**3,173**
- later than one year and not later than five years;	598	-	21	**619**
- later than five years.	1,223	-	1,132	**2,355**
Total	**1,980**	**118**	**4,049**	**6,147**

*Legal claims relate to employer / public liability claims notified by the NHS Resolution.

**Other provision balances relate to employment tribunals linked to holiday pay and staff pay rates, potential contract refunds, invoices not yet received, and a provision for clinical pensions tax reimbursement.

Note 31.2 Clinical negligence liabilities

At 31 March 2024, £5,600k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Tees, Esk and Wear Valleys NHS Foundation Trust (31 March 2023, £4,039k).

Note 32 Contingent assets and liabilities

	31 March 2024	31 March 2023
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(240)	(240)
Net value of contingent liabilities	**(240)**	**(240)**

The contingent liabilities relate to employer liability legal cases, all cases relate to NHS Resolution and are due within 1 year.
The trust is no longer in litigation with the liquidators of Three Valleys Healthcare Limited, the former PFI provider of the trust's terminated Roseberry Park Hospital PFI.

The Trust has a contingent asset (amount uncertain) linked to a potential VAT rebate for building works completed in the financial year.

Note 33 Contractual capital commitments

	31 March 2024	31 March 2023
	£000	£000
Property, plant and equipment	2,181	670
Total	**2,181**	**670**

Note 34 Other financial commitments

The trust had no other financial commitments as at 31 March 2024 (31 March 2023, £nil).

Note 35 Defined benefit pension schemes

The trust does not operate an on-Statement of Financial Position pension scheme.

Note 36 On-SoFP PFI, LIFT or other service concession arrangements

The trust has full control of clinical services provided from its PFI funded hospital (Lanchester Road), and full access and use of the buildings, which are maintained by the PFI project company as part of the PFI procurement contract.

The PFI project company provides services for “hard” facilities management including building maintenance and life cycle replacement programmes. A contractual commitment exists for the PFI project company to maintain the building at “category b” status for the contract life (30 years from commencement for Lanchester Road).

The contract can be terminated within the 30 year contract period if contractual obligations for service delivery (maintenance) and building availability are not met. This is controlled by a points based payment deduction methodology within the standard PFI contract. The trust has the right to cease the contract early, subject to payment of a financial penalty.

Note 36.1 On-SoFP PFI, LIFT or other service concession arrangement

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2024	31 March 2023 *restated
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**26,109**	**16,102**
Of which liabilities are due		
- not later than one year;	1,824	911
- later than one year and not later than five years;	7,194	4,174
- later than five years.	17,091	11,017
Finance charges allocated to future periods	(7,175)	(4,693)
Net PFI, LIFT or other service concession arrangement obligation	**18,934**	**11,409**
- not later than one year;	939	379
- later than one year and not later than five years;	4,110	2,276
- later than five years.	13,885	8,754

*31 March 2023 restated to remove contingent rent (future inflation) as per guidance (this is not linked to implementation of IFRS 16).

Note 36.2 Total on-SoFP PFI, LIFT and other service concession arrangement

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2024	31 March 2023
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**53,125**	**47,895**
Of which payments are due:		
- not later than one year;	3,188	2,604
- later than one year and not later than five years;	13,571	11,085
- later than five years.	36,366	34,206

Note 36.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession

	2023/24	2022/23
	£000	£000
Unitary payment payable to service concession operator	**2,919**	**2,560**
Consisting of:		
- Interest charge	919	561
- Repayment of balance sheet obligation	652	657
- Service element and other charges to operating expenditure	746	651
- Capital lifecycle maintenance	602	64
- Contingent rent	-	627
Total amount paid to service concession operator	**2,919**	**2,560**

Note 37 Impact of change in accounting policy for on-SoFP PFI, LIFT and other service concession liabilities

IFRS 16 liability measurement principles have been applied to PFI, LIFT and other service concession arrangement liabilities from 1 April 2023. When payments for the asset are uplifted for inflation, the imputed lease liability recognised on the SoFP is remeasured to reflect the increase in future payments. Such increases were previously recognised as contingent rent as incurred.

The change in measurement basis has been applied retrospectively, without restatement of comparatives, and with the cumulative impact on 1 April 2023 recognised in the income and expenditure reserve. The incremental impact of applying the new accounting policy on (a) the allocation of the unitary charge in 2023/24, and (b) the primary statements in 2023/24, is set out in the disclosures below.

Note 37.1 Impact of change in accounting policy on the allocation of unitary payment

	IFRS 16 basis (new basis)	IAS 17 basis (old basis)	Impact of change
	2023/24 £000	2023/24 £000	2023/24 £000
Unitary payment payable to service concession operator	**2,919**	**2,919**	**-**
Consisting of:			
- Interest charge	919	533	**386**
- Repayment of balance sheet obligation	652	378	**274**
- Service element	746	746	**-**
- Lifecycle maintenance	602	602	**-**
- Contingent rent	-	660	**(660)**

Note 37.2 Impact of change in accounting policy on primary statements

Impact of change in PFI accounting policy on 31 March 2024 Statement of Financial Position:	**£000**
Increase in PFI / LIFT and other service concession liabilities	(7,903)
Increase in cash and cash equivalents (impact of PDC dividend only)	240
Impact on net assets as at 31 March 2024	**(7,663)**

Impact of change in PFI accounting policy on 2023/24 Statement of Comprehenaive Income:	**£000**
PFI liability remeasurement charged to finance costs	(2,381)
Increase in interest arising on PFI liability	(386)
Reduction in contingent rent	660
Reduction in PDC dividend charge	240
Net impact on surplus / (deficit)	**(1,867)**

Impact of change in PFI accounting policy on 2023/24 Statement of Changes in Equity:	**£000**
Adjustment to reserves for the cumulative retrospective impact on 1 April 2023	(5,796)
Net impact on 2023/24 surplus / deficit	(1,867)
Impact on equity as at 31 March 2024	**(7,663)**

Impact of change in PFI accounting policy on 2023/24 Statement of Cash Flows:	**£000**
Increase in cash outflows for capital element of PFI / LIFT	(274)
Decrease in cash outflows for financing element of PFI / LIFT	274
Decrease in cash outflows for PDC dividend	240
Net impact on cash flows from financing activities	**240**

Note 38 Off-SoFP PFI, LIFT and other service concession arrangements

The trust had no off-SoFP PFIs as at 31 March 2024 (31 March 2023, £nil).

Note 39 Financial instruments

Note 39.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the trust has with Integrated Care Boards (ICBs) and the way those ICBs are financed, the trust is not exposed to the same degree of financial risk faced by business entities. Financial instruments also play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The trust has limited powers to borrow or invest surplus funds, and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the trust in undertaking its activities.

The trust's treasury management operations are carried out by the finance department, within parameters defined formally within the trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the trust's internal auditors.

Currency risk
The trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The trust has no overseas operations and therefore has low exposure to currency rate fluctuations.

Market risk
The main potential market risk to the trust is interest rate risk. 100% of the trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Tees, Esk and Wear Valleys NHS Foundation trust is not, therefore, exposed to significant interest-rate risk.

Credit risk
Credit risk exists where the trust can suffer financial loss through default of contractual obligations by a customer or counterparty.

Trade debtors include high value transactions with Integrated Care Boards and Foundation Trusts under contractual terms that require settlement of obligation within a time frame established generally by the Department of Health. Consequently the credit risk exposure is not significant.

Credit risk exposures of monetary financial assets are managed through the trust's treasury policy which supports investment with Government Banking Service and National Loans Fund only.

Credit risk exposures of monetary financial assets are managed through the Strategy and Resources Committee, which is required to approve all methods used for investing cash balances. For the financial year 2023/24 main cash balances were held in Government Banking Service (GBS) accounts, with a small amount held in a Barclays current account to cover unpresented cheques etc.

Liquidity risk
The trust's net operating costs are mainly incurred under legally binding contracts with Integrated Care Boards, NHS England Commissioners and Foundation Trusts, all of which are financed from resources voted annually by Parliament. This provides a reliable source of funding stream, which significantly reduces the trust's exposure to liquidity risk.

Note 39.2 Carrying values of financial assets

All of the trust's financial assets are carried at amortised cost. Fair value is not considered to be significantly different from book value.

Carrying values of financial assets as at 31 March 2024	Held at amortised cost
	£000
Trade and other receivables excluding non financial assets	7,385
Cash and cash equivalents	60,198
Total at 31 March 2024	**67,583**

Carrying values of financial assets as at 31 March 2023	Held at amortised cost
	£000
Trade and other receivables excluding non financial assets	27,958
Cash and cash equivalents	75,171
Total at 31 March 2023	**103,129**

Note 39.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost
	£000
Obligations under leases	16,764
Obligations under PFI, LIFT and other service concession contracts	18,934
Other borrowings	270
Trade and other payables excluding non financial liabilities	33,309
Provisions under contract	118
Total at 31 March 2024	**69,395**

Carrying values of financial liabilities as at 31 March 2023	Held at amortised cost
	£000
Obligations under leases	17,022
Obligations under PFI, LIFT and other service concession contracts	11,409
Trade and other payables excluding non financial liabilities	54,717
Provisions under contract	115
Total at 31 March 2023	**83,263**

Note 39.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the Statement of Financial Position, which are discounted to present value.

	31 March 2024	31 March 2023 restated
	£000	£000
In one year or less*	37,783	57,936
In more than one year but not more than five years	15,524	12,295
In more than five years	24,534	18,475
Total	**77,841**	**88,707**

*31 March 2023 balances included an accrual for the impact of the (then proposed) non-consolidated pay award of £15,904k.

** 31 March 2023 values restated to remove contingent rent on a PFI contract as per guidance.

Note 39.5 Fair values of financial assets and liabilities

It is the trust's opinion that book value is a reasonable approximation of the fair value of financial assets and liabilities.

Note 40 Losses and special payments

	2023/24		2022/23	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	3	2	1	-
Total losses	**3**	**2**	**1**	**-**
Special payments				
Ex-gratia payments	35	11	42	305
Total special payments	**35**	**11**	**42**	**305**
Total losses and special payments	**38**	**13**	**43**	**305**

Note 41 Related parties

Tees, Esk and Wear Valleys NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.

The Department of Health and Social Care is regarded as the parent department, and a related party. During the period Tees, Esk and Wear Valleys NHS Foundation Trust has had a significant number of material transactions with entities for which the Department is regarded as the parent department, or a related party.

The main entities that the trust has dealings with are its commissioners, namely;

NHS North East and North Cumbria ICB

NHS Humber and North Yorkshire ICB

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

NHS England

The trust also has material expenditure with the following:

NHS Pension Scheme

HM Revenue & Customs

The related parties disclosure below includes organisations the trust has a joint venture, subsidiary or other partnership arrangement with. The trust is not required to report other public bodies as related parties.

The trust has two subsidiary companies, Positive Individualised Proactive Support Ltd, and TEWV Estates and Facilities Management Ltd (made dormant in 2019/20 financial year). The trust is also sole corporate trustee for the Tees Esk and Wear Valleys NHS Trust General Charitable Fund.

During the period none of the Board members, members of the key management staff, or parties related to them, has undertaken any material transactions with Tees, Esk and Wear Valleys NHS Foundation Trust, or any of the trust's subsidiary companies or charities.

2023/24	**Income**	**Expenditure**	**Receivables**	**Payables**
Entity	**£000**	**£000**	**£000**	**£000**
Non-consolidated subsidiaries and associates / joint ventures	-	-	510	-
Total balances with related parties	**-**	**-**	**510**	**-**

2022/23	**Income**	**Expenditure**	**Receivables**	**Payables**
Entity	**£000**	**£000**	**£000**	**£000**
Non-consolidated subsidiaries and associates / joint ventures	-	-	510	-
Total balances with related parties	**-**	**-**	**510**	**-**

Note 42 Events after the reporting date

The trust has no events after the reporting period to disclose.

** If you would like additional copies of this report please contact:

The communications team

Email: tewv.enquiries@nhs.net

Our chairman, directors and governors can be contacted through the Trust secretary's office by emailing: tewv.ftmembership@nhs.net

For more information about the Trust and how you can get involved please visit our website www.tewv.nhs.uk

For General Release

Meeting of:	**Board of Directors**
Date:	**25 June 2024**
Title:	**Quality Account 2023/24**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Author(s):	**Phil Bellas, Company Secretary** **Leanne McCrindle, Associate Director of Quality Governance, Compliance and Quality Data**

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	Under its Provider License, the Trust must take all reasonable precautions against the risk of failure to comply with: a. The Conditions of the License, b. Any requirements imposed on it under the NHS Acts, and c. The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

Executive Summary:

Purpose: Board is invited to review and approve the Quality Account for 2023/24.

Proposal: The Quality Account document will be published on the Trust's website and submitted to the Department of Health and Social Care once the Board of Directors have given their approval, as per the guidance.

Overview: Quality Accounts are annual reports, prepared under the Health Act 2009 and in accordance with regulations made by the Secretary of State for Health and Social Care, to inform the public about the quality of services delivered by providers of NHS services.

They are aimed at encouraging boards and leaders of healthcare organisations to assess quality across all the healthcare services they offer; to demonstrate their commitment to continuous, evidence-based quality improvement; and to explain progress.

Under the Regulations, key stakeholders (Integrated Care Boards, Health Overview and Scrutiny Committees, local HealthWatch, etc)

are provided with an opportunity to comment on the Quality Account before it is published. This is to support confidence in the accuracy of the data and conclusions drawn by the Trust.

The draft Quality Account for 2023/24 is attached as Appendix 1 to this report. It is required to be approved by the Board and published by 30 June 2024.

In summary, the following process has been developed for the preparation, consultation on, and approval and submission/publication of the document:

- Circulation of a "requirements" document to lead officers based on the regulations

  Please note that the regulations have not been updated for some years and do not reflect current circumstances (e.g. the change in the approach to management and reporting of serious incidents during 2023/24). A pragmatic approach has been taken to the information contained in the document.
- Compilation of the draft Quality Account based on submissions from the lead officers.
- Compliance check against the "requirements document".
- Circulation of the draft Quality Account to key stakeholders in accordance with the statutory consultation period.
- Review of the draft Quality Account, and consultation responses received, by the Quality Assurance Committee (see "Prior Consideration and Feedback" below).
- Review of the document by the Audit and Risk Committee.
- Review and approval by the Board.
- Submission to the Department of Health and Social Care and publication on the Trust's website.

The Quality Account is no longer subject to a limited (scope) review by the External Auditors.

Appendix 1 – Draft Quality Account 2023/24 post review by the Quality Assurance Committee.
Appendix 2 – Feedback received to date

Prior Consideration and Feedback

Written responses received as part of the consultation exercise are provided in Appendix 2 to this report

In addition:

- A presentation on the draft Quality Account was provided to the Durham Council Adults Wellbeing and Health Oversight and Scrutiny Committee on 09/05/24.
- Presentations on progress against the Trust's Quality Priorities have also been provided to a number of other Local Authorities during 2023/24.

The draft Quality Account and consultation responses were reviewed by the Quality Assurance Committee at its meeting held on 6th June 2024. It was agreed that the document provided a fair, balanced and understandable description of the quality of services.

The report was also considered by Audit and Risk Committee at its meeting held on 17 June 2024.

Please note that any further responses received from stakeholders will be provided to the Board under separate cover.

Implications: The Trust is required to establish and implement processes and systems to identify risks and guard against their occurrence.

Failure to do so would be a breach of the provider licence.

Recommendations: The Board is recommended to approve the Quality Account document and its publication on the Trust's website by 30 June 2024.

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Tees, Esk and Wear Valleys NHS Foundation Trust

Quality Account

2023/24

Contents

Part one

1.1 Welcome to the Quality Account and its purpose

What is a Quality Account?
A Quality Account is an annual report describing the quality of services provided by a NHS healthcare organisation. Quality accounts aim to increase public accountability and drive quality improvements in the NHS.

Our Quality Account looks back on how well we have done in the past year at achieving our quality goals.

It also looks forward to the year ahead and defines what our priorities for quality improvement will be and how we expect to achieve and monitor them.

The aims of the Quality Account

1. To help patients and carers make informed choices about healthcare providers
2. To empower people to hold providers to account for the quality of services
3. To engage leaders of an organisation in their quality improvement agenda

Who reads the Quality Account?
Lots of different people read the Quality Account. Some are people who we support through our services, their loved ones, colleagues, commissioners, partners and regulating bodies.

We produce our report for anyone who wants to know more about the quality of our services, and how we plan to maintain and improve them.

What information can be found in the Quality Account?
In this document, you will find information about how we measure and review the quality of services that we provide. You will also find our priorities for improvement for the year ahead. Like all NHS healthcare providers, we focus on three different aspects or domains of quality:

- Patient safety
- Clinical effectiveness
- Patient experience

Structure of the Quality Account
The structure of this Quality Account is in line with guidance published by the Department of Health and NHS England, and contains the following information:

- **Part 1:** Introduction and context
- **Part 2:** Information on how we have improved in the areas of quality we identified as important for 2023/24, our priorities for improvement in 2024/25 and the required statements of assurance from the Board
- **Part 3:** Further information on how we have performed in 2023/24 against our key quality metrics and national targets and the national quality agenda

1.2 Chief executive's statement on quality

Welcome to our Quality Account 2023/24. High quality patient care is the core of what we do every day and goes hand in hand with our focus on patient safety and clinical excellence. It's also fundamental in our commitment to achieving our goals - to co-create a great experience for people in our care, carers and families, for our colleagues and to be a great partner.

Whilst we are making progress, nationally and regionally, we continue to see unprecedented demand for our services. Staffing levels also continue to be a challenge across the NHS - and we are no different.

However, we're continuing to work in partnership, as part of the wider health and social care system. This is increasingly important as we focus on place-based care. We're committed to building strong relationships with partners across our communities and working closely with them to collectively support people and meet their needs.

Given the timing of our quality account, it's important to mention the Care Quality Commission (CQC) prosecution as sentencing took place in April 2024. The CQC investigators found that we failed to provide safe care and treatment to two individuals, who sadly died in our care at West Lane Hospital in 2019 and Roseberry Park Hospital in 2020. We held ourselves to account and pleaded guilty to the two charges as soon as we were able to. The care and treatment for those two individuals wasn't acceptable - they deserved better. We are deeply sorry for the events that led to these tragedies and our thoughts are with their families.

We are now a very different organisation, one that takes responsibility and is moving forwards. The CQC acknowledged this in our latest inspection and that noticeable improvements have been made. This is very much down to the hard work and dedication of colleagues across our trust, and the ongoing support and collaboration with our partners.

As I've reflected over the last year, there have been some significant milestones for our trust. Our latest Care Quality Commission (CQC) report was published in October and inspectors recognised that we're making progress. Overall, seven out of 11 of our services are rated 'good' and four areas are rated as 'requires improvement'. This is an improvement since our last inspection in 2021.

Inspectors could also see a positive culture change and patients said that staff were 'kind and considerate', friendly, kind and supportive' and that they were 'actively involved in their care planning'.

We know there's more to do but the fact that the CQC has told us we're making improvements, and that these positive changes have impacted on the quality of our care, is a really important step in our improvement journey.

There has also been a huge amount of work to ensure we provide safe and kind care, with a clear focus on patient safety, clinical effectiveness and patient experience through our clinical and quality journeys. This has included the successful introduction of the patient safety incident response framework (PSIRF) to ensure learning from incidents and to help prevent an incident happening again and a new incident reporting and quality management system. This means we can learn quickly from incidents, identify common causes and make improvements.

Linked to PSIRF, we also relaunched our organisational learning group. This brings together a range of different teams, such as nursing, patient safety, clinical, therapies and complaints. The group triangulates learning and actions, monitor progress and looks at the impact on the quality of care we provide.

We also implemented assistive technology to enhance patient safety in our wards and launched a new electronic patient record system called Cito at the beginning of 2024.

Whilst these innovations are key for us, people are at the heart of our organisation – and we know that this has a correlation to good patient care. We've been doing some focussed work on recruitment and retention and although there is more to do, we're seeing real progress.

I also want to mention our continued focus on co-creation, which is the golden thread through everything we do. Our ambition is for patient and carer voice to be sought out, listened to, and acted upon at every level.

There is a lot more detail in this report about the progress we've made, as well as areas where we're continuing to make improvements.

We remain committed to putting quality and safety above all else, working with patients and carers and our partners to support people in our region. And to make sure the communities we serve get the mental health and learning disability services they need and deserve.

Brent Kilmurray
Chief Executive
30 June 2024

1.3 About our Trust

At Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) we provide a range of inpatient and community mental health, learning disability and eating disorders services.

We serve a population of two million people across County Durham, Darlington and North Yorkshire and are geographically one of the largest NHS Foundation Trusts in England. We also provide mental health care in prisons located in the North East, Cumbria and parts of Lancashire.

We are a catchment area for the largest concentration of armed forces personnel in the UK – Catterick Garrison – and our adult inpatient eating disorder services and adult secure (forensic) wards serve the whole of the North East and North Cumbria.

TEWV was created in April 2006, following the merger of County Durham and Darlington Priority Services NHS Trust and Tees and North East Yorkshire NHS Trust.

In 2008 our Trust became the first mental health Foundation Trust in the North and, since then, it has expanded both geographically, and in the number and type of services provided. Our Trust now has around 8,100 staff, who work out of more than 90 sites, and an annual income of over £480 million.

From education and prevention to crisis and specialist care – our talented and compassionate teams work in partnership with patients, communities and partners to help the people of our region feel safe, understood, believed in and cared for. We nurture the recovery journey of people in our care.

Patients and carers have a say in how they are supported and treated, because we know how important it is to listen and treat people as individuals. Our patients, their families and carers work together with us towards better mental health.

We operate across two care group boards – one covering Durham, Tees Valley and Forensic services and one for North Yorkshire and York.

Across our care group boards, we provide:

- Adult mental health services
- Mental health services for older people
- Children and young people's mental health services
- Learning disabilities
- Health and justice
- Secure inpatient services

1.4 Our Journey to Change

In August 2020 we launched Our Big Conversation - the biggest listening exercise in the history of our Trust. Over 2,100 people shared 35,800 ideas, comments, and votes, exploring what could be possible if we got everything right and what we must do to achieve this.

We heard that some people had a good experience with the Trust, but this wasn't consistent, and we heard that there was a lot we needed to work on.

From the rich conversations and feedback we received from Our Big Conversation, we developed big ideas for change and a new strategic direction called Our Journey to Change.

It sets out why we do what we do, the kind of organisation we want to be and how we will get there by delivering our three goals and living our new values of respect, compassion, and responsibility all the time.

The big goals we have committed to deliver over the next five years are:
• to co-create a great experience for patients, carers, and their families
• to co-create a great experience for our colleagues
• to be a great partner

Our Journey to Change is at the forefront of everything we do, and all our decision making and 'supporting journeys' are aligned to it.

We have five underpinning journeys which are:
• clinical
• quality and safety
• people
• co-creation
• empowering infrastructure

We've now past the halfway point of Our Journey to Change, and we're seeing the positive impact this is having on people's experience of our Trust.

We continue to make significant improvements, with a focus on providing safe and kind care, and this was acknowledged in our latest CQC report. Whilst we know there is more work to do, we are continuing to build on our progress and make further improvements to make sure the communities we serve get the mental health and learning disability services they need and deserve.

1.5 Co-creation

We're embracing patient and carer experience and using their insights to continually improve; working in close partnership with patients, families, and carers to provide the best possible experience and outcomes. We also work together with our partners and regulators to ensure we understand what good looks like, so we bring meaningful change to the care we provide. We refer to this partnership-style of working as co-creation. It is at the heart of Our Journey to Change and is fundamental to how we improve the care we provide to the communities we serve.

We want co-creation to run through everything we do, so that it becomes the normal way of doing things including:

- Care plans written in partnership, where patients and families have choice about their care and make shared decisions with their clinician.
- A thriving and diverse involvement community that supports co-creation across all areas of our Trust, such as policy, research, recruitment and quality improvement.
- A growing and diverse peer workforce across all services, underpinned by peer values and driven by peer leadership.
- Innovative and diverse methods to really hear the experience of all patients and families and understand the relationship between patient experience, complaints, and serious incidents.
- Lived experience leadership roles supporting transformation and culture change. By lived experience we mean people who have experience of mental illness as a patient or carer and who are using their experiences and insights to help others.

We have made sustained progress in this area and we have two lived experience directors who joined the organisation in 2022. Throughout 2023/24 they have established themselves across both of our care boards, offering a lived experience lens, insight and challenge across strategic decision making in our trust. The lived experience directors have broadened the lived experience input across the organisation, by establishing two co-creation boards that work closely with our care boards and are shaping how we deliver services - putting lived experience voice at its heart. We have also employed a head of co-creation with lived experienced to lead the development of our approach co-creation across the organisation.

Several of our trainers have experience of mental illness and are supporting staff to put themselves in the shoes of both patients and their families so that we show true empathy in the care we deliver.

We also employ peer support workers, who have lived experience of mental illness either themselves or as a carer and these roles are continuing to grow.

Examples of co-creation and lived experience in action:

- The launch of a trust wide staff co-creation network, which has been co-developed with staff, service users and carers and aims to give staff the support and tools to put co-creation into action in their services.
- The co-creation and co-delivery of training to staff and students by patients at Ridgeway.
- Co-designing and co-hosting a patient safety summit across Teesside, which involved a range of local community organisations.
- A number of co-creation groups established and working with staff on major transformation projects across the trust, from the development of our electronic patient record system (Cito), community transformation in adult mental health services and the care programme approach.
- Service user and carers joining our PLACE inspections of our wards to offer their perspective of the wards from lived experience.
- Service users and carers involved in the recruitment of staff across the trust from board level to community-based teams.

1.6 A patient story

An inspirational North Yorkshire man is using his mental health experiences to support others – after finally seeking help for the anxiety which plagued him for decades.
Marc Blair, 48, battled "a constant background of anxiety" from childhood, which created problems at school, in the workplace and in his personal life.
Now, following treatment from our Trust's North Yorkshire Talking Therapies, he is looking forward to a brighter future – and has set up a support group for men in the same situation.

"*It felt like I was standing at the gates of hell when I was first referred for treatment*," said Marc, from Catterick Garrison. "*It was a very tough time, but the therapy was amazing. "I really appreciate the help I got from Talking Therapies, and now I want to support others. I'm here for them all the way. Helping people helps my own wellbeing, but it also makes me happy*."

Need to escape
Marc's anxiety struggles first became apparent as a child, when he found sitting in large groups – such as in a classroom or assembly – overwhelming.
His need to "get up and escape" led to dozens of skipped lessons and, ultimately, Marc left school without any qualifications.
"*I didn't realise my feelings were caused by anxiety at the time – no one did. Back then, people didn't really recognise the symptoms, they just thought I was disruptive*," he said. Marc was determined to follow in the footsteps of his father and grandfather by joining the army – and had a long-cherished ambition of becoming a physical training instructor. However, anxiety again became a barrier to success after he secured a place to study sport at college. Within months he had dropped out.
"I loved sport – running and athletics had always been a big thing for me. But it was just too much being around so many strangers. It was very difficult for me," he said.

Troubled times
Marc then enlisted in the army at 17 but, after eight weeks of training, he discharged himself. It was a decision he blames on his anxiety – and which he immediately regretted.
A succession of jobs followed before Marc was eligible to re-enlist. This time it went well – at first. But difficulties started after he was posted overseas, and he ended up going AWOL.
"I won trophies for best physical training and best shot during training. I found things I was good at," he said. "But, after a while, my anxiety returned and I felt the need to escape again."
Marc later transferred to a different regiment and, after three years, left the army and joined the guard service with the Ministry of Defence.
He spent several happy years as a dog handler, among other roles, before becoming a truck driver for a new company. Sadly, his anxiety again caused problems.
"I found the job very, very stressful, and it was the first time since the army that I didn't want to go to work," he said.

Switching roles
The company was sympathetic to his struggles and offered Marc an alternative job as a groundworker, which he enjoyed. Then, in 2021, he moved to a similar role with the MoD.
Despite his initial happiness, his mental health started to deteriorate, so he switched jobs yet again – and went back to truck driving.
"Anxiety can make you make some very strange decisions," he said. "I knew truck driving wasn't for me, yet I did it again. I lasted about six weeks before the stress became too much.
"My anxiety really started to get the better of me around then. One night, while at an event with my wife and friends, I kept having to go outside. I felt so overwhelmed – like when I was at school."

Seeking support

As the weeks went by, so Marc's anxiety continued to "go through the roof" – putting his marriage under strain. The loss of his mother, followed the collapse of his relationship, left him in a "dark place".

By the time Marc finally sought medical help, he felt as if he was "stood at the gates of hell." Taking part in Talking Therapies, however, helped turn his life around. NHS Talking Therapies provides a range of talking therapies designed for supporting people with symptoms of depression, panic, anxiety, stress, worry and scary thoughts. Joe Greensmith, a psychological wellbeing practitioner, supported Marc through 12 weeks of specialist treatment – helping him to develop skills and techniques to manage his anxiety.

"I had tried to manage my anxiety with exercise, but I needed a structure in my life. Joe helped so much. He was always there for me, always willing to listen to me."

Here to help others

Marc is now keen to use his experience to help others – and recently set up a men's mental health support group in Colburn with a friend.

The drop-in group, named Together Strong, is held in the village hall on the third Monday of every month from 7pm.

"One person's mental health challenges can affect other people within their family and friends," Marc said. "I'm now at the point when I'm finally looking after my mental wellbeing properly. I use the advice Joe gave me to help not only the people in the group, but my friends and family too."

Marc is now planning to train as a mental health counsellor and, in the future, he may even re-take his GCSEs and go on to university.

"I can't help every single person, but if I can make a difference to one person's life, that would be good. Joe helped change my life, and I'd like to do the same for others," he said.

Helen Dodd, the associate practitioner for North Yorkshire Talking Therapies, today praised Marc's work on the new group and said:

"He is an inspiration to us all. Marc's experience demonstrates the empowerment that learning to manage anxiety can bring."

1.7 The services we provide

We deliver care under six clinical directorates across our care group boards:

- Adult mental health services
- Mental health services for older people
- Children and young people's mental health services
- Learning disabilities
- Health and justice
- Secure inpatient services

There is further detail about our Trust and the services we deliver in section 1.3.

1.8 Our CQC ratings

The CQC's current ratings for our Trust overall and for each key domain is as follows:

Overall rating: Requires improvement

For each key domain our Trust is rated:

- Safe: **Requires improvement**
- Effective: **Good**
- Caring: **Good**
- Responsive: **Requires improvement**
- Well-led: **Requires improvement**

Further information can be viewed within section 2.13: What the Care Quality Commission (CQC) says about us.

1.9 What we have achieved in 2023/24

We're making progress on our goals and working together to deliver a great experience for patients, carers and families, for colleagues and to be a great partner.

How we're co-creating a great experience for patients, carers and families

- In our latest inspection report (October 2024), the Care Quality Commission (CQC) recognised we are making progress. Seven out of 11 of our services are rated 'good' and four areas are rated as 'requires improvement'. This is an improvement since our inspection in 2021.
- Introduced a new incident reporting and management system called InPhase. It makes it easier for our colleagues to report incidents, learn quickly from events, involve different areas of the organisation in learning, identify common causes and make improvements.
- Successfully introduced the patient safety incident response framework (PSIRF) to ensure learning from incidents and to help prevent an incident happening again. It includes compassionate engagement and involvement for all involved or affected by a patient safety incident.
- Retained our 2 star rating from the Carers Trust for continuing to work with carers, following the Triangle of Care principles.
- Launched two co-creation boards – one in our Durham, Tees Valley and Forensics care group and one in our North Yorkshire York and Selby care group.
- Supported a further 600 people through our Individual Placement Service, with over 300 people progressing into paid employment in the last year.
- Launched Cito, our new electronic patient record system. This was one of the largest and most ambitious investments in technology to improve patient care that we have undertaken.
- Established our new complaints service, which was co-created with people in our care and carers. Importantly, throughout the review and development, we considered the experiences of people that had used our PALS and complaints service.
- Opened a new sensory room in our children's respite unit in Teesside.
- Launched the 'Think Together Team', a transformation project designed to support children and young people to access mental health services in North Yorkshire.
- Appointed two more positive and safe practitioners to support us to reduce our use of restrictive interventions.
- Our children and adolescent mental health services (CAMHS) teams are now engaging in an 'Investors in Children' accreditation.
- Our eating disorder home treatment (EDHT) team, part of the North Yorkshire and York CAMHS service, marked its milestone first year and has helped to significantly reduce both admissions and re-admissions.
- Our children and adolescent mental health services (CAMHS) launched the iThrive model of care in Durham and Tees Valley. iThrive is designed to support children and young people to access mental health services in Durham and Tees Valley. It aims to talk about mental health and wellbeing help and support in a common language that everyone understands.
- Increased the number of therapy pets by 47%.

- Organisational Development have worked with our experts by experience to develop our culture plan and look at what gaps there are.
- We are co-creating the range of ways in which people can work with us to make it more flexible for people to be paid for the time they give to us.
- Co creation programme for staff and co creation board for experts by experience is in development
- We are developing ways to improve the experiences of trans and non-binary patients.
- Working with partners to improve the access to our services for people from Gypsy, Roma, Traveller communities.

How we're co-creating a great experience for colleagues

- Recruited to over 1,780 positions - 781 of these posts were to external candidates.
- Welcomed over 150 newly qualified nurses into our workforce, supporting them in the start of their nursing careers.
- Reduced our use of whole time equivalent agency staff by 44.6%.
- Increased our peer support workforce by 27%.
- 221 staff started an apprenticeship with us and during the same period 120 successfully achieved their apprenticeship.
- A 28% increase in volunteers.
- Our annual staff survey response rate was up 4%. 95% of colleagues said they'd not experienced discrimination from patients, care givers, members of the public or colleagues and 91% said they felt trusted to do their job.
- Continued our international recruitment drive to expand our workforce. We also received the NHS Pastoral Care Quality Award for giving great pastoral support to our internationally recruited nurses.
- Junior doctors ranked our Trust as the top organisation for their training in the North East, in the GMC national training survey.
- Achieved Better Health at Work Award Scheme Silver-level accreditation.
- Recruited more staff health and wellbeing champions – we now have 304 people in these roles supporting colleagues across our trust.
- Received a record number of nominations (484) for our annual staff awards.
- Established a staff-led health and wellbeing council.
- Our staff networks continue to develop - we now have more than 500 colleagues who are members.
- Developed a charter for the medical workforce, outlining our commitments to current and future medical colleagues.
- Reaccredited for reducing restraint network standards for positive and safe care.

- The intentions to leave process has been updated and improved.
- A new managers programme has been updated and rolled out.
- Promoting and using the National Staff survey and the National Quarterly Pulse Survey – introduced staff experience champions to support with this – increased response rate and maintained or improved in 100/103 areas following being the most improved Mental Health/ Learning Disability and Autism Trust last year. Notably rates of discrimination continue to drop and staff report feeling more fairly treated after an incident or near miss.
- Achievement of Better Health At Work Award Scheme Silver-level accreditation in 2023 (aiming for Gold-level status in 2024).
- Recruited many more Staff Health & Wellbeing Champions, 304 staff now in the role.
- Staff-led Health & Wellbeing Council has been established and is meeting regularly – there is a process for spending charitable funds for the benefit of staff wellbeing now in place across the Trust.
- Started a centralised reasonable adjustment pilot to support staff and managers access and implement appropriate workplace adjustments.
- Roll out of core leadership and management training for all staff in formal senior roles continues and Leadership Academy has been scoped and is due to launch in May 2024.
- The Freedom to Speak Up (FTSU) service has continued to see a rise in the number of people accessing the service and reporting that they feel it is a trusted service.

How we're working with our partners

- Our innovative and world-class research team, in partnership with the University of York, delivered the largest clinical trial ever undertaken to combat loneliness and depression.
- Led a pilot of a portable ECG device that helped protect mental health patients during the COVID-19 pandemic, resulting in it being used across the country. Our pilot has now played a key role in changing national guidance around ECGs.
- Expansion of Mental Health Support Teams for schools service in Darlington and Durham.
- Community transformation work in Tees Valley has seen the introduction of a Peer Support Network in partnership with Red Balloons. There are plans in place to develop similar networks in Durham and North Yorkshire, York and Selby.
- In partnership with local authorities and commissioned substance misuse service providers in North Yorkshire and Middlesbrough, our teams are taking part in a 12-month pilot to help prevent drug related deaths.
- Signed a Memorandum of Understanding (MoU) with Teesside University, which builds on successful joint working. We'll work collaboratively on a broad range of initiatives to help support students and graduates within the healthcare sector, as well as support the transformation of practice.
- A new two-year project providing mental health and well-being support for women aged 18-25 launched following funding from the North Yorkshire and York Community Mental Health Transformation programme.
- Hosted research into food insecurity (also known as food poverty) in collaboration with Fuse, the Centre for Translational Research in Public Health (Teesside University and Newcastle University) and Equally Well UK (a collaborative hosted by the Centre for Mental Health). It found that over 50% of people with Severe Mental Illness (SMI) in the north of England live with food insecurity.

- Launched a new hub aimed at helping people leaving prison to re-integrate into the community in Durham. The new hub has been developed by the Reconnected to Health partnership – including our Trust, Humankind, Spectrum Community Health CIC and Rethink.

- Our performance team were Governance Showcase winners at the NHS Providers Governance Conference 2023 for our new integrated performance approach to quality and performance assurance and improvement.

- Held our first ever hybrid Annual General and Members Meeting allowing guests in person and online.

- We are active members of regional work in both integrated care boards (ICBs). We are working on streamlining employment processes and making it easier for colleagues to move around the health care system.

- We are working in partnership with Middlesbrough College on a work based academy, initially piloting a 'Business admin academy'.

Living our values

Our Journey to Change sets out why we do what we do and the kind of organisation we want to become. It also sets out how we'll get there by living our values, respect, compassion and responsibility – all of the time.

It's important that we recognise and celebrate when we're truly living our values and we encourage people to share examples of this. Each month we hold a living our values award, recognising colleagues who are living our values and the positive impact it has on the experience for people in our care, families and carers, colleagues and our partners. In 2023/24 there were a total of 292 nominations from patients, carers, partners and colleagues.

1.10 National awards – won and shortlisted

In addition to our Trust achievements listed above, external bodies have recognised the work of individuals or teams through the award shortlisting, or award wins listed in the table below.

Award body	Awarding status	Name / category of award	Team / individual
Better Health at Work	Awarded	Bronze and Silver standard	Trustwide wellbeing service
	Awarded	Gold standard	NHS Durham and Darlington Talking Therapies
Hospitality Assured	Accreditation	World Class Service	Trustwide hotel services
	Shortlisted	Team of the Year	Trustwide hotel services
NIHR School for Public Health Research	Shortlisted	Public Involvement & Engagement	Emma Giles and Jo Smith, Fuse (Food Insecurity in Adults with Severe Mental Illness)
Hull York Medical School Teaching Excellence Awards	Won	Physician Associate Tutor of Excellence Award	Polly Snelling
	Won	Medicine Phase II & III Tutor of Excellence	Dora Katalenac Zovko
	Shortlisted	Exceptional Contribution to Student Experience	Dora Katalenac Zovko
HSJ Digital	Shortlisted	Driving Change through Data and Analytics	Perinatal mental health clinical outcome reporting
BBC Radio 4 All in the Mind	Shortlisted		Nikki Lonsdale
Health Education England - Durham and Tees valley GP Training programme	Won	Hospital Supervisor of the Year	Grish Rao
NHS Providers Governance Conference 2023	Won	Governance Showcase	Trust performance team
Healthcare Financial Management Association	Won	Unsung Hero of the Year	Adam Hind
NHS England	Accreditation	NHS Pastoral Care Quality	International recruitment team
Nepacs' Ruth Cranfield	Won	Certificate of Excellence	Gemma Fawcett-Smith, registered learning disability nurse, Tracey Forster, speech and language therapist and

Award body	Awarding status	Name / category of award	Team / individual
			Pam Jenkins, speech and language assistant, HMP Holme House mental health team
Royal College of Psychiatrists	Accreditation Accreditation	Quality network from Eating Disorders (QED) Quality Network for Crisis Resolution and Home Treatment Teams (QNCRHTT)	Adult community eating disorders team Harrogate crisis resolution and home treatment team
National Service User	Shortlisted	Community and Collaboration Award	Ridgeway Recovery Awards Ridgeway Community Day
Nursing Times	Shortlisted Shortlisted	HRH The Prince of Wales Award for Integrated Approaches to Care Nursing in the Community	REACH team (Reducing Exclusion for Adults with Complex Housing needs) REACH team (Reducing Exclusion for Adults with Complex Housing needs)
Nursing Times Workforce	Shortlisted	Preceptor of the Year	Jade Jackson

Part 2: Quality priorities for 2023/24 and required statements of assurance from the Board

2.1 Introduction – purpose of this section

In part two of our Quality Account, we outline our planned quality improvement priorities for 2024/25 and provide a series of statements of assurance from the Board on mandated items as required by NHS England.

In this section, we will also review the progress we have made in relation to the quality priorities we set ourselves in the 2023/24 Quality Account.

2.2 Our approach to quality governance and improvement

Our Trust has a robust governance infrastructure. Our governance structure is focused on clear oversight and accountability and is supported by the Trust's accountability framework.

The governance structure supports the delivery of Our Journey to Change by making sure we are:

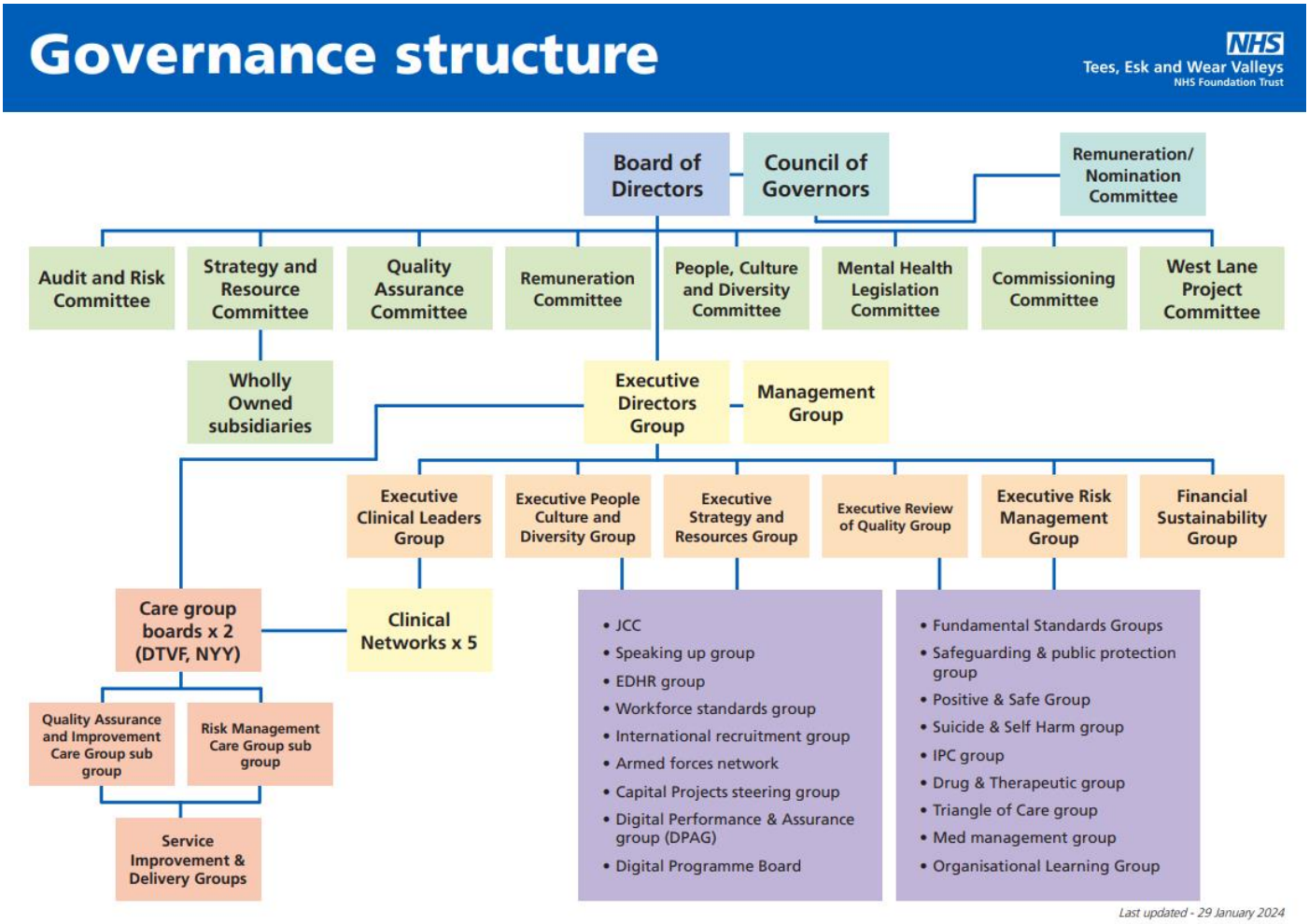
- Clinically led and operationally enabled.
- Better able to align around the regional changes in the form of the two Integrated Care Systems in which we provide services.
- Able to deliver on individual and collective system wide accountability effectively and consistently, by making all roles clearer and manageable for post holders.
- Organised in a more simple, less complex way formally incorporating patient leadership into our structures.

During 2024 our Trust will be reviewing Our Journey to Change.

During 2023 our Trust's governance structure was reviewed. The process and the report have helped us to reflect on the progress we have made since the Good Governance Institute (GGI) review in 2021 and to enable us to further embed and improve our governance arrangements.
The GGI review shared key themes and specific recommendations. We are currently in the process of preparing a formal response to the key themes and recommendations and developing an action plan to address the key areas. The main themes which we will focus on are:

- Reviewing Our Journey to Change and related priorities and delivery plan
- Reviewing our business planning approach
- Reviewing the governance model within care groups
- Reviewing and streamlining our executive level meeting structure
- Further developing and embedding our accountability framework
- Refining committee terms of reference, agendas and reporting
- Developing our approach to the use of data and its role in reporting
- Implementing our leadership development programme
- Reviewing executive portfolios
- Embedding PSIRF, completing the complaints review and embedding the approach to mortality and morbidity reviews
- Developing our Council of Governors further
- Reviewing and advancing our co-creation work
- Accelerating our developments in learning, innovation and quality improvement.

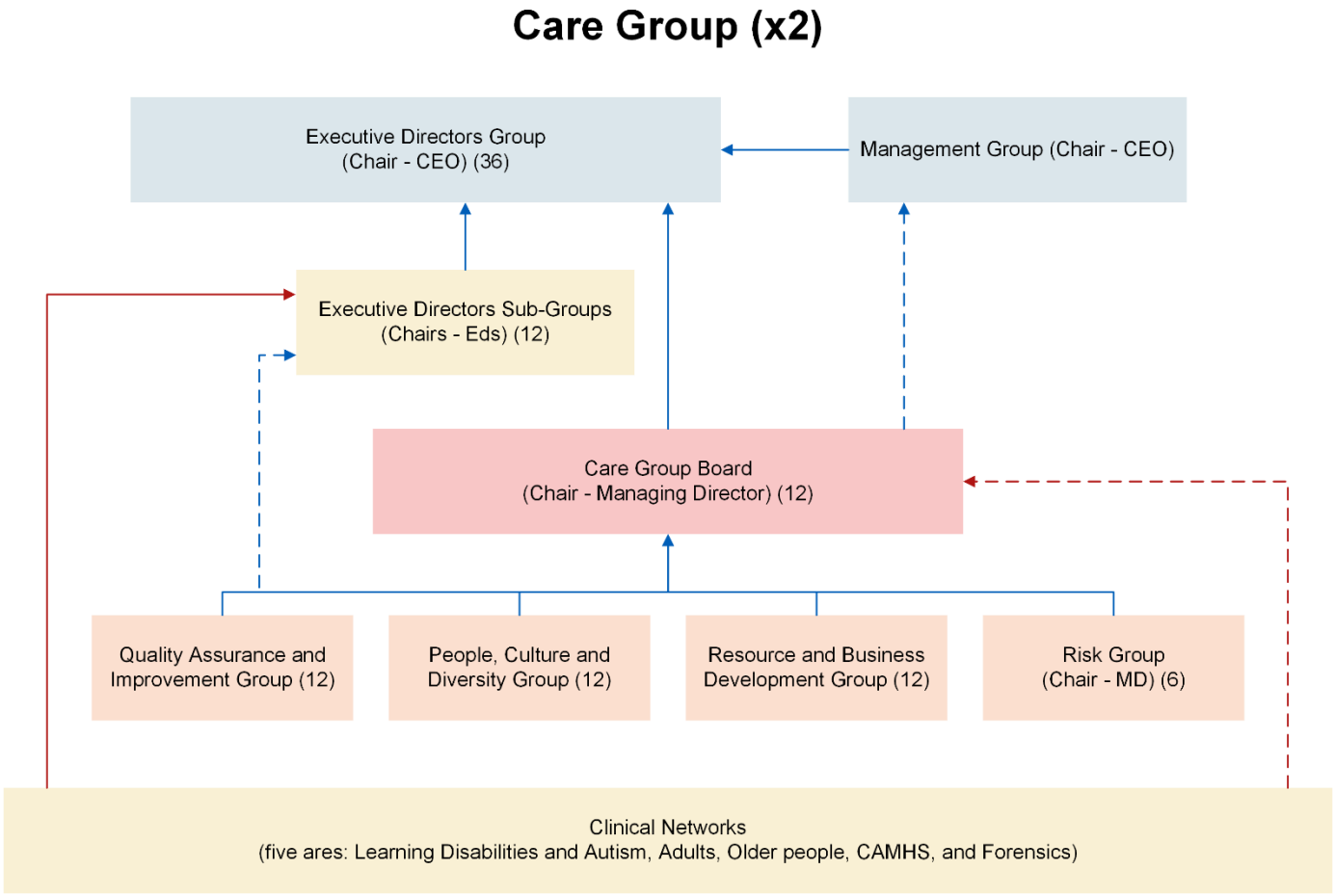
The governance structure in place during 2023/24 is shown in the figure below:



Our Trust Board ensures robust quality governance through the quality assurance committee, a committee of the Board.

The quality assurance committee is chaired by a non-executive director. Its strategic purpose is to provide assurance to the Board on the quality, safety and effectiveness of clinical and operational services through effective systems, structures and processes.

Each care group has quality governance arrangements to address the key elements of quality and safety. These are outlined in the figure below. Each care group reports directly to the executive quality assurance and improvement group monthly, and to the executive directors group weekly on quality performance issues that require executive oversight and/or escalation. Each care group is also required to provide assurance to the quality assurance committee against its quality improvement plans.



Quality assurance and improvement

Our quality assurance and improvement programme was first introduced in April 2021. This is well established and helps us to focus on key quality and safety issues. It has supported us to make improvements including to patient care documents, recognising that high quality documentation is an enabler of high-quality patient care. As part of the programme, there is also observation of practice and discussions with service users, carers and teams within clinical areas. This also helps us to address learning from incidents and support quality assurance and improvement.

The programme comprises of a range of quality assurance tools that are used to gain a holistic assessment of the quality of patient care. These tools have been reviewed during 2023 to ensure that they are informed by current areas of risk, where further assurance is required. Tools currently used are:

- Inpatient quality review
- Community quality review
- HMP 3 part plan
- Peer quality review
- Directors visits

The quality assurance and improvement programme is an effective method of monitoring compliance against key standards of care related to patient safety, clinical effectiveness and patient experience. It has facilitated significant sustained practice improvements and provides the organisation with both quantitative and qualitative assurance evidence. Our practice development practitioners continue to provide coaching, mentoring, training and education to clinical teams to facilitate any required practice improvements.

Key learning from incidents, patient feedback and other forms of intelligence helps to shape our Trust's quality improvement priorities. They also continue to be monitored using the quality assurance and improvement programme.

Key quality improvement work that our Trust has undertaken during 2023/24 includes:

- Continued implementation of our Trust's positive and safe plan (including reducing restrictive interventions)
- Worked with the HOPE(S) team and employed a HOPE(S) practitioner. HOPE(S) is a human rights-based approach to working with people in long term segregation developed from research and clinical practice.
- Increasing the number of wards using Oxevision (a technology that helps us to improve patient safety in inpatient areas)
- Implementation of the new national patient safety incident response framework (PSIRF)
- Agreed a new approach to intermediate life support (ILS) training
- Strengthened processes for organisational learning through the work of our organisational learning group and fundamental standards groups.

Co-creation is central to our overall approach. We work closely with patients, families and carers to identify and deliver our priorities. As part of our ongoing commitment to co-creation, from 2024/25, our directors of lived experience and co-creation boards will lead on development of our Trust's quality priorities on an annual basis.

2.3 Our progress on implementing our 2023/2024 quality improvement priorities

In this first section of part 2, we reflect on the progress we made in implementing our quality priorities during 2023/24 and the impact this had for patients and their families/carers. Following this, we set out our quality improvement priorities for 2024/25.

Priority 1 – improving care planning

Why it is important:
In any health and social care organisation, care planning is a vital component of safe and effective patient care and treatment. In July 2021, NHS England published a formal statement advising all mental health trusts to move away from the Care Programme Approach (CPA) in favour of a community mental health framework. DIALOG+ as part of a wider piece of work, is the tool to enable the move away from CPA, while providing a clear, co-created care plan for patients.

The DIALOG+ process approach allows healthcare professionals to have supportive and meaningful conversations with patients about the aspects of their lives that are most important to them. This includes family, relationships, leisure activities and accommodation, in addition to their mental and physical health. It uses a person centred and patient rated scale that measures patient reported outcomes as well as a measure of patient experience. The output of the DIALOG+ assessment will be a care plan that the patient and health professional create together that is specific, co-created and clear. The care plan will be digital, easy to change and updated regularly as agreed with the service user.

The benefits/outcomes we aim to deliver for our patients and their carers are:

- Personal circumstances, and what is most important to the person and those closest to them, are viewed as a priority when planning care and treatment.
- Accessible, understandable and personalised care plan (including a crisis plan) containing contact details of those people and services that are best placed to help when the need arises.
- Discussions that lead to shared decision-making and co-creation of meaningful care plans.
- Agreed plans recorded in a way that can be understood by the patients and everybody else that needs to have this information.
- Information about support from people who have experience of the same mental health needs.

What we said we would do and what we did:

Record all care plans on our new electronic patient record (EPR) system which is called Cito
Cito went live in Feb 2024 and this has enabled us to meet our ambition of recording all patient care plans in this system.

Ensure all clinical staff are trained in our new DIALOG+ care planning system
Now that Cito is live, DIALOG+ is available for all patients. DIALOG+ training has taken place and further training is also planned. A training workstream has been formed to ensure that all relevant staff understand and can use the 3 patient reported outcome measures (which are DIALOG+, goal based outcomes and ReQoL-10) meaningfully in their work and to align with the evolving landscape of mental health care. Cito introduces critical tools like DIALOG and other patient recorded outcome measures (PROMs), enabling a more nuanced approach to understanding and responding to individual patient needs. The shift is guided by a comprehensive policy framework that draws upon the principles set forth in the NHS long term plan and the community mental health framework, emphasising integrated, person-centred care.

Our Trust, in moving from CPA towards a new universal standard of personalised care, has recognised that it relies on an integrated approach across partner organisations (primary care, VCSE, local authority) depending on:

- Joint working across partner organisations

- Interoperability
- Shared policies and agreements on responsibility and accountability for care and safety management
- Retirement of care coordinator roles and the development of new key worker roles
- Universal access to high quality intervention based (and evidence based) care and support
- Workforce development.
- Co-production at every level.
- A new approach to care planning including the use of DIALOG to guide this.
- A focus on recovery focused outcomes.

Personalised care represents a programme of work focusing on key areas:

- Policy development (TEWV and system-wide)
- Covering roles, responsibilities and accountability for care and safety of patients (TEWV, partner organisations)
- Co-produced care planning - implementing DIALOG to support this (TEWV)
- Increasing access to evidence based psychological therapies and psychosocial interventions (TEWV)
- Workforce development: identifying and addressing skills deficits & training needs. (TEWV)
- Implementation of the key worker role (Integrated care systems (ICS) and all partner organisations including TEWV)
- Interoperability (Integrated Care Boards (ICB).

Next Steps:

- Ratify our Trust's interim policy on personalised care planning
- Roll out of DIALOG to enhance co-produced care planning enabled by Cito.
- Develop and implement strategy to increase access to evidence based psychological therapies
- Establish workforce development group to support delivery of transformation.
- Liaise with and learn from services that are further ahead with delivery of personalized care
- Work with Integrated Care Board (ICBs) and partner organisations to establish the role and responsibilities of the key worker
- Work with ICBs to establish effective interoperability between systems
- Ensure there is a comprehensive communications plan to ensure all stakeholders are aware of developments and the related implications.

The implementation of the interim personalising care policy will mark a significant milestone in the journey toward redefining mental healthcare. This policy, rooted in the principles of personalisation and patient-centred care, sets the stage for a transformative shift in how mental health services are delivered and experienced. The policy underscores the importance of placing patients at the centre of their care journeys, empowering them to actively participate in decision-making, and tailoring interventions to meet their unique needs. The implementation of the policy is not the culmination of a process; rather, it is the continuation of a transformative journey. It is an ongoing commitment to delivering a universal high standard of care, improving patient outcomes, and ensuring that mental health services are inclusive, accessible, and responsive to the needs of all individuals.

Priority 2 – Feeling safe

Why it was important:
Patient safety continues to be our key priority. Our quality journey (the quality strategy) identifies a number of patient safety priorities that we will continue to focus on going forward.

Patients feeling safe on our inpatient wards is a key area for improvement for us. It is acknowledged nationally that some patients report not feeling safe while in the care of mental health services. A survey, undertaken in 2020 by the Parliamentary and Health Ombudsman, examined people's experiences of NHS mental health care in England, reporting that one in five patients reported feeling unsafe.

On a monthly basis patients on our wards are asked: do you feel safe on the ward? The data from our survey is telling us that on average 78.63% of patients feel safe within our inpatient areas against a target of 75%. There is a lack of consistency in how this data is asked, gathered, and reported on nationally to allow any benchmarking comparisons to be made.

The benefits/outcomes we aimed to deliver for our patients and their carers were:

- Improved patient safety and reduction of patient harm.
- An increase in the percentage of our patients feeling safe when they are in an impatient setting.
- Increased collaboration between patients, staff, and peers.
- A reduction in incidents e.g. violence and aggression, absence without leave, drug misuse.
- Improved understanding of ward environments and why patients feel unsafe.
- Increased opportunity to use digital technology to support the delivery of care.

What we said we would do and what we did:

a) Performance improvement plan (PIP) from services in each care board to provide better oversight and gain momentum on service improvement work.
b) Continue to progress our body worn camera pilot work and evaluate its impact.
c) Continue to implement the Safewards initiative.
d) Expansion of peer support workers and activity coordinators.
e) Co-create information leaflets for people newly admitted to include suggestions for what could help them feel safe.
f) Shared learning from the 'feeling safe' focus groups through the co-creation board.

We reviewed information from patient surveys, incidents, and complaints from all inpatient services to identify any new emerging themes that may help inform our programme of improvement work in this area.

From the review undertaken we were able to identify the following themes:

- The need for environmental improvements – for example, to ensure that patients are familiar with their surroundings while on the ward and that the ward is homely.
- Staffing – for example, ensuring that staff are always visible for patients and that there are enough staff available to meet patient's needs when required.
- The need to increase ward based activities available for patients – this includes ensuring that there are variety of meaningful activities available with good use of outdoor courtyards and access to leave.
- Patient safety – for example, improving personalised care planning, timely interventions and support, and helping patient's to feel safe when there are patients displaying aggression.
- Discharge – for example, ensuring that high quality discharge and crisis plans are in place and that patients are well prepared for discharge.
- Communication – for example, ensuring that telephone calls are answered in a timely way, that appointments are not cancelled at short notice and that patients feel listened to.
- Some concerns being raised by MPs or via CQC rather than being reported directly to the Trust, with repeated contacts from some individual patients.

These themes have informed our quality journey and further development of our quality assurance and improvement programme. In addition, the patient and carer experience team has undertaken a series of focus groups between September 2023 and December 2023 across all inpatient wards. This was to understand what feeling safe means to our patients and staff and ask them what they feel would improve safety.

Some of the things we have done in response to what our patients and staff have said:
Safe and visible staffing

- Continuous recruitment programme for qualified and non-registered nursing staff, including international colleagues.
- Embedding the SafeCare system (a nurse rostering system). This enables efficient allocation of staff and has inbuilt patient safety triggers to support patient safety.
- Recruitment of peer support workers, activity co-ordinators and volunteers.

- Reinforced zonal observations on the wards.
- Support from partners, for example introduction of a learning disability nurse on a mental health ward to provide bespoke skills when required.

Patient leave

- Introduced a dedicated leave team to support patients to access leave.
- Patient access to leave is consistently discussed in the daily ward huddles.

Patient activities

- Activity coordinators who work on wards across seven days a week.
- Introduced pet therapy animals within some wards.
- Co-created environmental displays and artwork.

Patient environment

- Autism team support with autism environmental checklist to identify any reasonable adjustments.
- Introduction of a new platform to enhance wi-fi capability.

Each care group has developed a patient experience improvement plan that incorporates actions related to a range of patient feedback and includes those actions related to patients feeling safe on our wards. The plans are reported and monitored through the patient and carer experience group and reported for assurance to the care board executive review of quality meetings. This area of patient safety will continue as a priority over the coming year.

What was the outcome / impact?

Indicator	Target	Actual 2021/22	Actual 2022/23	Actual 2023/24
Percentage of inpatients who report feeling safe on our wards	75%	64.37%	56%	**78.63%**
Percentage of inpatients who report that they were supported by staff to feel safe	66%	68.04	85%	**85%**

Priority 3 - Embed the new patient safety incident response framework

Why it was important
The patient safety incident response framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for proportionately responding to patient safety incidents for the purpose of learning and improving patient safety.

PSIRF is a contractual requirement under the NHS standard contract and as such is mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers. This includes maternity and all specialised services.

What we said we would do and what we did

Be compliant with the national requirements regarding PSIRF.
PSIRF was implemented on 29th January 2024 in line with the key quality priorities within the quality journey and quality strategy. Our Trust's incident policy has been re-written and consulted on. PSIRF actively supports the use of a greater range of evidence-based tools supporting learning from incidents of all severities. Oversight of serious incidents (under the 2015 framework), patient safety incident investigations (under PSIRF) and early learning processes have been reviewed to ensure appropriate rigour.

It was identified that to ensure compliance with the new national learning from patient safety events (LFPSE) standards, our Trust required a new incident reporting system and has therefore changed to a new system. This gives greater visibility and when optimised and will give the ability to triangulate learning from other parts of the reporting systems e.g., complaints. Importantly this system further supports monitoring and timely review and response to patient safety incidents.

The patient safety huddle is now embedded as routine practice and is operating effectively. The daily huddle reviews all incidents of moderate and above severity and in line with the national PSIR framework, a proportionate response is identified. This supports multi-disciplinary engagement, service user, family engagement and early learning.

The standard action plan is now embedded and is applied to both serious incidents, patient safety incident investigations and early learning processes (now referred to as after-action reviews). Action plans are divided into two-parts, local learning and recognising some learning is organisational, the second part will feed into an organisational learning plan. This will have oversight from the quality assurance and clinical effectiveness team. All previous serious incident action plans from 2021 have been reviewed to ensure the evidence of action completion is robust.

Increase the number of staff completing level 1 and 2 training within the national patient safety syllabus training.

Level 1 and Level 2 training is within the ESR system and monitored. As of March 2024, Level 1 is at 95% and Level 2 is at 79%. Additional training is being delivered to our Trust's patient safety team and members of care groups specific to PSIRF tool and processes. A train the trainer programme is planned for quarter 1 of 2024/25.

Introduce an annual patient safety summit.

A patient safety summit, focused on the impact of inequalities on patient safety, took place in March 2024 and was attended by service users, carers, partners, trust staff and other stakeholders.

Introduce the role of patent safety partners.
Our Trust has an identified non-executive director lead supporting work to develop the new patient safety partner role as part of PSIRF. Work is underway with lived experience directors to identify lived experience workers to participate at various points within the patient safety processes. Lived experience directors are currently invited to and attending directors assurance panels. A monthly patient safety partner oversight group has been commenced. There are now two family liaison officers to support engagement with families and carers offering support and signposting.

Complete the focused work we have initiated on the duty of candour through the delivery of an improvement plan
An internal audit of the duty of candour policy identified some areas for improvement and an improvement plan was developed. As part of the improvement work, a new policy was implemented, and internal training developed and delivered as part of the rollout of the new incident system. Bespoke training has been commissioned from NHS Professionals and is being delivered Trust-wide. Duty of candour has been incorporated into new staff induction and preceptorship induction. Duty of candour compliance is part of the early learning process and is to be re-audited in quarter 1 of 2024/25

2.4 Our quality journey

We continue to focus on five areas to support Our Journey to Change strategy. We have worked with patients, carers, partners and colleagues to create our strategy made up of five journeys:

The five journeys are:

- **Clinical** – how we will provide high quality, safe, kind, effective and personalised clinical care to the people we support.
- **Quality** – how we will make our services safer and improve patient experience through evidence-based care.
- **Co-creation** – how we will seek out and act upon the voices of the people we work with to improve care.
- **Infrastructure** – how the places we work, such as our hospitals and offices, the equipment we use, the information we gather and the systems and processes we put in place will support excellent patient care.
- **People** – how we will ensure everyone who works and volunteers with us has a great experience, whether they're permanent employees, people working as bank staff or through an agency, students or volunteers.

The journeys set out specific ambitions and principles that support the mission, values and goals of Our Journey to Change and drives both incremental and large-scale improvement initiatives. The journeys are delivered through a series of programmes and workplans that make up our 2024/25 delivery plan.

The journeys create a strong framework and strategic vision that allow our Trust to prioritise key work. They have introduced rigour and support through a programme management approach and allow the Trust Board to receive assurance that we are making sufficient progress and achieving the outcomes and impact required.

Our quality journey sets out our quality ambitions for the next two years showing where we want our journey to take us. It sets out key principles and explains how our objectives connect to the national NHS patient safety strategy. It also outlines our key strategic quality objectives.

Our ambition is that by 2028, we will achieve the specific aims and measurable improvements set out in our quality journey, through continuous learning and improvement using a range of tools and enablers. This journey has been shaped by our other journeys; clinical, co-creation, people and infrastructure.

We will continue to have an unrelenting focus on patient safety and are committed to:

- Driving improvements in patient safety across our Trust, together with patients, carers and families, colleagues, and partners, and supported by a positive culture.
- Providing a great experience for patients in our care and for patients, carers and families who want to work with us for better mental health in our region.
- Providing safe and kind care that's based on evidence and has outcomes that matter to people.

It is often important to make quick changes to tackle quality issues, and our governance system will promote a culture and processes where data is analysed holistically, and changes implemented swiftly. This means that not everything we need to improve will have a detailed, long-term plan around it.

However, there will be some potential changes which will require lengthy development and implementation periods. These will be governed as projects, grouped into programmes, and be backed by clear business cases which set out the benefits (improvements) that should be seen and when they should be expected to occur.

During 2024/25 the initial set of quality related programmes will be:

- Personalised care planning
- Physical health
- Improve patient safety

2.5 Our priorities for 2024/25

Implementation of quality priorities supports our Trust in ensuring that safe, high quality care is at the heart of service delivery and is in line with Our Journey to Change and the quality strategy.

Developing our priorities

As part of our Trust's ongoing commitment to co-creation, it was agreed that from 2024/25, development of our quality priorities would be led by people with lived experience. This approach enables the voice of service users, relatives and carers to be at the heart of quality improvement across the organisation.

To support the development of the quality priorities, a service user and carer focus group was held in March 2024. Members of the group were recruited through the involvement team and included those with personal lived experience and also those currently working with involvement networks and other community organisations. The focus group was facilitated by the care group director of lived experience for the Durham, Tees Valley and Forensic care group and the associate director of quality governance and compliance. Key quality issues from national and local sources (including learning from co-creation boards, lived experience directors, involvement networks, serious incidents and other governance intelligence) were shared with the group.

The following quality priorities for 2024/25 were agreed by the group and endorsed by our quality assurance committee:

Priority 1:

- **Patient experience: promoting education using lived experience**
  This priority is focused on improving accessibility of services and early intervention. Through the identification and review of themes of patient feedback regarding access to services; the use of the Recovery College and patient stories will establish a cycle of learning, which will be shared with key Partners.

Priority 2:

- **Patient safety: relapse prevention**
  This priority is focused on timely and proactive access to support for patients who experience relapse in order to minimise harm, particularly through the effective use of well-being plans.

Priority 3:

- **Clinical effectiveness: improving personalisation in urgent care**
  This priority is focused on improving the effective use of the 'my story once' approach. The priority will be linked with the community transformation work and also aims to improve patient experience when accessing urgent care services.

2.6 Statement of assurances from the Trust

In this section of the Quality Account, our Trust is required to provide statements of assurance in relation to a number of key performance indicators which are as follows:

- Review of services provided by or contracted our Trust
- Our 2023 Community Mental Health Survey results
- Our 2023 National NHS Staff Survey results
- Clinical Audit: participation in clinical audits and national confidential inquiries
- Clinical research
- Use of the Commissioning for Quality and Innovation (CQUIN) payment framework
- What the Care Quality Commission (CQC) says about us
- Information governance
- Freedom to Speak Up
- Learning from deaths
- PALS and complaints
- Data quality
- Mandatory quality indicators

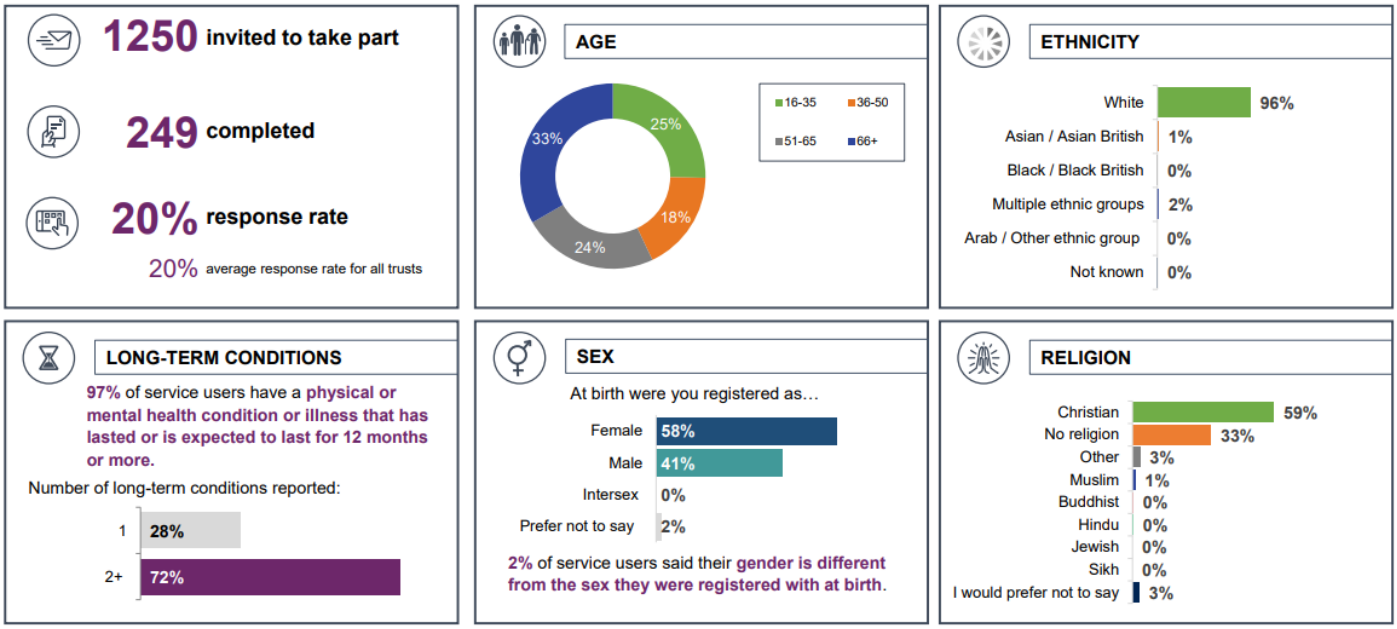
2.7 Review of services provided by or contracted by our Trust

During 2023/24 our Trust provided and/or subcontracted 20 relevant health services. Our Trust reviewed all the data available to us on the quality of care in 20 of these relevant health services.

The income generated by the relevant health services reviewed in 2023/24 represents 100% of the total income generated from the provision of relevant health services by our Trust for 2023/24.

2.8 Our 2023 Community Mental Health Survey results

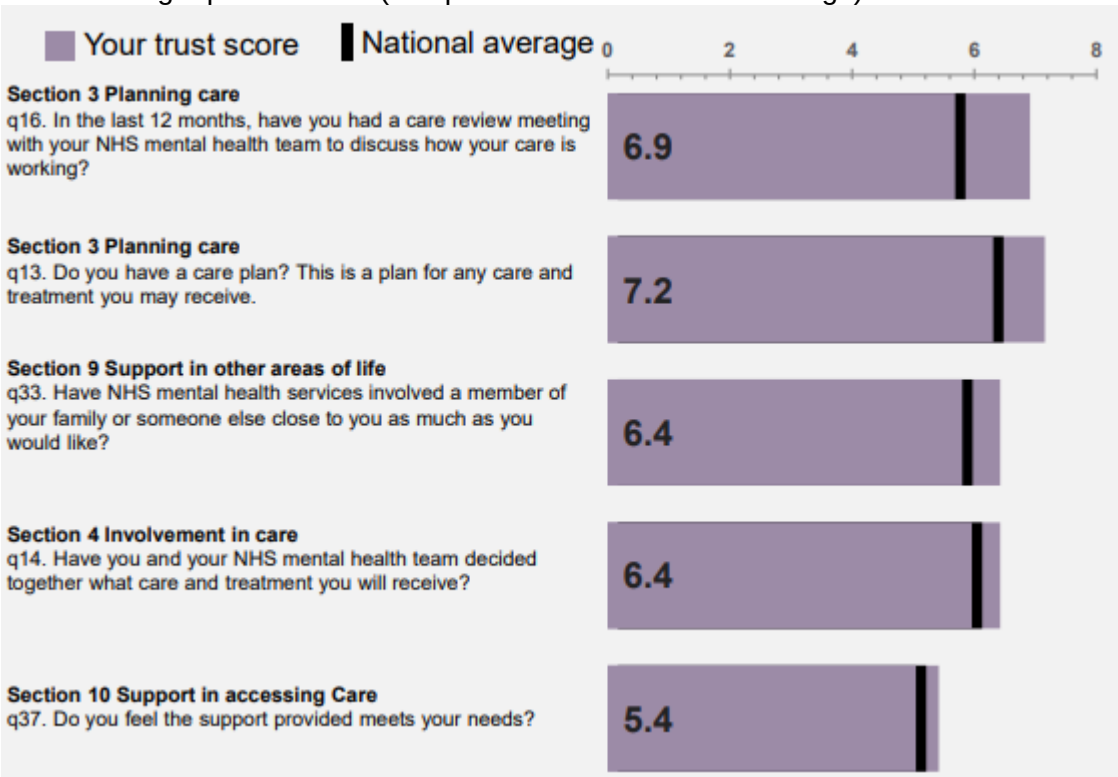
There were 249 completed surveys returned within our Trust for the 2023 Community Mental Health Survey, a response rate of 20%. This is the same as the national response rate and compares with a rate of 20.9% in 2022. The following image illustrates the population of our patients who took part in the survey.



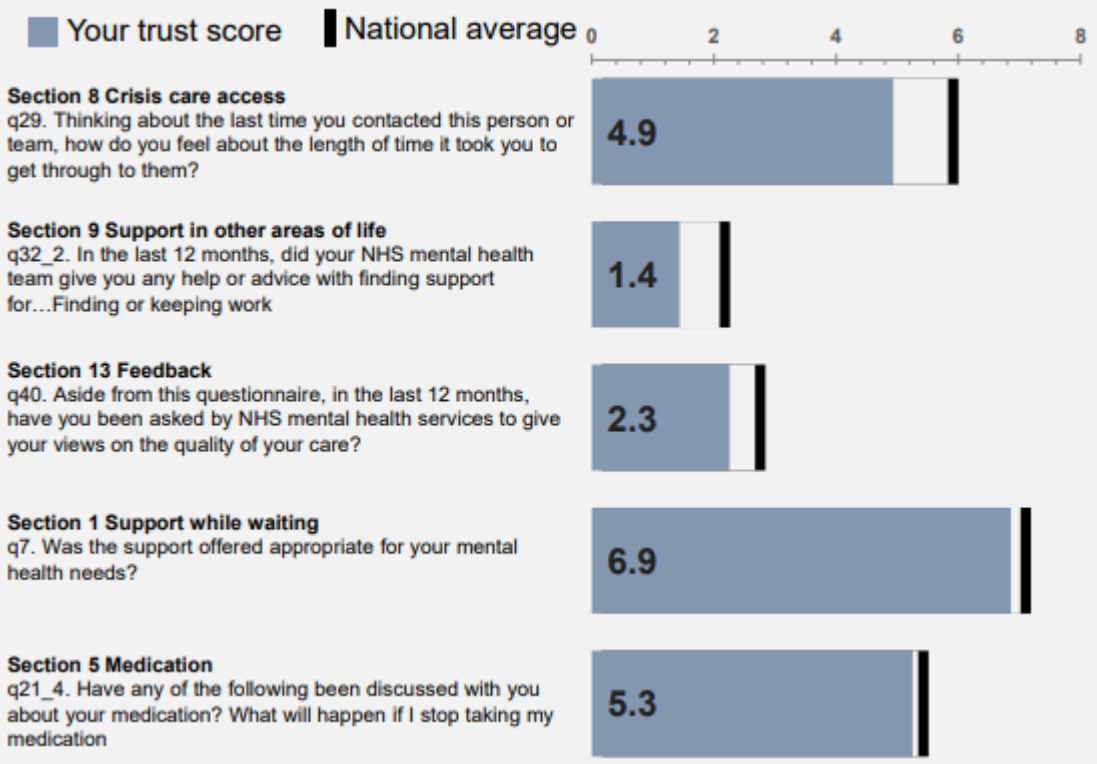
Benchmarking

The 2023 National Community Mental Health Survey was provided by a new supplier. Due to changes made in the sampling period, eligibility of service users included and the mode in which the survey was carried out, there is no comparability with previous years. The initial findings report does not include the lowest and highest national scores. The national results were published on 18th April 2024.

The following top five scores (compared with the national average) are illustrated as follows:



The following Bottom five scores (compared with the national average) are illustrated as follows:



Full results of the survey for our Trust can be found at:
https://www.cqc.org.uk/search/site?fulltext=Mental%20Health%20Survey

2.9 Our 2023 National NHS Staff Survey results

Our response rate increased by 4% to 48% which reflected a good return rate nationally. Ongoing progress is noted in the experience of staff in relation to harassment and discrimination, work hours/ time pressures, and 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).

Due to the way the meetings fell, the staff survey was discussed in detail in the January 2024 people, culture and diversity time out in order to set the priorities for 2024/25 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.

It is proposed that, overall, the staff survey results give good assurance of continued progress. The scores have remained the same or increased in 100 of 113 areas following the significant improvement last year when the trust was the most improved mental health/ learning disability and autism trust in the country.

Work needs to continue on the feedback to teams after an incident and what changes have been made to clinical practice as a result.

The committee also pulled out the theme of staff experience of their team/ team manager. The training and development of immediate line managers will be prioritised this year. We have invested a lot of resource into supporting leaders from service management level and up as a planned stage of implementing the new Trust-wide structure, and continued to run new managers courses and managers' bitesize programmes. We will begin 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'.

Communications have begun with local services to support them to explore their own local data and work with their teams to develop local plans.

Key Trust-wide areas of focus are the continuation of the central reasonable adjustments team, flexible working and sharing changes to clinical practice and the outcome/ experience data from people accessing our services.

The most improved results compared to 2022 are illustrated as follows:

Further detail of the most improved scores:

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%

There are, however, a few areas from the NHS National Staff Survey where we're performing below the national average illustrated as follows:

Further detail of the most declined scores:

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%

Areas where our Trust scored higher than the national average:

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%

Areas where our Trust scored lower when compared to the national average:

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%

2.10 Clinical Audit: Participation in clinical audits and national confidential inquiries

A clinical audit is the process by which the quality of care and services provided are measured against agreed standards. Where services do not meet the agreed standard, the audit provides a framework where suggestions for improvements can be made. A third party conducts national audits. Participating in these audits gives organisations the opportunity to compare their results with other organisations. Local audits are conducted by the organisation itself. For local audits, we evaluate aspects of care that the healthcare professionals themselves have selected as being important to their team. The statements on a clinical audit demonstrate the healthcare provider is concerned with monitoring the quality of their services and improving the healthcare provided.

- During 2023/24, five national clinical audits and two national confidential enquiry covered NHS services that Tees, Esk and Wear Valleys NHS Foundation Trust provides.

- During that period, Tees, Esk and Wear Valleys NHS Foundation Trust participated in 100% of national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in.

- The national clinical audits and national confidential enquiries that Tees, Esk and Wear Valleys NHS Foundation Trust was eligible to participate in during 2023/24 are as follows:
  - National Audit of Inpatient Falls (NAIF) – continuous audit
  - National Clinical Audit of Psychosis (NCAP) EIP re-audit in EIP Services
  - National Audit of Dementia (NAD): Spotlight Audit for Community-based Memory Services
  - POMH Topic 23a: Sharing Best Practice Initiatives
  - POMH Topic 22a: Use of anticholinergic (antimuscarinic) medicines in old mental health services
  - National Confidential Enquiry into Patient Outcome and Death (NCEPOD): End of Life Care Study
  - National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

- The national clinical audits and national confidential enquires that Tees, Esk and Wear Valleys NHS Foundation Trust participated in, and for which data collection was completed during 2023/24, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit Title	Cases Submitted	% of number of registered cases required
National Audit of Inpatient Falls (NAIF) – Continuous audit	2	100%
National Clinical Audit of Psychosis (NCAP) EIP re-audit	475 (and a further 7 contextual team level questionnaires)	100%
National Audit of Dementia (NAD): Spotlight Audit for Community-based Memory Services	Sample provided: 50	100%
POMH Topic 23a: Sharing Best Practice Initiatives	Sample provided: 1	100%
POMH Topic 22a: Use of anticholinergic (antimuscarinic) medicines in old mental health services	Sample provided: 303	100%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): End of Life Care Study	Sample provided: 5 Clinician Questionnaires	100%

Audit Title	Cases Submitted	% of number of registered cases required
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	62 questionnaires sent to the Trust with 42 returned	68%

- The reports of six national clinical audits were reviewed by the provider in 2023/24 and Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:
  - The criteria for monitoring plasma levels was updated as part of our Trust's psychotropic monitoring guidelines.
  - The Trust has implemented a new patient electronic record system (Cito) and prompts have been built in to ensure that staff ensure that patients prescribed melatonin have a review of side effects within the first three months.
  - The Trust psychotropic monitoring guidelines has been updated to include baseline monitoring requirements for valproate.
  - The Trust pharmacy lithium registers team has implemented a process of searching WebICE for relevant blood tests, and within the patient's electronic care record for a recorded weight/BMI, in the two months prior to the patient starting treatment.
  - Additional carer support workers were recruited to support Carer-focused education and support programme provision for our North Tees, South Tees and North Durham early intervention teams.
  - There has been additional Family Intervention investment provided for our Scarborough, Whitby, Ryedale early intervention teams.

- The reports of 125 local clinical audits were reviewed by the provider in 2023/24 and Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:
  - A Mental Capacity Act conference was held for non-medical clinical staff to increase awareness and understanding of Section 17 Leave processes.
  - Key amendments have been made to the quality assurance and improvement programme ensuring the quality and risk areas assessed remains relevant to changing systems and processes within the Trust supporting continuous improvements.
  - Communication across all teams has been provided by our safeguarding public protection team to ensure that there is a system in place to easily identify patients who are parents of children and / or patients who have requested a visit from a child.
  - The Trust safeguarding lead social worker has collaborated with the secure inpatient services to increase awareness of the Trust's Forensic child visiting procedure, alongside the child visiting policy thereby ensuring the person with parental responsibility must be contacted in all cases to consult on the visit.
  - All infection, prevention and control (IPC) audits are continuously monitored by the IPC team and any required actions are rectified collaboratively by the IPC Team and ward staff. Assurance of implementation of actions is monitored by the clinical audit and effectiveness team via the clinical audit action monitoring database. A total of 60IPC clinical audits were conducted during 2023/24 across inpatient areas, prison teams, and applicable community teams where there are clinic facilities. **65% (39/60)** of clinical areas achieved standards between 90-100% compliance. Local clinical audit action plans were implemented in collaboration with the IPC team and the clinical team members to mitigate any areas of non-compliance.

In addition to those local clinical audits reviewed (i.e., those that were reviewed by our quality assurance committee and quality assurance and improvement group), we undertook a further 58 clinical audits in 2023/24 including clinical effectiveness projects by trainee doctors, consultants and other professionals, in addition to those by directorates/specialty groups. These clinical audits were led by the services and

individual members of staff to support service improvement and professional development and were reviewed by specialties.

The Trust has procured an electronic clinical audit application and over the next year will be using this system to make clinical audits more efficient and easier for teams. Teams will be able to review their clinical quality information in a live format and to make any changes needed to improve practice and ultimately the quality of care and the experience of our patients and their families.

We continued to implement an extensive quality assurance and improvement programme during 2023/24. This provides ongoing assurance that key quality and risk issues identified are addressed. Significant improvements in practice and patient safety continue to be facilitated through this programme.

2.11 Participation in clinical research

Our Trust participates in research activity to help provide new knowledge that has the potential to be valuable in improving care for patients. It is important that such research is open to critical examination and open to all that would benefit from it.

The number of patients receiving relevant health service provided or sub-contracted by our Trust in 2023/2024 that were recruited during that period to participate in research approved by a research ethics committee was 939. Of the 939 participants, 901 were recruited to 29 National Institute for Health Research (NIHR) portfolio studies. This compares with 827 patients involved as participants in 36 NIHR research studies during 2022/23. As well as acting as a research site and participant identification centre, our Trust sponsors research including six NIHR grant-funded studies. As part of this role our research and development team are actively engaged in governance activities such as site set-up and performance tracking. As sponsor, during 2023/2024, our Trust oversaw the completion of the BASIL+ trial, an urgent public health study. It shows that depression and loneliness can be prevented using structured telephone-based psychological care, delivered over 8 sessions (Behavioural activation to mitigate the psychological impacts of COVID-19 restrictions on older people in England and Wales (BASIL+): a pragmatic randomised controlled trial - ScienceDirect). Another of our sponsored studies explored food insecurity in adults with severe mental illness living in Northern England. The study was co-produced with four peer researchers with lived experience of severe mental illness from its conception to dissemination and found a 50.4% prevalence of food insecurity in the reported sample (Food insecurity in adults with severe mental illness living in Northern England: A co-produced cross-sectional study - Smith - Nutrition & Dietetics - Wiley Online Library).

Other examples of how we have continued our participation in clinical research include: We continue to work closely with the NIHR Clinical Research Network North East and North Cumbria to support large scale national portfolio research studies, and to measure patient research experience when taking part in studies with feedback and any actions reported to our research governance group. 27 different staff members took on the role of principal investigator for NIHR supported studies. We continue to collaborate with a wide range of universities and other NHS providers to deliver large multi-site research studies for the benefit of our service users, carers, and staff.

2.12 Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion of Tees, Esk & Wear Valleys Foundation Trust's income in 2023/24 was conditional on achieving quality improvement and innovation goals agreed between Tees, Esk and Wear Valleys NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2023/24 are available on request from Ashleigh Lyons, Head of Performance. Email Ashleigh.lyons@nhs.net

There will be no 2024/25 CQUIN requirements.

2.13 What the Care Quality Commission (CQC) says about us

The Care Quality Commission (CQC) is the independent regulator for health and social care in England. It ensures that services such as hospitals, care homes, dentists and GP surgeries provide people with safe, effective, compassionate and high-quality care, and encourages these services to improve. The CQC monitors and inspects these services, and then publishes its findings and ratings to help people make choices about their care.

Tees, Esk and Wear Valleys NHS Foundation Trust is required to register with the CQC and its current registration status is registered without conditions for services being delivered by the Trust. The Trust is therefore licensed to provide services.

The CQC has not taken enforcement action against Tees, Esk and Wear Valleys NHS Foundation Trust during 2023/24.

Tees, Esk and Wear Valleys NHS Foundation Trust is subject to periodic reviews by the CQC and the last review was on 29 March 2023 to 02 June 2023. The CQC's assessment of the Tees, Esk and Wear Valleys NHS Foundation Trust following that review was an overall rating of requires improvement.

Our Trust's CQC inspection took place 29 March 2023 to 02 June 2023. As part of the inspection, the CQC visited 59 of our wards/teams. This comprised of inspections of wards/teams from a range of Core Services including Adult Learning Disability Community and Inpatient services, Secure Inpatient Services and Community and Inpatient MHSOP services. The CQC published the results of the Trust's latest trustwide inspection on its website on 25 October 2023.

The CQC report demonstrates our continuous improvement and the positive impact that this has had on people's experience of the services that we provide. It also acknowledges that we still have more to do.

Importantly, the report recognises the hard work and commitment of Trust colleagues in making improvements. A running theme throughout the report is that our staff are kind and caring and demonstrate our values in the care that they provide. This is something that is seen every day, not just during CQC inspections. We know there is more to do but we're proud that we're moving forward together.

The CQC inspections took place from March to June 2023 and while the Trust's overall rating has stayed at requires improvement, there are no longer any areas that are rated as inadequate and the majority of our services are rated as good. Overall, the CQC recognises that we're making good progress.
This has been a real team TEWV effort. It is of particular note, that Ridgeway (our secure inpatient services), wards for people with a learning disability or autism and wards for older people had all improved since their last inspection.

Inspectors found that our Trust had a clear vision and strategic direction, which is understood by all staff. They could also see a positive culture change. This was demonstrated by colleagues who felt supported and valued and had confidence in our freedom to speak up process. Most importantly by patients who told inspectors that staff were 'kind and considerate', 'friendly', 'kind and supportive' and that they were 'actively involved in their care planning'.

We all agree that further improvements are needed, however, we have come a long way in a relatively short space of time and in difficult circumstances. The areas for improvement are already in our sights and are being worked on every day. As with other trusts throughout the NHS, successful staff recruitment and retention and development of the excellent staff we have, remains a pressing priority and is key to us achieving all our goals.

Key facts and figures:

- Seven out of 11 of our services are rated 'good'. Four areas are rated as 'requires improvement'. This is an improvement since our last inspection in 2021.
- All services were rated as 'good' for caring.
- Nine out of 11 services were rated as 'good' or 'outstanding' for effective.

- No warning notices were served as a result of the inspection.
- No services were rated as 'inadequate'.

As expected, the areas for improvement include issues seen nationally such as staffing and waiting times. We've also got some more work to do around mandatory training and recording supervision, physical health monitoring and responding to complaints. The backlog of serious incidents is highlighted as a 'must do', and we are committed to completing these in a timely way, with significant progress now made in reducing this. There is a clear plan in place to reduce delays and are making good progress.

We know that there is further work to do however, the fact that the CQC has told us we're making improvements, and that these positive changes have impacted on the quality of our care, is a really important step on Our Journey to Change.

Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following action to address the points made in the CQC's assessment:

- The quality governance team has co-created the CQC improvement plan in collaboration with care group colleagues and specialty/directorate leads, in response to the CQC must and should do recommendations made within the inspection report. Two improvement planning events were held 31 October 2023 and 01 November 2023 to develop the improvement actions. The events were well-attended and the framework used was well received by those involved.
- Improvement actions have been developed taking into account the significant work which has already been completed, avoiding duplication where actions are already being addressed by established workstreams or ongoing improvement plans are being delivered. This includes how we check that there is ongoing assurance of actions being embedded and sustained.
- The Trust CQC improvement plan against the must do recommendations was formally submitted to the CQC on 27 November 2023 after approval by the quality assurance committee 22 November 2023.
- The quality governance team will continue to maintain the evidence repository to provide assurance of completion and implementation of improvement actions. Delivery progress for the CQC improvement plan (must and should do actions) will continue to be formally reported to the Quality Assurance Committee, noting where actions are implemented and embedded.
- Learning themes from the CQC improvement plan informed the Trust-wide learning event held on 3 November 2023, where these were triangulated with broader quality governance intelligence, including learning from serious incidents, quality assurance programme data and complaints feedback.

Tees, Esk and Wear Valleys NHS Foundation Trust has made the following progress by 31st March 2024 in taking such action:

- A revised schedule / work plan for the quality assurance committee includes learning from audits, incidents, CQC visits and complaints. Learning from executive visits is reported into the management group and informs the quarterly learning events (alongside the review of serious incidents, incidents and CQC visit themes).
- A procedure setting standards for responding to requirements and recommendations from external and internal reviews has been implemented.
- All external and internal reviews that result in recommendations will continue to have an associated improvement plan with a clear governance route to ensure delivery through to conclusion (including tracking of recommendations and actions).
- The duty of candour policy has been revised in line with national standards and there is weekly reporting of duty of candour to the executive directors group and the quality assurance committee to confirm compliance with the policy standards.
- Incident reporting on InPhase prompts clinicians to record the rationale where prone restraint is used. The use of prone restraint is reviewed within each care group positive and safe group and the Trust-wide positive and safe group. Performance against the standards is reported up through care groups and the Trust-wide positive and safe group to the quality assurance committee and the mental health legislation committee.
- We have reviewed, updated and implemented the Section 17 Leave Policy. The mental health legislation team has undertaken formal monitoring and checks in relation to completion of Section 17 leave documentation, ensuring that it is fully completed, and that staff are using the correct form. Feedback from these reviews has demonstrated improvements and has been reported to the Trust's

Mental Health Legislation Committee. We have also included monitoring of leave documentation within our quality assurance schedule to continue to quality assure until we are confident of embedded improvements.

- We have a forward plan for the mental health legislation committee to identify regular reporting requirements from the positive and safe group, including data on the use of restraint and Use of Force Act compliance.
- All governors have been informed of what support is available and from whom within the Trust. Contact details of non-executive directors and their biographies have been shared with all governors, and non-executive directors have been advised to make themselves available to governors wherever possible through normal Trust business, including Council of Governors meetings.
- We have agreed a plan on a page for the use of Speak Up Guardian data and intelligence, how it will be shared and how it will be triangulated with other information / data to lessen the risk of closed cultures.
- We have agreed process for the people, culture and diversity committee regarding how we manage and report Freedom to Speak Up outcomes (without breaking individual confidentiality).
- We have developed a workforce plan for pharmacy professionals and non-registered pharmacy staff.
- We have reviewed all blanket restrictions on Kestrel/ Kite ward to ensure that these are now individually assessed. These have been presented to the reducing restrictive interventions group.
- We have reviewed all wards within the service to ensure that rooms and facilities are accessible for patients with mobility needs, including access to emergency call alarms.
- We have developed a system in collaboration with occupational therapy to ensure that when patients need are assessed and a change of environment is required, that a monitoring and escalation process is in place.
- We have reviewed the contract for the provision of patient food and a new provider is now well established. We have held focus groups with patients to support the development of new ward menus and we have incorporated fridge checks by ward housekeepers into the daily workplan.
- Ward managers have co-produced a system with service users for dissemination and storage of community meeting minutes which will document the outcomes of actions taken.
- We have decommissioned the seclusion facility where an issue was observed in relation to use as a cut through by staff.
- Lockable safes have been checked on admission of new patients and at discharge to ensure that they are in good working order.
- We have developed and undertaken an oxygen assessment against the policy assurance statements for the storage of oxygen. This was reported to the care group quality assurance and improvement group and the executive review of quality group. We have developed and implemented fridge temperature assessments, which covered a 30-day period and assessed practice against the policy assurance statements. Where improvements were required, action plans were agreed and followed up to provide assurance of completion with oversight via the care group governance forums. We are continuing to quality assure until we are confident of embedded improvements.
- We have reviewed site maintenance (including the cleaning schedules) and have regular meetings between the service and the estates and facilities management team to ensure that the unit is well maintained.
- We continue to work in collaboration with the HOPE(S) model for all patients in long term segregation and seclusion. All people will have a plan that has a long-term goal of leaving long term segregation.
- We have reviewed the adult learning disabilities inpatient estates and took actions to ensure that people's living spaces are conducive to recovery and feel welcoming. We continue to work with service users and their loved ones to understand individual preferences.
- Care groups have developed a plan for site visits (peer quality reviews) across 7 days a week and the 24-hour period to ensure that balanced feedback is gathered.

Tees, Esk and Wear Valleys NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

2.14 Information governance

The reporting deadline for the toolkit is now 30 June 2024, therefore our position remains the same as for our 2022/23 position which is 'approaching standards'.

We are currently at **90%** completion of our information governance mandatory and statutory training. Our Trust currently has a sickness rate in the region of **5%** so our ability to achieve the **95%** target has been impacted.

However, the current iteration of the toolkit (2023/24) allows organisations to develop their own information governance mandatory and statutory training and set their own key performance indicator (KPI). The Trust is currently in the governance process of bringing this KPI in line with all other mandatory training which is **85%** and which the Trust is already exceeding. This will be mitigated by the introduction of refreshed induction training for new starters which will include information governance training on their first day with the Trust.

2.15 Freedom to Speak Up

There are a number of routes through which staff can raise concerns:

- Through their own management or professional structures.
- Through the Freedom to Speak Up team. This is as confidential as the person asks for it to be. Concerns are addressed in agreement with the person who spoke up. We have recently started directing the request for review to the senior leadership team. This has enhanced the process and increased the sense of service ownership and satisfaction from those who spoke up. However, we still offer an independent review for those who feel speaking outside their service is preferrable or want to ensure a level of confidentiality. We also signpost to other services such as employee support services or human resources. Feedback is given to the person on a regular basis, in line with our revised process. As much feedback is given as appropriate although, by the nature of some concerns and investigations, full feedback is not always possible.
  We have a monthly speaking up forum where we share soft intelligence, agree proactive work and agree what information is to be shared with the people and culture committee, the board, and each care board so that we can triangulate feedback from reviews, service action plans, and share outcomes.
- The online raising concerns form where people could previously complete anonymously has been discontinued.
- Through our safeguarding team or directly to the CQC.
- Through our formal HR processes, the timescales of which vary and are laid out in the relevant policy.
- Through the employee support service who will signpost and provide guidance on how to make best use of the options available.
- Through any trade union of which they are a member.

We have a process for addressing any concerns of detriment or demeaning treatment, in line with national guidance. We have recently agreed that concerns will be passed to our associate director for operations and resourcing, who will quarterly share themes with our non-executive director for speaking up.

With regard to the medical workforce, the role of Guardian of Safe Working for postgraduate doctors within our Trust sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The work of the Guardian is subject to external scrutiny of doctors' working hours by the CQC and by the continued scrutiny of the quality of training by Health Education England.

The Guardian is required to levy a fine against a department(s) if a postgraduate doctor:

- Works on average over 48 hours/week
- Works over 72 hours in seven days
- Misses more than 25% of required rest breaks
- On non-residential on call (NROC) does not have a minimum of continuous rest for five hours between 10pm and 7am
- Does not have the minimum eight hours total rest per 24-hour non-resident on-call (NROC) shift
- Has more than the maximum 13-hour residential shift length
- Does not have the minimum 11 hours rest between resident shifts

The Guardian of Safe Working for postgraduate doctors within our Trust produces quarterly and annual reports to the Board that focus on gaps in medical rotas and safety issues.

The Board received the Guardian's annual report for 2023/24. During the year, the most common reasons for needing short-term/locum cover was due to vacancies on the rotas and staff sickness (short/long term).

Exception reports received related mostly to claiming additional hours whilst on NROC, having to stay later than normal working hours or shift end time or missing teaching/training due to staff shortages. Discussions on these issues have taken place at the relevant forums and additional staffing put in place where possible.

2.16 Community transformation

The aims of the Community Mental Health Transformation Framework were to redesign and reorganise core community mental health teams which are place based and to create a core mental health service which is aligned with Primary Care Networks, local authority and voluntary care sector organisations.

Key achievements made as part of the ongoing community mental health transformation work in line with the NHS England five year programme and provides a breakdown of next steps and key areas of delivery for the next 12 months.

Durham Tees Valley care group:
Key achievements of note include; County Durham

- An average increase of 26% in monthly referrals into the Durham mental well-being alliance with contact remaining within 48 hours.
- The number of people signposted to system services rather than referred to secondary care increased 8 fold.
- GP Aligned services received a total of 5,737 referrals in 2022/23 with only 14.8% of those being stepped up into secondary care.
- In the past six months, 22,560 people have seen by first contact practitioners with majority (90+%) having needs met in primary care or through signposting to community offers.
- Community Navigation met 72.5% of people's needs when referred to them, with 94% receiving support within 1 week.
- Access "waiting" caseload (excluding neurodevelopmental) has halved and waiting times for assessment reduced from approximately six weeks to approximately two weeks on average.
- Tees Valley Lived Experience involvement has helped to drive the work forward at all levels with members involved in key decision making.
- Establishment of the primary care workforce has resulted in only 3% of individuals now being stepped up into secondary care services.
- Introduction of the South Tees dual diagnosis team has allowed a completely new way of working which fits individual needs.
- The introduction of a new skill mix, care navigators, have enabled individuals to find support at the right place.
- Restructure of adult mental health community teams has been completed seeing a reduction of three teams into one team that now has two functions.

North Yorkshire, York and Selby care group:

Key achievements of note include:

- Lived experience voices are at the heart of transformation and have driven forward the work of the programme at all levels as key decision makers. The passion and enthusiasm seen from our members has ensured the programmes progress to date and enabled the true meaning of this work to be delivered. Within our Trust, the establishment of lived experience forums will keep the transformation accountable and has created a partnership between service and communities to deliver new and improved services. Work is underway to broaden this approach and support across the whole system. The Roundhouse will provide a central point to seek advice, guidance and support to engage from people with a lived experience.
- The establishment of the new first contact mental health practitioners in the primary care workforce has enabled an individual's needs to be met at the earliest opportunity. Currently less than 5% of individuals being seen in primary care are stepped up into secondary care, this indicates that the right individual care is being met at the right time, in the right place. Relationships and understanding of services have improved and led to closer multi discipline team working (across primary care, secondary care and the voluntary care sector), improving decision making, problem solving and integrating primary and secondary care. Work is under way to develop trusted assessor status for these practitioners which will increase integration further and reduce waiting times. We have held workshops and question and answer sessions across the whole system to look at development and refining pathways to make the system more user friendly. This is already having a positive impact on referral practices.

- The introduction of a new skill mix, new 'system' roles across complex and emotional needs services, adult eating disorders, peer support, social prescribers, early intervention in psychosis and trauma informed care, have enabled individuals to find support at the right place. Their knowledge of the system and support within offered, as well as their relationships with key delivery partners, has ensured our local communities can navigate the correct support for their needs. These system roles work across the whole system, delivering specialist interventions, advice, guidance, training and co-working in several locations across the communities.
- Place based delivery workstreams with voluntary care sector leads from across the system have been able to act at pace. Capacity has been enhanced across the voluntary care sector and joined up, wrap around and supportive care delivered alongside statutory services, increasing access and interventions available across communities.
- Development of new community mental health hubs in the city of York and across North Yorkshire. We have successfully prototyped a new community mental health hub in the city of York where individuals can access the care they need from the whole system to meet their mental health needs. The model has been co-produced with stakeholders and people with lived experience. The prototype has now moved to implementation and is currently recruiting its full team ready for formal launch in March. Two further hubs are planned for the City of York, whilst other hubs are developing or already partially operational in Selby, Harrogate, Ryedale and Hambleton.
- Community grants have been provided at place to fund small and grass-root voluntary care sector organisations to bolster the resilience, provide the necessary support and wrap-around services to underpin the development of the new community hubs.

Recruitment
In the year 2023/2024, we booked 1,781 start dates with 781 of them being external to the Trust.
We have continued with our international recruitment drive to fill nursing posts and expanding our workforce. We remain driven to improve our service, always looking at ways we can streamline and enhance the service we provide.

We have recruited over 150 newly qualified nurses into our workforce, supporting them in the start of their nursing careers.

The apprenticeship and talent team has attended numerous careers events at local schools and colleges – as a direct result of this, we have recruited four young people into permanent posts.

Between April 2023 and March 2024, we had 221 staff start an apprenticeship and during the same period 120 successfully achieved their apprenticeship. We are now working with partner organisations of the Leadership Academy to deliver apprenticeships which incorporate leadership programmes such as Edward Jenner and Mary Seacole.

We are in the process of looking at ways of bringing under 18's into TEWV either as students on placement; as volunteers and as apprentices.

2.17 Learning from deaths

During 2023-24, 1322 deaths were reported to Tees, Esk and Wear Valleys NHS Foundation Trust's incident reporting system, with the majority of these considered to be from natural causes.

This comprised of the following number of deaths which occurred in each quarter of that reporting period:

- Q1 - 534
- Q2 - 330
- Q3 - 273
- Q4 -185

Of the 1322 deaths, in line with the national guidance on learning from deaths, 259 deaths fit the criteria for further review and 143 mortality reviews were carried out.

In mental health and learning disability services we have a number of older people who are cared for in the community and their needs are such they only require minimal contact with us. Many of these people, who die, do so through natural causes as happens in the wider population. This explains the difference between the total number of deaths (from all causes including natural causes) and the numbers we go on to investigate further. To support staff in their decision making regarding the investigation of deaths, staff have clear policy guidance, setting out criteria for categories and types of review.

Of the 1322 of the patient deaths during the reporting period 0.007% are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been based on the information contained within Structured Judgement Reviews carried out under the learning from deaths policy.

It is noted that from 1st April 2023 – 29th January 2024 case record reviews have been defined as those cases falling under the Trust's mortality review process and investigations as cases that have been reported on the Strategic Executive Information System (StEIS) and investigated under the Serious Incident Investigation Framework. From 29th January 2024 we moved from the Serious Incident Framework to the Patient Safety Incident Response Framework (PSIRF). This advocates a proportionate approach to investigation offering further tools for review of incidents. From 29th January 2024 case record reviews continue to be those falling under the trust mortality review process and investigations are those investigated using either an after-action review process or a patient safety incident investigation.

The Trust does not record information in the format previously detailed by the national guidance for this mandated statement. In line with the national guidance, the Trust no longer categorises learning into contributory and incidental findings.

All learning from serious incidents and patient safety incident investigations is themed and informs key workstreams to address any identified quality and safety issues.

- During 2023/2024 PSIRF was implemented. This is in keeping with Our Journey to Change and a focus on just culture and learning. During each quarter the number of learning points identified from case record reviews and investigations were as follows: 120 in the first quarter, 180 in the second quarter, 288 in the third quarter, and 220 in the fourth quarter. This reflects the significant increase in case record reviews and investigations undertaken compared to the previous year.

In 2023/2024 a 12-month thematic multi-disciplinary review was undertaken which built on existing theming work undertaken during 2022/2023. This thematic review extended the original seven learning themes identified from serious incidents investigations.

The original seven themes from serious incidents were identified as:

- Risk assessment and management (safety summary/plan/contingency planning)

- Care planning
- Safeguarding (including use of PAMIC tool)
- Family involvement
- Record keeping
- Multi-agency working
- Records management

From the 2023/24 review an additional five, themes were identified where it was felt that there needed to be a specific focus. These five additional themes are:

- Physical healthcare
- Personalised care
- Staffing
- Positive and safe care / reducing restrictive interventions
- Environment

Themes from case record reviews were identified as:

- Care planning
- Multi-agency working
- Family involvement
- Physical health monitoring
- Medication monitoring
- Record keeping
- Risk assessment/risk management

- All learning in the Trust is referred to as actionable learning and supports our approach towards a just and learning culture in line with Our Journey to Change and a systems-based approach to learning as advocated by PSIRF.

Actionable learning continues to be monitored against the themes identified. Our quality assurance programme is regularly updated to reflect learning from patient safety incidents. It provides assurance that improvements are being made in relation to risk assessment, risk management, and contingency planning, care plans and carer involvement and that these improvements are being sustained in both inpatient and community settings. Ongoing quality assurance processes have highlighted specific learning themes. These have been presented through a monthly system wide quality meeting. Since January 2024 themes explored in this forum are care planning/CPA/intervention plans, risk assessment, management and safety summaries, physical health, record keeping and staffing.

Our Trust continues to strengthen arrangements for organisational learning via the organisational learning group which has had a full review of its membership and terms of reference, resulting in multi-disciplinary and executive level membership. The group's role is:

- Develop and maintain processes to learn and improve after patient safety incidents, complaints, safeguarding, leadership visits, investigations etc.
- To alert the Trust of systemic areas for improvement and / or safety issues.
- To ensure the group escalates or delegates concerns or issues to the appropriate forums / workstreams.
- To ensure the organisation has a structure that supports learning and improvement with strong triangulation and governance through:
- clear collation of information
- transparent processes to explore and investigate issues based in the PSIRF principles of Just Culture.
- Work with care groups and clinical networks to identify and theme learning opportunities.
- Ensure governance structure that will implement and monitor any identified changes.
- Disseminate learning and developments through a variety of identified solutions.
- Proactively seek out best practice and provide guidance to fundamental standards, clinical networks and care groups to ensure that safe high-quality care remains at the forefront of service delivery.

- To invite identified work streams to feedback areas of development and positive practice to update and share progress.
- Review and raise awareness of wider system learning from across a range of organisations or publications for discussion.

Learning from case record reviews can be discussed within the organisational learning group, and will be disseminated via clinical networks, fundamental standards, briefings where appropriate, to ensure that learning feeds into existing improvement work. Learning for individuals is also shared with operational teams where appropriate and addressed via supervision and other local governance processes.

Twenty-one patient safety briefings have been circulated trust wide during 2023/24 as a result of learning.

Examples of these briefings include:

- Awareness raising related to spare Emergency Automated External Defibrillator (AED) Pads
- Recording of allergy information in the clinical record
- Information related to the operation of anti-barricade door systems
- Communication with families
- Liaison with the police
- Oxehealth functionality
- Safety planning whilst awaiting admission
- Reviewing of laboratory results
- A number of public health issues in partnership with other agencies linked to increased risks of suicide and potential harmful substances within communities.

The briefings circulated are specific about any assurance required from services. On receipt of completed actions these are documented in the local safety alert and learning database.

The environmental risk group receives monthly incident reports involving ligatures and other risks where environmental factors may have contributed to harm as well as progression of initiatives to reduce harm. Any urgent learning from this group is disseminated Trust-wide via patient safety briefings. Environmental surveys with multi-professional input from estates, health and safety and clinical services continue to be undertaken.

Connecting for people, suicide awareness training, continues, and our mandatory harm minimisation training was updated to include relevant areas of actionable learning. The training considers completion of documentation/record keeping, patient/carer involvement and the importance of multi-agency working. Bespoke training sessions in hot spot areas are available on request.

The learning from deaths policy is currently under review to align it to PSIRF. It is aligned to Our Journey to Change and will ensure carers and families receive compassionate care following the loss of a loved one.

We continue to work collaboratively as part of the Better Tomorrow Programme to facilitate shared learning/good practice and valid comparisons with other trusts.

A new risk management system has been implemented bringing additional benefits in terms of triangulation of learning and oversight of organisational action plans with oversight from the organisational learning group.

Deaths of people with a dual diagnosis are increasing. Community transformation work has facilitated collaborative pathways across the system it operates within. It aims to create a core mental health service which is aligned with primary care networks and voluntary sector organisations to ensure that services are accessible to the community it serves and inclusive of population need.

- 96 case record reviews and 103 investigations completed after 31/03/2023 which related to deaths which took place before the start of the reporting period. This represents a significant increase and reflects our commitment to resolving any backlog of reviews

- As stated during 2023/2024, in keeping with Our Journey to Change and in line with our transition to PSIRF, both of which focus on just culture and learning, all learning from case reviews and investigations is considered actionable learning. Within 2023/2024 we completed 199 case record reviews and investigations from deaths occurring in previous years and undertook 402 case record reviews and investigations from deaths in the reporting period. This meant we undertook a total of 601 case record reviews and investigations. This is a significant increase on the 276 case record reviews and investigations completed in the 2022/2023 period. 808 learning points were identified over 2023/2024 and this included the cases in point 6 above.

2.18 PALS and complaints

All complaints are managed in line with national guidance, and we are committed to providing opportunities for our patients, their carer, or their families to seek advice or information, raise concerns or make a complaint about the services that the trust provides. Our complaints policy outlines how they can do this and to feel confident that they will be listened to, and their issues taken seriously.

In 2023, we carried out a full end to end review of our PALS and complaints function. The review had a very clear aim of ensuring a quicker, simpler, and more streamlined complaint handling service with a strong focus on early resolution and learning.

We implemented our new approach to complaints handling on the 11 December 2023 following a robust cycle of quality improvement whilst ensuring that everything was co-created. The new approach fulfils the expectations set out by the Parliamentary and Health Service Ombudsman (PHSO) for NHS Complaint Standards (2022).

We are encouraging people to discuss any issues they have with our staff, as we may be able to sort the issue out to their satisfaction quickly and without the need for them to make a complaint.

We recognise that we cannot always resolve issues as they arise and that sometimes people will want to make a complaint. We have simplified and streamlined our approach and we no longer differentiate between PALS and complaints, instead we are calling everything a ‘complaint’. We are working on the principle of ‘investigate once and investigate well’ with each complainant receiving an open and honest written response that outlines any learning to demonstrate how we have listened and taken seriously their complaint.

We recognise that all complaints give a vital and direct insight into the quality of services that we provide. As part of the review, we also implemented a new electronic system to give greater visibility and when optimised the ability to triangulate learning from across the trust e.g., patient safety incidents etc. In time this will feed through to the Trust’s organisational learning group.

In 2023/24 we received the following concerns:

Financial year	Local issue resolution	PALS	Complaints	Total
2023/24	206	1,773	498	2,477
2022/23	N/A	2,446	338	2,784

2.19 Data quality

The latest published Data Quality Maturity Index (DQMI) score is **97%**. This is for December 2023.

Our Trust did not submit records during 2023/24 to the secondary uses service for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

Our Trust was not subject to the payment by results clinical coding audit during 2023/24 by the Audit Commission.

We have had our annual external clinical coding audit for the data security and protection toolkit. The results were 96% correct for primary diagnosis and 83.1% correct for secondary diagnosis.

We stopped making commissioning data sets submissions that go to secondary uses service and HES approximately five years ago as the data was duplicated with the Mental Health Services Data Set. The Mental Health Services Data Set data quality for NHS number and GP practice from the Data Quality Maturity Index publication for December 2023 were both 100%.

2.20 Mandatory quality indicators

Since 2012/13, all NHS foundation trusts have been required to report performance against a core set of indicators:

Inpatients that are discharged are followed up within 72 hours.
531 people were not followed up within 72 hours between April 2023 and March 2024.

The 72 hour measure is the percentage of people discharged from a CCG-commissioned adult mental health inpatient setting, that were followed up within 72 hours. This includes all people over the age of 18 years.

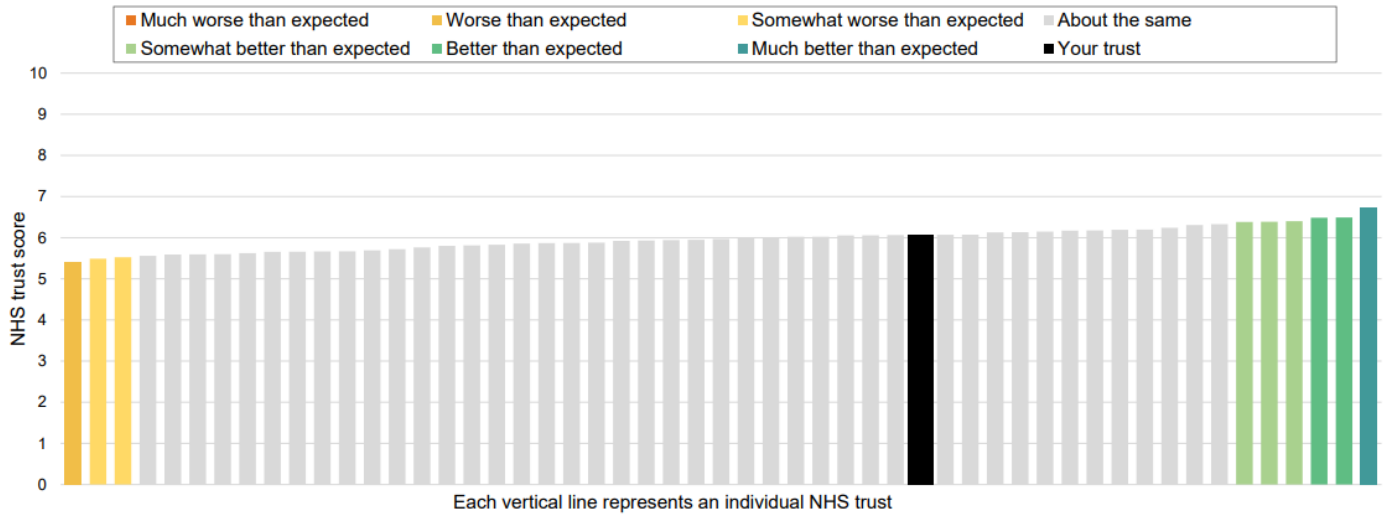
Of our commissioned services, 2938 patients were discharged between 1 April 2023 and 31 March 2024, of those:

- 2407 were followed up
- 531 were not

This measure has been impacted following the implementation of Cito and a comprehensive validation of the data for Quarter 4 is currently being undertaken.

Crisis resolution home treatment acted as a gatekeeping
This is no longer an indicator required to be reported.

Patients' experience of mental health teams
For 2023, we have reported the mental health section score of the NHS Community Mental Health Survey Benchmark (this has been replaced from previously indicated as a health and social care workers section). The Trust has reported a score of 6.1 which is indicated below as 'about the same' compared to all other trusts.



The section score is compiled from the results of the three survey questions below.

Question	TEWV mean score 2023	National average 2023	TEWV mean score 2022	TEWV mean score 2021
Were you given enough time to discuss your needs and treatment?	**6.9**	**6.8**	7.7	7.5
Did you get the help you needed?	**6.0**	**6.0**	*Question updated from 2023*	*Question updated from 2023*
Did your NHS mental health team consider how areas of your life impact your mental health?	**6.7**	**6.4**	*Question updated from 2023*	*Question updated from 2023*

Did you have to repeat your mental health history to your NHS mental health team?	**4.7**	**4.6**	*Question updated from 2023*	*Question updated from 2023*

National patient safety incident reports

NHS England provided an update in September 2023 on the six monthly reports due in 2023/2024. They confirmed that they have paused the annual publishing of this data while we consider future publications in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the NRLS.
Please refer to the narrative in section 2.17 related to the implementation of the patient safety incident response framework.

PART 3: Further information on how we have performed in 2023/24

3.1 Introduction to part 3

Part 3 of this document contains further information which the legal guidance requires us to include. This includes statutory statements. As with Part 2, this helps to develop an overall picture of quality at our Trust.

3.2 Our performance against our quality metrics

The Quality Account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report. The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

Quality metrics:

Patient safety indicators	Target	Whole Trust 23/24	Whole Trust 22/23	Whole Trust 21/22	Whole Trust 20/21	National benchmark (where available)	Further comments
Percentage of patients who report 'yes, always' or 'yes quite a lot' to the question 'do you feel safe on the ward?'	75.00%	**78.63%**	55.57%	65.30%	64.66%	Not measured nationally	The end of 2023/24 position was 78.63% which relates to 1453 out of 1847 surveyed. This is 3.63% above our target of 75.00%. It is noted that the metric for scoring has changed this year, previous years have only reported on people who answered 'yes always' to the question, this year 'yes quite a lot' is also included in the rating.
Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) – for inpatients	0.35	**0.10**	0.28	0.17	0.13	The Royal College of Physicians discourage any benchmarking or comparisons due to the high number variables that exist that makes comparison unreliable.	Analysis of information suggests the slight increase in the rate of falls is associated with the increase in the acuity of patients accessing our services.
The number of incidents of physical intervention/ restraint per 1000 occupied bed days	19.25	**29.2**	33.27	28.84	20.9		
The number of medication errors with a severity of moderate harm and above	2.5	**11**	13	12	7		
The number of serious incidents reported on STEIS	-	**126**	144	141	142	The Patient Safety Incident Response Framework (PSIRF) was implemented on the 29th January 2024. In addition to changing the way the NHS responds to patient safety incidents, the term 'serious incident' and the rules applying to them are no longer applicable. Trusts now monitor patient safety	

Patient safety indicators	Target	Whole Trust 23/24	Whole Trust 22/23	Whole Trust 21/22	Whole Trust 20/21	National benchmark (where available)	Further comments
						incident investigations and to support this we have implemented InPhase as our risk and quality management system. Transfer to the new recording system has highlighted areas where data quality can be improved, and several actions to support improvement in the quality of the incident data have been implemented.	

Clinical Effectiveness Indicators	Target	Whole Trust 23/24	Whole Trust 22/23	Whole Trust 21/22	Whole Trust 20/21	National Benchmark
Percentage of adults discharged from CCG-commissioned mental health inpatient services receive a follow-up within 72 hours	85%	**81.93%**	88%	*Previously reported indicator: (Existing percentage of patients on Care Programme Approach who were followed up within 72 hours after discharge from psychiatric inpatient care)*		-
Adults with a long length of stay over 60 for adult admissions	N/A	**12.47%**	N/A	12%	N/A	According to the NHS Oversight Framework System Benchmarking as at January 2024, national rank 7 out of 52 mental health providers and are performing within the highest performing quartile.
Older adults with a long length of stay over 90 days for older adult admissions	N/A	**58.04%**	35%	N/A	N/A	According to the NHS Oversight Framework System Benchmarking as at January 2024, national rank 18 out of 52 mental health providers and are performing within the interquartile range.

Patient experience indicators	Target	Whole Trust 23/24	Whole Trust 22/23	Whole Trust 21/22	National benchmark
Percentage of patients who reported their overall experience as very good or good	92%*	**92.17%**	92.16%	94.34%	87%
Percentage of patients that report that staff treated them with dignity and respect	94%	**88.00%**	86.69%	84.72%	-
Number of complaints raised	-	**498**	338	257	-

** Previous target was 94% changed December 2023 to 92%*

Further comments on areas for improvement

Number of incidents of physical intervention/ restraint per 1000 occupied bed days (OBDs) – for inpatients

The end of 2023/24 position was 28.5 which relates to 6560 incidents and 230,269 OBDs. This is 9.25 above our target of 19.25

Our North Yorkshire York and Selby care group achieved the target with a rate of **18.4**. Within Durham, Tees Valley and Forensics care group the actual rate was **31.0.**

The high rate of incidents reported in the Durham Tees Valley and Forensic Care Group is linked to a small group of wards supporting specific patients with a range of complex needs often waiting on discharge from hospital.

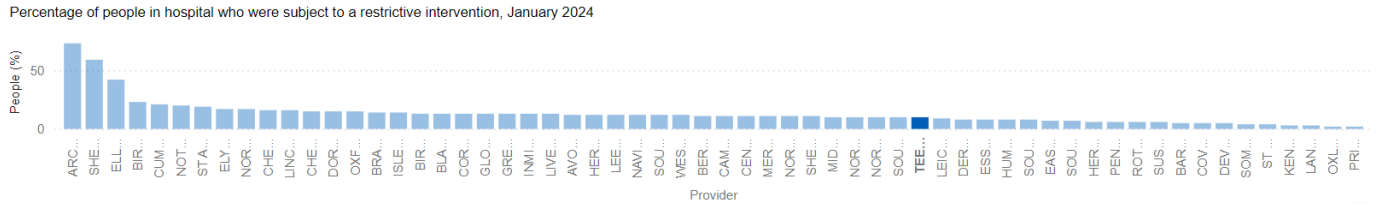
We have made significant improvements in reducing restrictive interventions across our learning disability inpatients areas over the last 12 months, and have presented this work at a range of regional and national events.

To support our ongoing work to reduce the use of restrictive practice across the organisation we have recently appointed 2 new Specialist practitioners to support each of our care groups.

In order to build on our previous work, we are currently cocreating a new 3 year Positive and Safe strategy to support our ongoing journey to reduce the use of restrictive practices.

The graph below taken form the NHS national data illustrates the Trusts positive position against other mental health Trusts nationally.

The graph below taken from the NHS National data illustrates the Trusts positive position against other mental health trusts nationally. We continue to work towards the long-term reduction of all forms of restrictive intervention. A range of actions are in progress via our Restrictive Intervention Reduction Plan.



Percentage of patients that report that staff treated them with dignity and respect

The end of **2023/24** position was **95.47%** which relates to **12,672** out of **13,274** surveyed. This is **1.47%** above our target of **94.00%.**
Broken down by care groups, we are pleased that the majority of our patients are treated with dignity and respect. North Yorkshire, York, and Selby with **96.08%** and Durham, Tees Valley, and Forensics **95.16%**.

We continue to focus on this important area of patient experience. Our patients tell us that treating people with dignity and respect includes staff treating people in a caring and compassionate way which will be strengthened by the work we are doing on our Trust values and empathy training for staff. It is also about involving people in decisions around their care which will be supported by the ongoing quality priority around personalised care planning and our goal of co-creation. Having an environment that respects privacy and dignity is important, and we are proud that we have eliminated all dormitory accommodation and all patient bedrooms are now single, many with ensuite facilities.

The number of medication errors with a severity of moderate harm and above

The end of **2023/24** position was **12** which is **9.5** above our target of **2.5.**

These 12 were split across the care groups. North Yorkshire, York and Selby had three and Durham, Tees Valley and Forensics had nine medication errors with a severity of moderate harm and above

In 23/24 the key focus was to implement electronic prescribing and medicines administration (EPMA) across all our in-patient units (excluding respite). In total, 52 wards have EPMA, starting with a pilot ward in June 2023 and then all other wards between 05/09/23 and 16/01/24. The focus of 24/25 will be to implement EPMA in community services.

3.3 Our Performance against the system oversight framework targets and indicators

The NHS Oversight Framework is built around five national themes:

- Quality of care, access and outcomes
- Leadership and capability
- People
- Preventing ill health and reducing inequalities
- Finance and use of resources

A sixth theme focusses on local strategic priorities.

The five themes are underpinned by 31 key performance measures and sub-measures and Trust and Integrated Care Board (ICB) performance is monitored via an allocation to a top, inter or bottom quartile. Typically, those within the top quartile indicate the higher performing Trusts.

To provide an overview of the level and nature of support and the oversight arrangements required across systems, ICBs and Trusts are allocated to one of four segments, determined by the scale and nature of their support needs, ranging from no specific support needs (segment 1) to intensive support needs (segment 4).

Our Trust is currently placed within segment 3; bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required.

There are a number of measures where we are placed in the lowest performing quartile which indicates a position of concern or where we are not achieving the oversight standard.

These are:

- Women accessing specialist community perinatal mental health services (North East & North Cumbria and Humber & North Yorkshire Integrated Care Boards)
- NHS Staff Survey compassionate culture people promise element sub score
- Proportion of staff in a senior leadership role who are from a black and minority ethnic (BME) background
- Staff survey engagement theme score
- Sickness absence rate
- CQC well led rating

Further details on our performance are below:

1) Quality, access and outcomes: mental health
There are five mental health measures monitored as part of the 2023/24 framework; one is monitored at Trust level and four are monitored at ICB level. Our achievement against these has been provided in the tables below.

TEWV	Oversight standard	Q1	Q2	Q3	Q4	Latest national position
Number of inappropriate out of areas placement (OAP) bed days for adults by quarter that are either internal or external to the sending provider	0	**1608**	**494**	**671**	**516**	Interquartile range as at December 2023 (670) 30 out of 56 Trusts

North East and North Cumbria ICB	Oversight standard	Q1	Q2	Q3	Q4	Latest national position
Access rate for IAPT services	100%	87.54%	95.24%	91.24%	106.53 %	Interquartile range as at January 2024 (67%) 31 out of 42 ICBs
Number of children and young people accessing mental health services as a % of population	100%	113.66%	114.72%	115.34 %	111.53 %	Interquartile range as at January 2024 (95%) 13 out of 42 ICBs
Access rates to community mental health services for adult and older adults with severe mental illness	100%	115.05%	118.13%	123.27 %	122.14 %	Interquartile range as at January 2024 (93%) 24 out of 42 ICBs
Women accessing specialist community perinatal mental health services	100%	194.25%	129.87%	107.83 %	105.76 %	Lowest performing quartile (a position of concern) as at December 2023 (75.4%) 34 out of 42 ICBs

Humber and North Yorkshire ICB	Oversight standard	Q1	Q2	Q3	Q4	Latest national position
Access rate for improving access to psychological therapies (IAPT) services	100%	87.30%	83.67%	91.57%	91.75%	Interquartile range as at January 2024 (69%) 28 out of 42 ICBs
Number of children and young people accessing mental health services as a % of population	100%	122.25%	118.98%	118.19%	111.85%	Interquartile range as at January 2024 (88%) 21 out of 42 ICBs
Access rates to community mental health services for adult and older adults with severe mental illness	100%	103.76%	101.34%	99.29%	96.03%	Interquartile range as at January 2024 (95%) 21 out of 42 ICBs
Women accessing specialist community perinatal mental health services	100%	87.02%	61.83%	60.05%	60.31%	Lowest performing quartile (a position of concern) as at December 2023 (51.5%) 28 out of 42 ICBs

Quality of care, access and outcomes: safe, high-quality care

Quality of care, access and outcomes: safe, high-quality care	Oversight standard		Q1	Q2	Q3	Q4	Latest national position
National patient safety alerts not completed by deadline	0		**0**	**0**	**0**	**0**	Latest position as published at April 2024
Consistency of reporting patient safety incidents	100.00%		**100.00 %**	Not available	Not available	Not available	National reporting paused pending the introduction of the new Learn from Patient Safety Events (LFPSE) service.
Overall CQC rating	N/A		Requires improvement				Interquartile range as at February 2024. 52 out of 69 Trusts. Latest inspection June 2023
NHS Staff Survey compassionate culture people promise element sub-score	As per staff survey benchmarking group results	6.86	6.99				Lowest performing quartile (a position of concern) as at 2022 survey (6.85) 65 out of 71 Trusts Note: Q3 and Q4 Trust data as at 2023 Staff Survey
NHS Staff Survey raising concerns people promise element sub-score	As per staff survey benchmarking group results	6.71	6.68				Interquartile range as at 2022 survey (6.71) 43 out of 71 Trusts Note: Q3 and Q4 Trust data as at 2023 Staff Survey
Adult acute length of stay over 60 days	0%		**13.59%**	**13.30 %**	**14.26 %**	**12.47 %**	Highest performing quartile (a positive position) as of January 2024 (13%) 7 out of 52 Trusts
Older adult acute length of stay over 60 days	0%		**25.81%**	**33.58 %**	**42.74 %**	**58.04 %**	Interquartile Range as of January 2024 (33%) 18 out of 52 Trusts

Quality of care, access and outcomes: Compassionate and inclusive culture

Quality of care, access and outcomes: Compassionate and inclusive culture	Oversight standard	2023/24	Latest national position
Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants	1.00	**1.83**	Interquartile range as at 2023 (1.8) 48 out of 69 Trusts. Latest submission July 2023.
Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants	1.00	**1.12**	Interquartile range as at 2023 (1.1) 50 out of 69 Trusts Latest submission July 2023.

Leadership and capability: leadership

Leadership and capability: leadership	Oversight standard	2023/24	Latest national position
CQC well-led rating	N/A	**Requires improvement**	Lowest performing quartile (a position of concern) as at February 2024. 54 out of 69 Trusts

Leadership and capability: leadership	Oversight standard	2023/24	Latest national position
			Latest inspection report published 25 October 2023

People: Looking after our people

People: Looking after our people	Oversight Standard		Q1	Q2	Q3	Q4	Latest national position
Staff survey engagement theme score	As per staff survey benchmarking group results	6.85	**6.94**				Lowest performing quartile (a position of concern) as at 2022 survey (6.85) 65 out of 71 Trusts Note: Q3 and Q4 Trust data as at 2023 Staff Survey
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	As per staff survey benchmarking group results	7.30%	**7.21%**				Interquartile range as at 2022 survey (7.32%) 24 out of 71 Trusts Note: Q3 and Q4 Trust data as at 2023 Staff Survey
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	As per staff survey benchmarking group results	13.64%	**13.98%**				Interquartile range as at 2022 survey (13.7%) 34 out of 71 Trusts Note: Q3 and Q4 Trust data as at 2023 Staff Survey
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	As per staff survey benchmarking group results	22.48%	**22.31%**				Highest performing quartile (a positive position) as at 2022 survey (22.7%) 17 out of 71 Trusts Note: Q3 and Q4 Trust data as at 2023 Staff Survey
Staff Survey – We Are Compassionate and Inclusive People Promise element score	As per staff survey benchmarking group results		**7.40**		**7.49**		Interquartile range as at 2022 survey (7.44) 53 out of 71 Trusts Note: Q3 and Q4 Trust data as at 2023 Staff Survey
NHS staff leaver rate	None		**10.90%**	**11.12 %**	**11.1 3%**	**11.25 %**	Highest performing quartile (a positive position) as at December 2023 (6.52%) 10 out of 71 Trusts
Sickness absence rate (working days lost to sickness)	None		**5.65%**	**6.12%**	**6.38 %**	**6.71%**	Lowest performing quartile (a position of concern) as at October 2023 (6.33%) 50 out of 71 Trusts

People: Belonging in the NHS

People: Belonging in the NHS	Oversight Standard		Q1	Q2	Q3	Q4	Latest national position
Proportion of staff in senior leadership roles who a) are from a BME background b) are women c) disabled staff							
BME background	12%		**1.37%**	**1.72%**	**5.88%**	**5.24%**	Lowest performing quartile (a position of concern) as at 2022 calendar year (1.28%) 67 out of 69 Trusts
Women	62%		**65.75%**	**64.22%**	**63.73%**	**65.71%**	Interquartile range as at December 2023 (65%) 25 out of 45 Trusts
Disabled staff	3.20%		**10.96%**	**11.64%**	**8.33%**	**9.05%**	Interquartile range as at 2023 (6.02%) 19 out of 69 Trusts
Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	As per staff survey benchmarking	62.38%	**63.83%**				Interquartile range as at 2022 survey (62.4%) 20 out of 71 Trusts Note: Q3 and Q4 Trust data as at 2023 Staff Survey

Finance and use of resources

There are four measures and sub measures monitored as part of finance and use of resources.

Finance and use of resources	Oversight Standard	Q1	Q2	Q3	Q4	Latest national position
Financial efficiency - variance from efficiency plan - Recurrent	N/A	**£1,178,000**	**£3,858,000**	**£6,269,000**	**£12,209,000**	Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.
Financial efficiency - variance from efficiency plan - non-recurrent	N/A	**£363,000**	**£2,645,000**	**£5,349,151**	**£8,638.000**	
Financial stability - variance from break-even	N/A	**£3,881,456**	**£4,424,811**	**£4,700,532**	**£0**	
Agency spending: Agency spend compared to the agency ceiling	100%	**86.26%**	**99.96%**	**91.08%**	**86.39%**	
Agency spending: Price cap compliance	100%	**67.00%**	**63.40%**	**61.61%**	**63.34%**	

Improved performance relative to control totals set in year have supported financial recovery that has allowed the Trust to deliver our 2023/24 breakeven plan, based on a mid-case scenario.

3.4 Other external reviews/ publications:

ICB commissioner and Provider Collaborative safety reviews

Commissioner safety review visits were undertaken in June 2023 which focused on key lines of enquiry derived from a range of performance metrics, soft intelligence and information from partners and stakeholders. Commissioners visited five inpatient wards where there were reported serious incidents involving the unexpected death of patients receiving inpatient care between November 2022 and March 2023:

- Maple Ward, West Park Hospital
- Bilsdale, Roseberry Park Hospital
- Roseberry Ward, Lanchester Road Hospital
- Bedale Ward, Roseberry Park Hospital
- Moorcroft Ward, Foss Park Hospital

During each visit the visiting team assessed the environment, observed staff and patients, and conducted informal interviews with a number of staff members and patients.

The report received by the Trust in September 2023 showed that overall, the outcome of the visits was good with some improved areas of practice identified. The assessment team agreed that based on their findings, patients are being safely cared for and that ward staff and senior management have the care and safety of patients at the forefront of their work.

In addition, the North East and North Cumbria Provider Collaborative (NENC PC) were asked by the Trust quality board if they were assured on the safety of patients within commissioned services. Working with NHS England and the NENC Integrated Care Board (ICB) key lines of enquiry (KLOEs) were agreed, and a reporting template and methodology were developed to ensure consistency. All secure inpatient services were visited during July and August 2023. The NENC PC found no immediate patient safety concerns during their visits. The report received by the Trust in November 2023 reported overall outcomes of the visits were good with some areas that could benefit from improvement. Staff on the units and the Ridgeway leadership team demonstrated that they have the care and safety of patients throughout their work and within their environment.

Letby report

On 18th August 2023, Lucy Letby was convicted of murdering seven babies and attempting to kill six others at the Countess of Chester Hospital. She committed these crimes while working as a neonatal nurse at the Countess of Chester Hospital between June 2015 and June 2016. An inquiry will follow the conviction of Lucy Letby and in parallel, we expect policy changes to be considered by the National Bodies.

The Trust has considered the learning and implications from this event and how we can build the culture of openness that we know is crucial to delivering consistently safe care.

Key implications from this event included:

- A failure of systems around safety incident reporting and risk
- Leadership and governance – process and priorities and skills and competence
- Culture – speaking up, problem sensing, openness – a duty to speak up, and a duty to listen to concerns, far beyond formal Freedom to Speak Up.
- Understanding what a failure to listen to concerns means
- A lack of curiosity from the wider multi-disciplinary team (MDT) and management
- A breakdown of inter professional working – including between managers and clinicians
- Patient safety as the singular priority – within trusts and across the system
- How the partnership of clinicians, managers and patients / families works

We reviewed the learning from this with our Board and key sessions with care group Boards, corporate deputies and executives were facilitated. We adapted the foundations of leadership and management training that all leaders and managers from service management level up (clinical, operational and

corporate) are required to undertake. Although this event was an extreme case, learning has been taken forward relating to patient safety and governance.

Our response strengthened the oversight of accountability of, and support to, our leaders and managers including:

- Establishing a quarterly meeting led by the chief executive and reporting to the executive directors
- A three year leadership and management core programme is underway
- Reviewing additional portfolio of training offered through each leadership and management structure
- Focus on strengthening of diversity of leadership and management
- Professional reference groups have been established for all professions including new groups for operational colleagues, corporate and administrative roles.
- Bitesize manager training is underway.

Further information regarding the Letby verdict, see: Lucy Letby verdict, a future inquiry and patient safety - Patient Safety Learning

3.6 External audit

Under guidance from NHS England, the Quality Account 2023/24 is not subject to review by external audit.

3.7 Our stakeholders' views

Our Trust recognises the importance of the views of our partners as part of our assessment of the quality of the services we provide and to help us drive change and improvement.

How we involve and listen to what our partners say about us is critical to this process. We continue to listen and learn from the people we support, their carers and families, our colleagues and our partners.

In line with national guidance, we circulated our draft Quality Account for 2023/24 to the following stakeholders:

- NHS England
- North East and North Cumbria Integrated Care Board
- Humber and North Yorkshire Integrated Care Board
- Local Authority Overview and Scrutiny Committees
- Local Authority Health & Wellbeing Boards
- Local Healthwatch organisations

All the comments we have received from our stakeholders are included verbatim in Appendix 3.

Insert comments for any feedback received and how these will feed into our future learning for next annual Quality Account

Appendix 1: 2023/24 Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Accounts/Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Account/Report.

In preparing the Quality Account/Report, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Account/Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2023/24 and supporting guidance
- The content of the Quality Account is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2023 to March 2024
  - Papers relating to quality reported to the Board over the period April 2023 to March 2024
  - Feedback from the Commissioners dated (*insert date*)
  - Feedback from Healthwatch dated (*insert date*)
  - Feedback from Overview and Scrutiny Committees dated (*insert date*)
  - Feedback from Health and Wellbeing Boards dated (*insert date*)
  - The Trust's complaints information reported to its Quality Assurance Committee of the Board of Directors, which will be published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - The latest community mental health survey published 18 April 2024
  - The latest national staff survey published 07 March 2024.
  - CQC inspection report dated 25 October 2023.
- The Quality Account/Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Account/Report is reliable and accurate There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account/Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Account regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account/Report

By order of the Board.

David Jennings
Chair

30 June 2024

Brent Kilmurray
Chief Executive
30 June 2024

Appendix 2: Glossary

Adult Mental Health (AMH) Services: Services provided for people aged between 18 and 64 – known in some other parts of the country as 'working-age services. These services include inpatient and community mental health services. In practice, some patients younger than 64 may be treated in older people's services if they are physically frail or have Early Onset Dementia. Early Intervention in Psychosis (EIP) teams may treat patients less than 18 years of age as well as patients aged 18-64.

Audit: An official inspection of records; this can be conducted either by an independent body or an internal audit department.

Autism: This describes a range of conditions typically characterised by social deficits, communication difficulties, stereotyped or repetitive behaviours and interests, and in some cases cognitive delays. People with autism are sometimes known as neuro-diverse. Autism cannot be cured, but the mental illnesses which are more common for people with autism can be treated.

Board/Board of Directors: Our Trust is run by a Board of Directors made up of the Chairman, Chief Executive, Executive and Non-Executive Directors. The Board is responsible for ensuring accountability to the public for the services in manages. It is overseen by a Council of Governors and monitored by NHS England. It also:

- Ensure effective dialogue between our Trust and the communities we serve
- Monitors and ensures high quality services
- Is responsible for our financial viability
- Appoints and appraises our executive management team

Business plan: A document produced once a year to outline what we intend to do over the next three years in relation to the services that we provide.

Child and Adolescent Mental Health Services (CAMHS): See Children and Young People's Services (CYPS).

Care Planning: See Care Programme Approach (CPA).

Care Programme Approach: describes the approach used in specialist mental health care to assess, plan, review and coordinate the range of treatment options and support needs for people in contact with secondary mental health services who have complex characteristics. It is called 'an approach' rather than a system because of the way these elements are carried out, which is as important as the tasks themselves. The approach is routinely audited.

Care Quality Commission (CQC): The independent regulator of health and social care in England. They regulate the quality of care provided in hospitals, care homes and people's own homes by the NHS, Local Authorities, private companies, and voluntary organisations, including protecting the interests of people whose rights are restricted under the Mental Health Act.

Children and Young People's Services (CYPS): Mental Health Services for children and young people under the age of 18 years old. This includes community mental health services, inpatient services and learning disability services.

Cito: An information technology system which overlays the Trust's patient record system (PARIS) which makes it easier to record and view the patient's records.

Clinical Commissioning Groups (CCGs): NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. CCGs are clinically led groups that include all GP practices in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients. CCGs are overseen by NHS England.

Clinical Supervision: a supportive mechanism which involves clinicians meeting regularly to reflect on practice, with the intention of learning, developing practice and providing high quality, safe care to patients.

Commissioners: The organisations that have responsibility for purchasing health services on behalf of the population in the area they work for.

Commissioning for Quality and Innovation (CQUIN): A payment framework where a proportion of NHS providers' income is conditional on quality and innovation.

Community Mental Health Survey: a survey conducted every year by the CQC. It represents the experiences of people who have received specialist care or treatment for a mental health condition in 55 NHS Trusts in England over a specific period during the year.

Confidential Inquiry: A national scheme that interviews clinicians anonymously to find out ways of improving care by gathering information about factors which contributed to the inability of the NHS to prevent each suicide of a patient within its care. National reports and recommendations are then produced.

Co-production/Co-creation: This is an approach where a policy or other initiative/action is designed jointly between our staff and patients, carers, and families.

Council of Governors: Made up of elected public and staff members and includes non-elected members such as the prison service, voluntary sector, acute trusts, universities and local authorities. The Council has an advisory, guardianship and strategic role including developing our Trust's membership, appointments and remuneration of the non-executive directors including Chairman and Deputy Chairman, responding to matters of consultation from the Trust Board, and appointing the Trust's auditors.

Crisis Resolution & Home Treatment (CRHT) Team: Provide intensive support at home for individuals experiencing an acute mental health crisis. They aim to reduce both the number and length of hospital admissions and to ease the pressure on inpatient units.

Dashboard: A report that uses data on a number of measures to help managers build up a picture of operational (day-to-day) performance or long-term strategic outcomes.

Data Protection and Security Toolkit: A national approach that provides a framework and assessment for assuring information quality against national definitions for all information that is entered onto computerised systems whether centrally or locally maintained.

Data Quality Strategy: A strategy which sets out clear direction and outlines what the Trust expects from its staff to work towards our vision of providing excellent quality data. It helps TEWV continue to improve the quality and value of our work, whilst making sure that it remains clinically and financially sustainable.

Department of Health: The government department responsible for health policy.

DIALOG+: A clinical tool that allows for assessment, planning, intervention, and evaluation in one procedure and allows more personalised care planning.

Forensic Adult and Mental Health and Learning Disability Services: Work mainly with people who are mentally unwell or who have a learning disability and have been through the criminal justice system. The majority of people are transferred to a secure hospital from a prison or court, where their needs can be assessed and treated.

Formulation: When clinicians use information obtained from their assessment of a patient to provide an explanation or hypothesis about the cause and nature of the presenting problems. This helps in developing the most suitable treatment approach.

Freedom to Speak Up Guardian: Provides guidance and support to staff to enable them to speak up safely within their own workplace.

Friends and Family Test (FFT): A survey put to service users, carers and staff that asks whether or not they would recommend a hospital/community service to a friend or family member if they need treatment.

Gatekeeper/gatekeeping: Assessing the service user before admission to hospital to consider whether there are alternatives to admission and the involvement in the decision-making processes that result in admission.

General Medical Practice Code: The organisation code of the GP Practice that the patient is registered with. This is used to make sure a patient's GP code is recorded correctly.

Guardian of Safe Working: Provides assurance that rotas and working conditions are safe for doctors and patients.

Harm minimisation: Our way of working to minimise the risks of sometimes multiple and conflicting harm to both service users and other people.

Health and wellbeing boards: The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system (i.e., local authorities and the NHS) would work together to improve the health and wellbeing of their local population and to reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities, and encourage commissioners to work in a more joined-up way.

HealthWatch: Local bodies made up of individuals and community groups, such as faith groups and resident's organisations associations, working together to improve health and social care services. They aim to ensure that each community has services that reflect the needs and wishes of local people.

Home Treatment Accreditation Scheme (HTAS): Works with teams to assure and improve the quality of crisis resolution and home treatment services for people with acute mental illness and their carers.

Hospital Episode Statistics (HES): The national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, Government and many other organisations and individuals.

Improving Access to Psychological Therapies (IAPT): An NHS initiative to increase the provision of evidence-based treatments for common mental health conditions such as depression and anxiety by primary care organisations.

Integrated Information Centre (IIC): Our system for taking data from the patient record (PARIS) and enabling it to be analysed to aid operational decision making and business planning.

Intranet: This is our Trust's internal website used for staff to access relevant information about the organisation, such as Trustwide policies and procedures.

Learning Disability Services: Services for people with a learning disability and/or mental health needs. We have an Adult Learning Disability (ALD) service in each Care Group and also specific wards for Forensic LD patients. We provide child LD services in Durham, Darlington, Teesside, and York but not in North Yorkshire.

LeDeR: The learning from deaths of people with a Learning Disability (LeDeR) programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a Learning Disability and reduce health inequalities.

Local authority Overview and Scrutiny Committee (OSC): Statutory committees of each local authority which scrutinise the development and progress of strategic and operational plans of multiple agencies within the local authority area. All local authorities have an OSC that focusses on health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar and Cleveland councils have a joint Tees Valley Health OSC that performs this function.

Mental Health Act (1983): The main piece of legislation that covers the assessment, treatment, and rights of people with a mental health disorder. In most cases when people are treated in hospital or in another mental health facility they have agreed or volunteered to be there. However, there are cases when a person can be detained (also known as sectioned) under the Mental Health Act and treated without their agreement. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

Mental Health Services for Older People (MHSOP): Services provided for people over 65 years old with a mental health problem. They can be treated for functional illness, such as depression, psychosis, or anxiety, or for organic mental illness (conditions usually associated with memory loss and cognitive impairment) such as dementia. The MHSOP Service sometimes treats people less than 65 years of age with organic conditions such as early-onset dementia.

Mortality Review Process: A process to review deaths, ensuring a consistent and coordinated approach, and promoting the identification of improvements and the sharing of learning.

Multi-Disciplinary: This means that more than one type of professional is involved, for example, psychiatrists, psychologists, occupational therapists, behavioural therapists, nurses, pharmacists all working together in a Multi-Disciplinary Team (MDT).

National Institute for Clinical Excellence (NICE): NHS body that provides guidance sets quality standards and manages a national database to improve people's health and to prevent and treat ill health. NICE works with experts from the NHS, local authorities, and others in the public, private, voluntary and community sectors – as well as patients and carers – to make independent decisions in an open, transparent way, based on the best available evidence and including input from experts and interested parties.

National Institute for Health Research (NIHR): An NHS research body aimed at supporting outstanding individuals working in world class facilities to conduct leading edge research focused on the needs of the patients and the public.

National Reporting and Learning System (NRLS): A central (national) database of patient safety incident reports. All information submitted is analysed to identify hazards, risks, and opportunities to continuously improve the safety of patient care.

NHS England (NHSE): leads the National Health Service in England.

NHS Long-Term Plan (2019): A new plan for the NHS to improve the quality of patient care and health outcomes. It sets out how the £20.5 billion budget settlement for the NHS, announced by the Prime Minister in summer 2018, will be spent over the next five years.

NHS Staff Survey: Annual survey of staff experience of working within NHS trusts.

Non-executive directors (NEDs): Members of the Trust Board who act as a critical friend to hold the Board to account by challenging its decisions and outcomes to ensure they act in the best interests of patients and the public.

North Cumbria and North East Integrated Care System: Consists of four Integrated Care Partnerships – North, South, East, and West (see Integrated Care Partnerships).

PARIS: Our electronic care record, designed with mental health professionals to ensure that the right information is available to those who need it at all times.

Patient Advice and Liaison Service (PALS): A service within our Trust that offers confidential advice, support, and information on health-related matters. The team provides a point of contact for patients, their families, and their carers.

Peer worker: Someone who is trained and recruited as a paid employee within the Trust in a specifically designed job, to actively use their lived experience (as a patient or carer) to support other patients, in line with the recovery approach.

Prescribing Observatory in Mental Health (POMH): A national agency led by the Royal College of Psychiatrists, which aims to help specialist mental health services improve prescribing practice via clinical audit and quality improvement interventions.

Programme: A coordinated group of projects and/or change management activities designed to achieve outputs and/or changes that will benefit the organisation.

Project: A one-off, time limited piece of work that produces a product (such as a new building, a change in service or a new strategy/policy) that will bring benefits to relevant stakeholders. Within our Trust, projects will go through a scoping phase, and then a business case phase before they are implemented, evaluated, and closed down. All projects will have a project plan and a project manager.

Psychiatric Intensive Care Unit (PICU): A unit (or ward) that is designed to look after people who cannot be managed on an open (unlocked) psychiatric ward due to the level of risk they pose to themselves or others.

Quality Account: A report about the quality of services provided by an NHS healthcare provider, the report is published annually by each provider.

Quality Assurance Committee (QuAC): Sub-committee of the Trust Board responsible for quality and assurance.

Quality Assurance Groups (QuAG): Locality/divisional groups within the Trust responsible for quality and assurance.

Quarter one/quarter two/quarter three/quarter four: Specific time points within the financial year (1 April to 31 March). Quarter one is from April to June, quarter two is from July to September, quarter three is October to December and quarter four is January to March.

Reasonable adjustments: A change or adjustment unique to a person's needs that will support them in their daily lives, e.g., at work, attending medical appointments, etc.

Research Ethics Committee: An independent committee of the Health Research Authority, whose task it is to consider the ethics of proposed research projects which will involve human participants, and which will take place, generally, within the NHS.

Royal College of Psychiatrists: The professional body responsible for education and training and setting and raising standards in psychiatry.

Safeguarding: Protecting vulnerable adults or children from abuse or neglect, including ensuring such people are supported to get good access to healthcare and stay well.

Secondary Uses Service: The single, comprehensive repository for healthcare data in England which enables a range of reporting and analysis to support the NHS in the delivery of healthcare services.

Section 29a Notice: This is a warning notice served by the CQC where concerns are identified across either the whole or part of an NHS trust and where it is decided that there is a need for significant improvements in the quality of healthcare.

Serious incident (SI): An incident that occurred in relation to NHS-funded services and care, to either patient, staff, or member of the public, resulting in one of the following – unexpected/avoidable death, serious/prolonged/permanent harm, abuse, threat to the continuation of delivery of services, absconding from secure care.

Single Oversight Framework: sets out how NHS trusts and NHS foundation trusts are overseen.

Staff Friends and Family Test: A feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It helps us identify what is working well, what can be improved and how.

Statistical Process Control (SPC) charts: a graph used to show how a process changes over time and to see whether a situation is improving or deteriorating, whether the system is likely to be capable to meet the standard and whether the process is reliable or variable.

Steering group: Made up of experts who oversee key pieces of work to ensure that protocol is followed and provide advice/troubleshoot where necessary.

Strategic framework: primarily intended as a framework for thinking about the future and a guide to inform the investment and disinvestment decisions by those tasked with future planning.

Substance Misuse Services: Clinical services who work with people who abuse alcohol, illegal drugs or over the counter or prescription medications in a way that they are not meant to be used.

TEWV: Tees, Esk and Wear Valleys NHS Foundation Trust.
Thematic review: A piece of work to identify and evaluate Trustwide practice in relation to a particular theme. This may be to identify where there are problems/concerns or to identify areas of best practice that could be shared Trustwide.

The Trust: Tees, Esk and Wear Valleys NHS Foundation Trust.

Trust Board: See Board/Board of Directors above

Trustwide: The whole geographical area served by our Trust.

Unexpected Death: A death that is not expected due to a terminal medical condition or physical illness.

Urgent Care Services: Crisis, Acute Liaison and Street Triage services across our Trust.

Whistleblowing: this is a term used when a worker highlights a concern about their organisation and/or services to the Freedom to Speak Up Guardian or NHS Regulators. This will normally be regarding something they have witnessed at work.

Year (e.g., 2023/24): These are financial years, which start on the 1 April in the first year and end on the 31 March in the second year.

Appendix 3: Stakeholders' views

This Appendix contains letters received from our stakeholders in response to the draft Quality Account circulated to them in May 2024.

To be inserted following consultation

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Appendix 2 – Feedback to the Quality Account 23/24 received to date

21/05/2024:

Scrutiny of Health Overview and Scrutiny Committee - North Yorkshire Council

"*Thank you for providing the NYC Scrutiny of Health Overview and Scrutiny Committee with a copy of the TEWV draft Quality Account 2023/24.*
We acknowledge that it has been a difficult period for TEWV and the Committee has really appreciated the time and effort taken by TEWV to make sure that elected Members are fully informed. They have not shied away from tackling the issues and answering difficult questions. The Scrutiny of Health Committee has really appreciated their honesty and transparency and we look forward to monitoring their progress as they strive to achieve their ambitions for all our residents."

24/05/2024:

Durham Adults Wellbeing and Health Oversight and Scrutiny Committee

"*The Adults Wellbeing and Health Overview and Scrutiny Committee welcomes Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust's draft Quality Account 2023/24 and the opportunity to provide comment on it. The Committee are mindful of their statutory health scrutiny role and the need to demonstrate a robust mechanism for providing assurance to the residents of County Durham that health service provision is efficient and effective. The Quality Account process provides the Committee with one such mechanism.*

The Adults Wellbeing and Health OSC has engaged with the Trust in respect of inpatient adult learning disability services in County Durham and Darlington; the reconfiguration of community mental health services for Older People in County Durham and Darlington; the Trust's CQC Inspection results and associated Improvement Action Plan and the Trust's Community Services Transformation Plan. Additional engagement with the Trust has been undertaken by the Council's Children and Young Peoples' OSC in respect of CAMHS demand for service access, assessments and waiting times together with an evaluation into a pilot for Mental Health support in schools in the Consett area.

The Committee considers that the Quality Account is clearly set out and that progress made against 2023/24 priorities is clearly identified. The Committee welcome the inclusion of the patient's story within the document and also the information regarding the CQC inspection results. The positive initiatives referenced within the document are noted alongside the Trust's success in terms of recruitment and staff training and development.

With reference to the Improved Care planning priority the implementation of the CITO and DIALOG+ care planning systems are welcomed alongside appropriate staff training on the systems which aim to put patients at the centre of their Care. Regarding the feeling safe priority the Trust's work in improving the ward environment and increasing staff visibility on the wards is welcomed alongside the discharge planning improvements made and improved patient safety performance indicators.

The third priority for 2023/24 in embedding the national Patient Safety Incident Response Framework has been delivered and supported by an increase in the number of staff undertaking level 1 and 2 training.

In respect of the proposed Quality Account priorities for 2024/25, the Committee notes and supports the trust's plans to utilise patient experiences of service to improve access and early intervention. The second priority of implementing timely relapse intervention is also welcomed as a means of minimising harm to patients and improving mental health and wellbeing. This is especially important given the reports fed into the Committee of continuing pressures experienced in respect of access to crisis support. The priority to improve personalisation on urgent care by using the "my story once" approach is supported and the Committee notes the initiatives links to the ongoing community transformation work on which the OSC has already engaged with the Trust.

Finally, in order to ensure that it continues to provide a robust health scrutiny function and to provide assurances in this respect to the residents of County Durham, the Committee would request a progress report on delivery of 2024/25 priorities and performance targets."

28/05/2024:

County Durham Health and Wellbeing Board

"*Thank you for the opportunity to comment on the Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust Quality Account 2023-24. The County Durham Health and Wellbeing Board (HWB) appreciate this transparency and as such would like to provide the following comments on the document.*

The HWB note that there is unprecedented demand for mental health services, as well as staffing issues across the NHS, and acknowledge the challenges this brings for TEWV in serving two million people across County Durham, Darlington and North Yorkshire.

We note the CQC prosecution and sentencing in April 2024 and your acknowledged responsibility for these failings. We are pleased to see that the latest CQC inspection note that the organisation is very different now and is making noticeable improvements as you move forward.

It is noted that, following the CQC Inspection in 2023, TEWVs overall rating remains at 'requires improvement'. We note that seven of the 11 services are rated 'good', whilst four 'require improvement' however, this is an improvement from the previous inspection.

We acknowledge that following the inspection, the Trust developed an improvement plan to enable the areas identified for improvement to be achieved. We are pleased to see that this has been co-created with colleagues, speciality leads and subject experts in response to the 'must do' and 'should do' recommendations. It's noted that at the time of receiving the draft QA, there are 34 completed recommendations, 59 in progress and only one behind target.

It is pleasing to note that the two lived experience directors are now established and are offering their knowledge and insight as well as providing challenge to strategic decisions. It is great to see Marc's story in the quality account, it really brings to life that the right mental health support can be a lifeline for people.

It's good to see the progress being made against your big goals as part of your 'Journey to Change', in relation to co-creating a great experience for patient's, carers and families / co-creating a great experience for colleagues / working with partners. Particular points to note are:

- *The use of the iThrive model of care in CAMHS to support young people to access mental health services.*
- *The increased use of therapy pets by 47%, it will be interesting to see the impact of this moving forward.*
- *Developing ways to improve experiences / access for trans and non binary patients, and GRT communities.*
- *Recruitment, including over 150 newly qualified nurses, a 10% reduction in use of agency staff, and 28% increase in volunteers.*
- *Establishment of a staff led health and wellbeing council, continued development of staff networks, and additional health and wellbeing champions recruited.*
- *Expansion of mental health support teams for school services in Durham and Darlington.*
- *Research which found that over 50% of those with severe mental illness in the North East live with food poverty.*

We acknowledge performance against the following priority areas of improvement for 2023-24:

Priority 1: Improving care planning
We are particularly pleased to see the use of the digital co-created tools, to create more personalised care plans.

Priority 2: Feeling safer
We are pleased that 78.63% of patients are reporting that they feel safe, but moving forward would like to see some standardisation in consistency of how this information is sought and reported on to allow benchmarking. We would like to see continuous improvements in relation to the feedback from the review themes to understand what feeling safe means to patients, and what improvements they would like to see on wards.

Priority 3: Embedding the new Patient Safety Incident Response Framework
We appreciate that PSIRF is mandatory as a contractual requirement under NHS standard contracts from January 2024, and are pleased to see that to ensure compliance a new incident reporting system is now in use within TEWV.

We note the proposed areas of focus for 2024-25 as follows and are reassured that these have been developed based on co-creation and continuous engagement with those who have lived experience, including service users, carers and relatives. We are pleased to see that there are a range of routes available for people to raise their concerns, so that timely and appropriate interventions can be made.

Priority 1: Patient experience: promoting education using lived experience
Priority 2: Patient safety: Relapse prevention
Priority 3: Clinical effectiveness: Improving personalisation in urgent care

It is important that the TEWV quality account aligns, where appropriate to the County Durham Joint Local Health and Wellbeing Strategy (JLHWS) 2023-28 which has been agreed through the HWB.
The HWB recognises the importance of good mental health, and the JLHWS has four priority areas of focus, one of which is 'Improving Mental Health, Resilience and Wellbeing'.

Positive partnership working in County Durham is evidenced through the overarching Mental Health Strategic Partnership Board and is a key priority across the integrated health and care system. The Mental Health Strategic Partnership Board are developing new approaches to improve everyone's mental health and to enable local residents to gain access to mental health support within their communities.

In relation to community transformation, it is pleasing to see that there has been an eight-fold increase of people being signposted to system services rather than being referred to secondary care. Similarly, its good that the Community Navigation Team met 72% of people's needs, with 94% of these receiving support within 1 week.

Serious Incidents
It is noted that Patient Safety Incident Response Framework was implemented during this reporting period.

There were 1322 deaths during the period, with 0.007% of these judged to be more likely than not to have been due to problems in the care provided to the patient. We understand that as part of the PSIRF, actionable learning will continue to be monitored and that 21 patient safety briefings have been circulated during the period as a result of this learning.

We note the unfortunate increase in deaths of those with dual diagnoses, and hope that the community transformation work and learning from case record reviews will create a core mental health service to ensure that services are accessible to the community, and inclusive of need.

The County Durham HWB look forward to continuing work with TEWV as an important partner to achieve our vision for County Durham being 'a healthy place, where people live well for longer', and to support the place-based integrated health and social care systems."

31/05/2024:
Tees Valley Joint Health Scrutiny Committee

The Committee continues to welcome its annual opportunity to comment on key elements of the latest Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) Quality Account. This statement is reflective of another year of engagement with the Trust, a key part of which was a presentation given to the Committee in March 2024 which outlined TEWVs performance against its agreed 2023-2024 quality priorities and the process for setting the priorities for 2024-2025, as well as the content of the

draft Quality Account document which was circulated to stakeholders in early-May 2024. Members hope to see this, and other, third-party statements in TEWVs published Quality Account document (the 2022-2023 version on the Trust's website did not appear to include these).

Addressing the 2023-2024 quality priorities in turn, the Committee firstly welcomes the (albeit delayed) introduction of the new electronic patient system (CITO) in February 2024, particularly given its anticipated benefits in bringing improvements to the care planning process. It will be interesting to observe how this impacts upon future feedback from patients in relation to their experience of services (measured via the Trust's quality indicators).

Developments around TEWVs second priority – 'feeling safe' – are of specific interest to the Committee. When trying to assess progress, Members recognise that those using the Trust's services can present with a vast array of personal issues and that creating an environment where an individual can feel safe is challenging. That said, the Committee expressed unease at the lack of a national metric which allowed some form of benchmarking, a situation which led to a call for an approach to be made by the Committee to the Integrated Care Board (ICB) about the potential introduction of a baseline measure around the question of safety. In terms of how TEWV ascertains a patient's sense of safety, Members are cautious about re-moulding the existing question (which some could argue is merely a way of getting a better-looking outcome), though acknowledge the limitations brought about by the previous blunt wording.

Continuing this theme, the Committee expressed frustration during the presentation in March 2024 that, despite the range of work undertaken around 'feeling safe', the two inpatient safety indicators for each of the first three-quarters of 2023-2024 remained consistently and comfortably below the Trust's targets. It is noted that the final 2023-2024 statistics quoted in the draft Quality Account document (circulated to the Committee in early-May 2024) have increased significantly compared to what was presented to Members in March 2024 ('*inpatients who report feeling safe on TEWV wards*' rising from around mid-50% to now 78.63%, and '*inpatients who report that they were supported by staff to feel safe*' increasing from 60% to now 85%) – the latter indicator also appearing to have had its target reduced from 75% to 66%.

Achievements in relation to the final priority around embedding the new patient safety incident response framework (PSIRF) are highly important, particularly given the high-profile challenges the Trust has faced in recent times. The introduction of an annual patient safety summit is an interesting development, though of more pressing concern is the work undertaken around serious incidents and duty of candour, requirements which were identified by the Care Quality Commission (CQC) following its last inspection of TEWV services in mid-2023. Emerging doubt about the ability to fund the two part-time Patient Safety Partner (PSP) posts was less encouraging.

Regarding other aspects of the Quality Account document, the Committee note both the 2023 Community Mental Health Survey and the 2023 National NHS Staff Survey results – learning more about how those measures which fell below the national average are being addressed, particularly the time taken to get through to the Crisis Team (highlighted via the former survey) would be useful. Regarding the latter

survey, only 55% of staff being happy with the standard of care provided by the Trust if this was a friend / relative needing treatment is a cause of concern, as is only 57% of staff who would recommend TEWV as a place to work. When challenged, TEWV representatives often point to great strides being made with regards staff feedback – the Committee continues to hope that the Trust can provide some more detailed data and analysis on these claims (including comparisons to previous years) at some point in the future.

In terms of the 'PALS and complaints' section (not included within the presentation to the Committee in March 2024), it would be helpful for the Trust to provide complaint themes, whether these had changed in comparison to previous years, the speed with which these were addressed, and any feedback on the complainants' satisfaction of the Trust's response. The Committee note the significant increase in the number of complaints received in the last year (498) compared to 2022-2023 (338), a figure which is now nearly double that of 2021-2022 (257).

TEWV continue to co-operate with requests for attendance at Committee meetings and the provision of information, and Members are grateful for the time and input of Trust officers. The 2023-2024 municipal year saw senior representatives address the Committee on several topics including a Lived Experience and Co-Creation update in July 2023, CAMHS and Adult Learning Disability Respite Services updates in October 2023 (two areas of provision that have long been of interest to the Committee), and an informal briefing session on the Trust's use of physical intervention / restraint in March 2024. Last year's Committee statement noted progress around reductions in physical intervention, however, the CQCs subsequent inspection (April – June 2023) found that '*the Trust's reducing restrictive practice programme for 2022-2023 had failed to reduce overall rates of restraint*' and that '*the use of restraint had increased by 17% in the Trust's services since the previous year*' – Members will continue to challenge this area of practice which has long prompted concern.

Looking ahead, the Committee supports the identified priorities for 2024-2025 (particularly given they reflect the voice of service-users, families and carers), though note little mention within the Quality Account document of 18-25-year-old provision and the challenges around transitioning into adult mental health services. There is also the continuing need for robust concentration on patient safety across all TEWV services. The Trust stresses that patient safety continues to be its key priority, yet nine of its 11 service types are currently rated 'requires improvement' by the regulator for the 'safe' domain (a position which, since the end of 2021, has seen two of these nine service areas improve from 'inadequate', but two others downgraded from 'good'). From a scrutiny perspective, there continues to be limited data provided by the Trust with which to properly scrutinise (particularly benchmarking) – determining performance / progress is therefore difficult. Members note the CQCs latest observations that '*the Trust did not have effective systems to consistently collate, analyse and present information about quality and performance in a way that identified risks and challenges, or supported effective decision making*'. Improvements in this regard will not only benefit the Trust itself, but also those charged with holding it to account.

TEWV is understandably keen to promote the improvements it has made (and which have been acknowledged by the CQC) since launching its 'journey to change', and

the Committee welcomes these positive developments. However, there continues to be significant issues which need addressing (as identified by the regulator in its October 2023 published report). Senior Trust personnel accept there is 'work to do', and the Committee look forward to the opportunity to learn more about what is being done to strengthen mental health services that mean so much to so many across Tees Valley.

31/05/2024:

NHS North East and North Cumbria Integrated Care Board (ICB) and NHS Humber and North Yorkshire Integrated Care Board (ICB)

NHS North East and North Cumbria Integrated Care Board (ICB) and NHS Humber and North Yorkshire Integrated Care Board (ICB) commission healthcare services for the local population. The ICBs take seriously their responsibility to ensure that the needs of patients are met with the provision of safe, high-quality services and therefore welcome the opportunity to submit a statement on the Annual Quality Account for Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV).

The quality of services delivered by TEWV, and associated performance measures are the subject of discussion and challenge at the Quality Assurance Committee meetings. The meetings provide an opportunity to gain assurance that there are robust systems in place to support the delivery of safe, effective and high-quality care. In addition, the Trust continues to further engage in a collaborative approach with colleagues from the wider healthcare system to support system wide learning opportunities and Commissioners.

Like many organisations across the country, TEWV has faced a challenging year, as the NHS continued its recovery from the pandemic. The ICBs would like to commend the Trust and all its staff for the excellent commitment and dedication demonstrated throughout these difficult times and for striving to ensure the Trust's five-year transformation programme remains on track.

The ICBs recognise the Trust's continued efforts to improve quality, which was reflected in the October 2023 CQC report which showed an improved rating. The majority of services are now rated as 'Good' and in other areas the CQC recognised that progress is still being made.

The ICBs acknowledge the progress made towards achieving the quality priorities set out for 2023/24. The improved care planning and move to DIALOG+ will ensure service users are fully involved in decision making and a real focus on achievable outcomes.

It is pleasing to see that more inpatients have reported feeling safe on the wards. Whilst we recognise there is still more work to do, it is positive to see attention has been placed on the physical environment and the activities available to service users.

The embedding of the Patient Safety Incident Response Framework (PSIRF) will assist the Trust in providing greater focus on learning from adverse events. The introduction of the patient safety huddles into daily practice will enable a more multidisciplinary approach to improving safety.

The implementation of two major IT systems in the new electronic patient record (CITO) and the incident reporting system (InPhase) is to be commended. It is hoped that the added benefits the systems bring, will soon be realised to improve the experience of both service users and staff.

Commissioners fully support the identified quality priorities for 2024/25 and acknowledge that these will underpin continued progress by the Trust in meeting their overall quality improvement goals within the Trust's 'Journey to Change'. It is particularly impressive to see that these have been co-produced with those with lived experience of services.

The ICB notes the strong work in embedding lived experience voices within the development and review of services, including the increasing number of peer support worker roles to embed a coproduction approach within the organisation. Paired with an increasing focus on capturing and reviewing patient reported outcome and experience measures this will ensure that the organisation has clear evidence of areas for further improvement.

The close joint working arrangements with CNTW and other partners is also welcomed and will support system wide aspirations to improve the consistency of services for our patients regardless of location. The commitment of the organisation to collaborate on large scale change including community and inpatient transformation is welcomed and is demonstrated through the continued development of primary mental health workers and other initiatives to embed early intervention and support in community and primary care settings.

The ICBs look forward to continued partnership working to ensure that there remains a coordinated, collaborative approach towards the quality and safety of services provided to our patient population, whilst developing new ways of working to deliver improvements across pathways of care.

The ICBs can confirm that to their best knowledge the information provided within the TEWV 2023/24 Annual Quality Account is an accurate and fair reflection of the Trust’s performance. It is clearly presented in the format required and the information it contains accurately represents the Trust’s Quality profile.

Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of: Board of Directors
Date: 25 June 2024
Title: Data Security and Protection Toolkit TEWV 2024-25-01
Executive Sponsor(s): M Brierley, Assistant Chief Executive
Author(s): A Shotton, Head of Information Governance and Data Protection

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***
5	**Digital**	There is a risk that failure to implement appropriate, cost effective and innovative approaches to digital infrastructure, caused by lack of resources, infrastructure challenges and digital expertise resulting in limited delivery of OJTC goals today and for the future.

Executive Summary:

Purpose: The Data Security and Protection Toolkit is an online self-assessment tool published by NHSE that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly.

Proposal: The report is accepted and progress towards achieving standards is monitored via the Digital and Data Services Senior Leadership Team. A final position report will be provided to Digital Performance and Assurance Group at the meeting immediately following 30 June 2024.

Overview: The Trust's annual independent audit fieldwork took place in the two weeks 26 February 2024 to 08 March 2024, with the final findings published 29 May 2024.

The independent audit found 3 High, 6 Medium and 11 Low recommendations. The actions to meet the recommendations, together with planned completion dates, trajectories and action owners are documented in Appendix 2.

	1 Medium and 2 Low actions were completed between the draft and final audit reports, and 2 High, 1 Medium and 2 Low actions remain in progress. All action owners have confirmed that the remaining 5 actions to satisfy the recommendations are on track and achievable prior to toolkit submission on 30 June 2024.
Prior Consideration and Feedback	The report was considered by Audit and Risk Committee on Monday 17 June 2024.
Implications:	See attached report.
Recommendations:	That Board notes the contents of the paper with the aim of achieving all recommendations as discussed above.

MEETING OF:	**Board of Directors**
DATE:	**25 June 2024**
TITLE:	**Data Security and Protection Toolkit Audit TEWV 2024/25-01**

1. INTRODUCTION & PURPOSE:

1.1 The Data Security and Protection Toolkit is an online self-assessment tool published by NHSE that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly.

1.2 The purpose of this paper is to:-

- Discuss the findings of the independent audit of the Trust's evidence and the planned actions to achieve full assurance by 30 June 2024. This audit is a mandatory requirement of the toolkit itself.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The toolkit is divided into ten standards, and each standard is broken down into a number of assertions. Evidence items are required against each assertion, most of which are mandatory, and some being non-mandatory.

2.2 The 2023-24 iteration sees 108 mandatory and 20 non-mandatory evidence items, and for an organisation to be rated 'standards met', they must have completed all mandatory evidence items in their toolkit by 30 June 2024.

2.3 The Trust's annual independent audit fieldwork took place in the two weeks 26 February 2024 to 08 March 2024, with the final findings published 29 May 2024. This is important to note as the fieldwork was at a point in time as was the publication of the final report. However, work to achieve a satisfactory submission has been and is ongoing throughout this time. It would therefore be prudent to consider the report as a 'gap analysis' of the evidence available at the time in order to achieve a 'standards met' rating.

2.4 The final report, Appendix 1, is attached to the agenda, the findings of which identified 3 High, 6 Medium and 11 Low recommendations:

	Priority			
	Critical	**High**	**Medium**	**Low**
Compliance with control framework	0	3	6	11
Veracity of Toolkit Submission	0	0	0	0
Total	**0**	**3**	**6**	**11**

The overall risk assessment across all 10 National Data Guardian standards was rated **Limited.** No standards were rated as Unsatisfactory, but two or more were rated as Limited. This risk rating was given as three of the audit recommendations are rated 'High'.

The confidence level of the Independent Assessor in the veracity of the self-assessment was rated **Moderate**. The assessor considered there to be a medium level of deviation against the toolkit between the Trust's self-assessment and the auditor's independent assessment. This is because we provided some evidence towards business continuity assertions, but the auditors considered there to be a significant gap between the evidence and the audit strengthening framework.

3. KEY ISSUES:

The independent audit found 3 High, 6 Medium and 11 Low recommendations. The actions to meet the recommendations, together with planned completion dates, trajectories and action owners are documented in Appendix 2.

As discussed in 2.3 above, it is important to note that the independent audit was undertaken at a point in time whilst work is ongoing to achieve a final rating of 'standards met'.

1 Medium and 2 Low actions were completed between the draft and final audit reports which are acknowledged within the report itself. Also, 1 High, 5 Medium and 9 Low actions have been completed since the audit report was issued.

Therefore, there remains 2 High, 1 Medium and 2 Low recommendations remaining in progress, 1 of which is partially completed.

The 2 High recommendations relate to Trust-wide business continuity processes. The committee have received updates regarding the Emergency Preparedness, Resilience and Response (EPRR) core standards and workplan going forward. The remaining High recommendation is also in progress and on track for completion.

All action owners have confirmed that the remaining actions to satisfy the recommendations are on track and achievable prior to submission on 30 June 2024.

The Trust is evidencing compliance against incrementally more challenging and strengthened technical security and audit requirements. This is apparent in that five evidence items which achieved audit assurance in 2021-22 did not achieve the same assurance in 2022-23, and the Trust is providing evidence to meet an improvement plan alongside the current submission.

Timeliness of evidence submission has been impacted by vacancies and/or absences in key subject matter expert roles. The risks associated with this has been raised through governance and assurance processes.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

CQC do receive the DSPT ratings for all Trusts.

4.2 Financial/Value for Money:

There are no direct financial implications from this report other than those that could result from the Trust not meeting its mandatory requirements as part of the Data Protection Act 2018.

4.3 Legal and Constitutional (including the NHS Constitution):

If an organisation does not meet its mandatory requirements, this would be reported to the CQC, DHSC and NHS England/Improvement.

4.4 Equality and Diversity:

There have been no equality and diversity issues raised as part of the reporting of the Data Security and Protection Toolkit.

4.4 Other implications:

None identified.

5. RISKS:

There are financial and operational/safety risks if information security breaches occur or information systems fail, impacting on the regulation and business of the Trust. The risk is also reputational and could affect the Trust's licence to practice depending upon the scale of a breach. Risks relating to GDPR/Data Protection, information and cyber security are documented on the Trust's risk management system.

The risks and issues identified above could have an impact on the Trust.

6. CONCLUSIONS:

The report is accepted and progress towards achieving standards is monitored via the Digital and Data Services Senior Leadership Team. A final position report will be provided to Digital Performance and Assurance Group at the meeting immediately following 30 June 2024.

7. RECOMMENDATIONS:

That the Group notes the contents of the paper with the aim of achieving all recommendations as discussed above.

Author: **Andrea Shotton**
Title: **Head of Information Governance and Data Protection**

Background Papers:

Appendix 1: DSPT 2023-24 Final Assessment Report
Appendix 2: Final Assessment Action Plan

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DATA SECURITY & PROTECTION TOOLKIT

TEWV 2024/25-01

TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST

Overall risk assessment across all 10 National Data Guardian standards	Confidence level of the Independent Assessor in the veracity of the self-assessment
Limited	**Moderate**
No standards are rated as 'Unsatisfactory', but 2 or more are rated as 'Limited'	**Medium level of deviation** - the organisation's self-assessment against the Toolkit differs somewhat from the Independent Assessment

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assurance . counter fraud . advisory

REPORT REFERENCE:	TEWV 2024/25 -01
REPORT STATUS:	Final
DATE:	29 May 2024
AUDIT TEAM:	Michael Campbell, Principal Auditor Deborah Aderemi, Data analytics auditor Karen Wass, Technology Risk Assurance Manager Preetha Kumar, Associate Director of Technology Risk Assurance
CLIENT SPONSOR:	Liz Romaniak, Director of Finance, Information and Estates / Facilities Mike Brierley, Assistant Chief Executive
DRAFT REPORT ISSUED:	25 April 2024
REPORT DISTRIBUTION:	**Draft** Liz Romaniak, Director of Finance, Information and Estates Mike Brierley, Assistant Chief Executive Nick Black, Chief Information Officer Steven Forster, Acting Head of Technology Services / Cyber Security Service Manager – Technology Services Andrea Shotton, Head of Information Governance and Data Protection Beverley Smith, Information Compliance Manager **Final** As above plus: Rachel Hobson, Business Intelligence (BI) Delivery Manager Simon Marshall, Emergency Planning and Business Continuity Manager Craig Etherington, Asset and Configuration Manager Lesley Lawton, Group Audit Manager, AuditOne Sarah McCloud, Counter Fraud Specialist, AuditOne Phillip Bellas, Company Secretary Gavin Barker, Mazars, External Audit

The matters raised in this report are only those which came to our attention during our testing and are not necessarily a comprehensive statement of all the weaknesses that exist, or of all the improvements that may be required. Whilst every care has been taken to ensure that the information in this report is as accurate as possible, based on the information provided and documentation reviewed, no complete guarantee or warranty can be given with regards to the advice and information contained herein. Our work does not provide absolute assurance that material errors, loss or fraud do not exist. This report is prepared solely for the use of the Board and senior management of Tees, Esk and Wear Valleys NHS Foundation Trust. Details may be made available to specified external agencies such as external auditors, but otherwise this report should not be quoted or referred to in whole or in part without prior consent. No responsibility to any third party is accepted as the report has not been prepared and is not intended for any other purpose.

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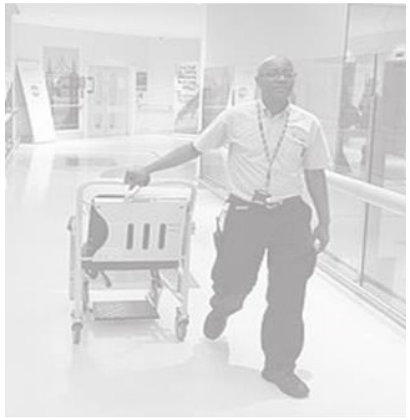
CONTENT



1. Introduction

In accordance with the agreed Internal Audit Plan for 2024/25 we have undertaken an independent assessment to understand and help address data security and data protection risk and identify opportunities for improvement, whilst also satisfying the annual requirement for an independent assessment of the data security protection toolkit (DSPT) submission for the Trust. The aim of this review was to provide:

- An assessment of the overall risk associated with the organisations' data security and data protection control environment i.e., the level of risk associated with controls failing and data security and protection objectives not being achieved. This will be an indicator for those assertions and evidence items assessed, as to the level of risk to the organisation and how good, or otherwise, the data security and protection environment is in terms of helping the organisation achieve the objectives in the DSPT; and
- An assessment as to the veracity of the organisations' self-assessment and DSPT submission and our level of confidence that the submission aligns our independent assessment of the risk and controls. Although the confidence level provides an indicator of the organisation's ability to accurately represent their security posture in their DSPT submission, it is the overall risk rating that is the primary indicator of the strength of the organisation's data security and protection control environment.

Our review followed NHS England's (NHSE) Strengthening Assurance Framework Guidance used by internal auditors when assessing DSPT submissions to:

- Better enable NHS organisations to continually improve the quality and consistency of DSPT submissions across the NHS landscape
- Deliver a framework that is adaptable in response to emerging information security, data and health and social care standards
- Help drive measurable improvement of data security across the NHS landscape and support annual and incremental improvements in the DSPT
- Deliver a framework that better enables and encourages organisations to publish a more granular, evidenced, and accurate picture of their organisation's position in terms of data security
- Deliver a framework that allows for data security and protection professionals to spend time on-site coaching organisations on security improvement options at the same time as assessing controls and risks
- Deliver a framework that helps ensure consistent delivery of 'independent assessments', including internal audits
- Enable and encourage appropriate feedback and dialogue between NHS England and Independent Assessors to help inform NHS wide communications and initiatives to help address common challenges and systemic or thematic security issues and to help inform the development and consumption of NHS Digital provided national services around data security
- Enable leveraging of other sources of assurance across the NHS to reduce the burden on organisations and reduce total effort, cost, and help minimise duplication of information gathering

We considered whether the organisations' met the requirement of each evidence text for each in scope assertion and also considered the broader maturity of the organisations' data security and protection control environment. 13 assertions were included in the review as mandated by NHSE and further details of the

evidence required are documented in appendix A.

2. Scope of the Assessment

Our assessment consisted of five core tasks:

- Pre-assessment preparation and information gathering
- Scope DSPT independent assessment
- Deliver DSPT independent assessment
- Post DSPT review meeting and reporting
- Assessment finalisation and quality management

Assessment approach

We completed our assessment using the following approach:

- Obtained access to your organisations' DSPT self-assessment
- Discussed the sample of 13 assertions that will be assessed with your organisations and define the evidence texts (mandatory only) that will be examined during the assessment
- Requested and reviewed the documentation provided in relation to evidence texts that are in scope of this assessment as detailed in Appendix A
- Interviewed the responsible stakeholders for each of the self-assessment responses
- Reviewed the operation of key technical controls using the DSPT assessment framework, professional judgement and knowledge of the organisation
- The assessment period was 26 February to 15 March 2024.

Reporting Approach

This formal audit report has been produced using the NHS England template and incorporated our observations and the analysis of key evidence provided to us. We have structured the report as follows:

- Used the reporting template as per the DSP Toolkit Strengthening Assurance Guide
- Where relevant and if we challenge the self-assessment; presented the level of deviation from the DSPT submission and assessment findings
- Explicitly referenced facts and observations from our on-site assessment to support our confidence and assurance levels
- Detailed recommendations that management can consider to address weaknesses identified

This final report includes the following ratings:

- Assurance level based on the confidence level of the independent assessor in the veracity of the Trust's self-assessment; and
- Overall risk rating across all 10 National Data Guardian Standards.

3. Limitations to the scope of the assessment

- Results were based on interviews with key stakeholders as well as a review of key documents where necessary to attest controls/processes. As we have assessed the operational effectiveness of a sub-set of assertions, our assessment should not be expected to include all possible internal control weaknesses that an end-to-end comprehensive compliance assessment might identify. We have been reliant on the accuracy of what we were told in interviews and what we reviewed in documents.
- Efforts have been made to validate accuracy only on a subset of evidence texts and therefore there was a dependency on the organisations to provide accurate information. Furthermore, onsite verbal recommendations by the Independent Assessor staff do not constitute formal professional advice and should be considered in line with broader observations. Our report contains recommendations for management consideration to address the weaknesses found.

4. Corporate significance & risk profile

This audit provides an independent source of assurance against BAF reference 7 – Cyber Security.

5. Executive Summary

DSP Toolkit Independent Assessment Report Outputs

Our review followed the Data Security and Protection (DSP) Toolkit Independent Assessment Framework and Guidance.13 assertions were reviewed across the 10 National Data Guardian Standards in the DSP Toolkit. All of these assertions were pre-determined as in-scope by NHS England.

21 findings have been raised with remediating recommendations for each of the in-scope assertions. These are detailed in Appendix A and B respectively.

Understanding your report ratings - Overall Risk Assurance Rating

The table below shows the 'Overall Risk Assessment Across all 10 NDG Standards' as well as the 'Overall NDG Standard Classification' based upon the 'Assertion-level Risk Assurance Ratings'. It includes the calculation of each risk assurance rating by detailing the scores obtained at each assertion level with respect to their category, (Low, Medium, High and Critical). To better understand the 'scoring methodology'.

The overall Risk Assurance Rating for Tees, Esk and Wear Valleys NHS Foundation Trust is 'Limited'. As per the published guidance, no standards are rated as 'Unsatisfactory', but 2 or more are rated as 'Limited'.

Table 1: Overall risk rating:

National Data Guardian (NDG) Standard	No. of Toolkit Assertions Assessed by Independent Assessor	Assertion level Risk Assessments				NDG standard level Risk Ratings		Overall DSP Toolkit Ratings
		No of Assertions rated **Critical** and (Weighted Risk Score)	No. of Assertions rated **High** and (Weighted Risk Score)	No. of Assertions rated **Medium** and (Weighted Risk Score)	No. of Assertions rated **Low** And (Weighted Risk Score)	Risk Rating Scores [Total points/ no. assertions assessed] - see appendix E.	Overall Risk Rating at the National Data Guardian Standard level- see appendix E.	Overall risk assurance across all 10 NDG standards
1.Personal Confidential Data	1 of 4			1(3)		3	Moderate	Limited
2.Staff Responsibilities	1 of 2				1(1)	1	Substantial	
3. Training	2 of 4				2(2)	1	Substantial	
4. Managing Data Access	1 of 5				1(1)	1	Substantial	
5.Process Reviews	1 of 2				1(1)	1	Substantial	
6. Responding to Incidents	1 of 3				1(1)	1	Substantial	
7.Continuity Planning	1 of 3		1(10)			10	Limited	
8.Unsupported Systems	1 of 4		1(10)			10	Limited	
9. IT Protection	3 of 6			1(3)	2(2)	1.6	Moderate	
10. Accountable Suppliers	1 of 3				1(1)	1	Substantial	
TOTAL	**13 of 36**							

Understanding your report ratings – Assurance Level

The assurance level for Tees, Esk and Wear Valleys NHS Foundation Trust (based on the confidence level of the Independent Assessor in the veracity of the self-assessment) is 'Moderate'. This means that the organisation's self-assessment differs somewhat from the Independent Assessment

Although differences were identified for five out of the 13 assertions, these were in relation to the Trust underestimating their achievement of these assertions rather than incorrectly stating their level of compliance.

NB: At the time of the assessment the Trust had not completed their toolkit online and instead had internal controls within the Information Governance Team to measure the completion of DSPT assertions within their Active Collab Project Management Tool. We have therefore based our opinion on the veracity of the Trust's toolkit submission upon this information as presented to us on 16th March 2023.

Assessing the veracity of your DSP toolkit self-assessment

Assessment Outputs

Overall risk assessment across all 10 National Data Guardian standards	Confidence level of the Independent Assessor in the veracity of the self-assessment
Limited	**Moderate**
No standards are rated as 'Unsatisfactory', but 2 or more are rated as 'Limited'	**Medium level of deviation -** the organisation's self-assessment against the Toolkit differs somewhat from the Independent Assessment

6. Key Findings Summary

We have identified four high, six medium and 11 low rated findings which should be addressed prior to 30th June 2023 submission date to ensure compliance with the Strengthening Assurance Framework. These findings are described in more detail in Appendix A.

Observations

We have also identified two evidence texts which were compliant at the time of the audit fieldwork but will require additional supporting evidence to re-confirm compliance before 30th June 2023 submission date. Formal recommendations have not been raised in respect of these observations but have been included here for information:

- *Evidence text 3.1.1 We were provided with a draft report document on the subject of the TNA due for release in April 2024. Ensure that current documentation is embedded and the report is published in April 2024*

- *Evidence text 9.5.7 – It was noted that the Trust had a baseline policy in place for servers which had the default behaviour enabled for auto run as 'Do not execute any auto run commands'. However, a review of the auto run setting from a sample server did not confirm that the policy was correctly applied. Further investigation from the Trust identified that there was a misconfiguration issue with the server configuration which resulted in the baseline policy not being applied to servers. This was planned to be fixed as a matter of urgency and was confirmed to have been fixed by the Trust on 13th March 2024. No further recommendation raised.*

7. Recommendation summary

	Priority			
	Critical	High	Medium	Low
Compliance with control framework	0	3	6	11
Veracity of Toolkit Submission	0	0	0	0
Total	**0**	**3**	**6**	**11**

8. Acknowledgment

We would like to thank management and staff for their help and cooperation in the course of this review.

Appendix A – Key Findings

The following findings have been raised during the assessment in relation to the Trust's data security and protection control environment.

Ref	Assertion	Evidence Text	Finding	Priority	Recommendation ref
1.1	1.1 The organisation has a framework in place to support Lawfulness, Fairness and Transparency	1.1.2 Your organisation has documented what personal data you hold, where it came from, who you share it with and what you do with it.	Data Protection Impact Assessments (DPIAs) were completed for new processing activity undertaken at the Trust and were used to update the Record of Processing Activity (ROPA). However, there was no evidence that regular reviews of the ROPA were undertaken to ensure that it accurately reflects the processing activity undertaken at the Trust. There was also no formally documented process to guide ROPA activity including the update and removal of processing activity and regular reviews of the record. Instead, the Trust used an 'as and when' approach to updating the ROPA but without any central control over its completeness or accuracy. In addition, the ROPA documented provided did not include the following information as required by GDPR requirements: • No details of data transfers outside the UK. • Compliance to common law duty of confidentiality • Frequency of transfer	**Medium**	1.1

Ref	Assertion	Evidence Text	Finding	Priority	Recommendation ref
			A sample of three in year DPIA's were traced through to the ROPA to test the completeness of the record and to ensure that the purposes for processing were documented as required per the General Data Protection Regulation. One processing activity could not be located (relating to DPIA reference 410). In the absence of assurance regarding the completeness and accuracy of the ROPA this may be scrutiny by the supervisory authority should they request to see this information There is a risk that appropriate controls may not be in place to protect the integrity and use of personal identifiable information if all the ROPA is incomplete.		
1.2	1.1 The organisation has a framework in place to support Lawfulness, Fairness and Transparency	1.1.4 Your business has identified, documented and classified its hardware and software assets and assigned ownership of protection responsibilities.	The Trust provided a copy of the Information Asset Register for software; however, this was incomplete as it did not include an asset owner for each of the assets recorded. This has not been subject to an independent review by the Senior Information Riks Owner (SIRO). A hardware asset register was not available for review at the time of the audit fieldwork as this was till under development therefore assurance could not be provided that the Trust has an understanding of its hardware estate.	**Medium**	1.2

Ref	Assertion	Evidence Text	Finding	Priority	Recommendation ref
			The security of Trust assets may be compromised if a complete and accurate record of is not maintained.		
1.3	1.1 The organisation has a framework in place to support Lawfulness, Fairness and Transparency	1.1.5 List the names and job titles of your key staff with responsibility for data protection and/or security.	It has been identified via AuditOne audits undertaken at the Trust in 2023/24 that the Trust is operating with vacancies in security roles, including a Chief Information Officer (CIO) and Network Manager as well as the Acting Head of Technology Services was fulfilling the role of Cyber Security Manager. There is a risk that data security may not be effectively managed in the absence of key roles	**Medium**	1.3
1.4	1.1 The organisation has a framework in place to support Lawfulness, Fairness and Transparency	1.1.8 A data quality forum monitors the effectiveness of data quality assurance processes	The Data Quality Working Group was responsible for overseeing data quality issues at the Trust. This group has been stood down since 5 February 2024 when new data quality governance arrangements were instated via the CITO Electronic Patient Record (EPR). No evidence was provided of this new arrangement operating in practice during the assessment. Poor data quality could impair decision making and the subsequent provision of patient care.	**Low**	1.4

Ref	Assertion	Evidence Text	Finding	Priority	Recommendation ref
1.5	3.1 Staff have appropriate understanding of information governance and cyber security, with an effective range of approaches taken to training awareness	3.1.2 Your organisation defined training and awareness activities are implemented for and followed by all staff	The Trust could not provide a report which records the mandatory data security and protection training uptake for individual directorates with the exception of the Information Governance Team In the absence of granular reporting the Trust may not have assurance regarding the level of staff training and awareness on data security and protection.	**Low**	1.5
1.6	3.2 Your organisation engages proactively and widely to improve data security and has an open and just culture for data security incidents.	3.2.1 Information governance and cyber security matters are prioritised by the board or equivalent senior leaders	Examples of cyber security and information governance events and campaigns conducted throughout the year via the Metacompliance training portal was provided as evidence to support this assertion. These events were aimed at all staff within the Trust, including the senior leadership team However, we noted that attendance was not mandatory and there was no record in place to verify that senior managers had attended such events. Senior leaders may not be sighted on key cyber security and information governance issues if they are not actively involved in awareness sessions.	**Low**	1.6
1.7	7.1 Organisations have a defined, planned and communicated response to Data	7.1.1 Your organisation understands the health care it provides	The Trust did not have documentation where its operational services along with the key dependencies were outlined. As a result, we were unable to review:	**High**	1.7

Ref	Assertion	Evidence Text	Finding	Priority	Recommendation ref
	security incidents that impact sensitive information or key operational services.		• what the Trust's key services were, • the technologies and other departments services relied on, • other dependencies the operational services have, • the impact of the loss of availability of the service • how frequently services and their dependencies were reviewed Due to the absence of key evidence a sample could not be tested to confirm the accuracy of dependency mapping. There may be poor coordination and response in the event of a data security incident which may impact on the availability of key services and the continuation of patient care.		
1.8	7.1 Organisations have a defined, planned and communicated response to Data security incidents that impact sensitive information or key operational services.	7.1.2 Your organisation has well defined processes in place to ensure the continuity of services in the event of a data security incident, failure or compromise.	The Business Continuity Plans (BCP) for the Trust's services were not provided during the audit field work therefore testing could not be undertaken confirm that the Trust would be able to continue to provide services in the event of a data security incident. There may be poor coordination and response in the event of a data security incident which may impact on the availability of key services and the continuation of patient care.	**High**	1.8

Ref	Assertion	Evidence Text	Finding	Priority	Recommendation ref
1.9	8.1 All software and hardware has been surveyed to understand if it is supported and up to date.	8.1.1 Provide evidence of how the organisation tracks and records all software assets and their configuration	The Trust had documented technical operating instructions to carry out a manual weekly, monthly and emergency review of the software asset register. However, the Trust was still in the process of implementing this control and outcomes of these reviews were yet to be formalised or documented. As a result, there was no evidence of the software asset register reviews to give assurance over the completeness and accuracy of the software asset register. The Trust provided evidence of software asset review completed on 4th March 2024 after the DSPT field work was completed. Also, the Trust did not have a software deployment mechanism to prevent the installation of unauthorised software on workstations. Users could download software without permission or through a formal request process. The desktop support manager stated that AppLocker was being trialled as a method to prevent end users from installing and running applications that by-pass administrative rights requirements however no timescales for implementing this had been agreed.	**Medium**	1.9 Also Refer to Recommendation ref 1.2

Ref	Assertion	Evidence Text	Finding	Priority	Recommendation ref
			The Trust stands the risk of malware infection and cyber incidents from the unauthorised installation of software		
1.10	8.2 Unsupported software and hardware is categorised and documented, and data security risks are identified and managed.	8.2.1 List any unsupported software prioritised according to business risk, with remediation plan against each item.	The Trust's software asset master list includes software that is no longer supported. However, it did not include details about any known vulnerabilities, remediation plans or risk assessment of the software. The Trust had however documented an action plan with plans to carry out a bi-weekly meeting and have an agenda item to review the software added to the 'End of Support – Upgrades' tab and evaluate the urgency of each software (and version if applicable) and agree the timescales for remediation. Absence of remediation and mitigation plans for unsupported software can expose the Trust to exploitable vulnerabilities.	**Low**	1.10
1.11	8.2 Unsupported software and hardware is categorised and documented, and data security risks are identified and managed.	8.2.2 The SIRO confirms that the overall risks of using unsupported systems are being managed and the scale of unsupported software is reported to you board along with the plans to address.	The Trust had documented a technical operating procedure for end of support software. However this had not been implemented at the time of the assessment and the Trust anticipated that this would be in place by June 2024. As a result, there was no evidence provided to confirm that the SIRO had approved the mitigating control of deleting the EOS log4j out of support software. The Trust advised that the	**Low**	1.11

Ref	Assertion	Evidence Text	Finding	Priority	Recommendation ref
			copies of these EOS Log4j 1.2.17.0 were 1,625 as at 2 February 2024 (out of the original 4,590 copies). No evidence was provided to confirm that gaps in patching identified had been addressed. Mitigating controls may not be appropriate without the SIRO's oversight and associated risk acceptance.		
1.12	8.3 Supported systems are kept up to date with the latest security patches.	8.3.1 How do your systems receive updates and how often.	Following the review of the patch management dashboard report dated January 2024, it was noted that there were 244 systems (out of 7,842 computers) which had missing patches. Of the 244 systems with missing patches: • 44 were critical patches, • 45 were rated as important, • 28 rated as moderate, • 14 rated as low and • 113 were unrated. Of the 44 missing critical patches: • 11 were patches released over 120 days, • 5 were patches released between 90 to 120days, • 9 were patches released between 60 to 90days, • 12 were patches released between 30 to 60days and 7 were patches released less than 30 days	High	1.12

Ref	Assertion	Evidence Text	Finding	Priority	Recommendation ref
			The Trust's patch procedure states that patches should be deployed within 7 days after the patch is made available. No evidence was provided to confirm that gaps in patching identified had been addressed. Failure to install patches on a timely basis my result in known vulnerabilities being exploited to gain unauthorised access to the Trust's systems.		
1.13	8.3 Supported systems are kept up to date with the latest security patches.	8.3.4 Where a security patch has been classed as critical or high-risk vulnerability it is applied within 14 days, or the risk has been assessed, documented, accepted and signed off by the SIRO with an auditor agreeing a robust risk management process has been applied.	There was no evidence provided to confirm that the SIRO has accepted the risk associated with not patching the aforementioned 244 systems with missing patches. Known vulnerabilities from the missing patches can be exploited to gain unauthorised access to the Trust's systems.	**Medium**	1.13
1.14	8.4 You manage known vulnerabilities in your network and information systems to prevent disruption of the essential service.	8.4.2 All infrastructure is running operating systems and software packages that are patched regularly, and as a minimum in vendor support.	Based on the non-compliance identified from the review of the following evidence items above: 8.1.1, 8.2, 8.3.1, 8.3.4; this evidence text is rated 'High'.	**High**	Recommendations 1.9 to 1.13

Ref	Assertion	Evidence Text	Finding	Priority	Recommendation ref
1.15	9.2 A penetration test has been scoped and undertaken.	9.2.1 The annual IT penetration testing is scoped in negotiation between the SIRO, business and testing team including a vulnerability scan and checking that all networking components have had their default passwords changed to a high strength password	We could not confirm that a review of network appliance passwords was carried out as part of the Trust's previous penetration test. This is not in line with the Strengthening Assurance framework which requires that password for network appliances should be tested during penetration testing.	**Low**	1.14
1.16	9.2 A penetration test has been scoped and undertaken.	9.2.3 The SIRO or equivalent senior role has reviewed the results of latest penetration testing, with an action plan for its findings.	There was no evidence to confirm that the SIRO has reviewed the Trust's penetration test report for the exercise carried out on 8th June 2023 or has approved the action plans associated with mitigating application security vulnerabilities identified. The Trust confirmed that the current SIRO has not formerly reviewed the last penetration test result which was largely due to unusual circumstance around the CIO departing the Trust in 2023 which has caused some disruption. The Trust plans to schedule a review in with SIRO in May 2024. Due to these unforeseen circumstances the results of the penetration test were reviewed by the Head of Networks and Data. Also, we could not confirm that a review of network appliance passwords was	**Medium**	1.15

Ref	Assertion	Evidence Text	Finding	Priority	Recommendation ref
			carried out as part of the Trust's previous penetration test. This implies that risks may not be properly managed, and the SIRO might not have complete oversight of the Trust's mitigating controls.		
1.17	9.5 You securely configure the network and information systems that support the delivery of essential services.	9.5.2 Confirm all data are encrypted at rest on all mobile devices and removable media and you have the ability to remotely wipe and/or revoke access from an end user device.	The Trust had an Information Security Policy which had information about the acceptable encryption standards. The policy has a next review date of 10 August 2023. The Trust stated that the policy was identified for update and will be considered the coming months. Outdated policies may fail to comply with new laws and regulations. They may not address new systems, processes or technology, which can result in inconsistent practices in the Trust.	**Low**	1.16

Ref	Assertion	Evidence Text	Finding	Priority	Recommendation ref
1.18	9.5 You securely configure the network and information systems that support the delivery of essential services.	9.5.3 You closely and effectively manage changes in your environment, ensuring that network and system configuration are secure and documented.	There was no evidence provided to confirm that the Trust carried out regular reviews/audit of the actual device configurations against these standards set out in (TOI - Running Build Task Sequence 1) and (WKS - TEWV BASELINE WIN10 v1803 -Master 1.13). In addition, the Trust did not have a policy or procedure setting out what should be undertaken as part of the change management process. The policy/procedure should identify types of changes, what would require approval, risk assessing etc. Issues from misconfiguration may not be identified if there are no regular reviews of device configuration against standards.	**Low**	1.17
1.19	9.6 The organisation is protected by a well-managed firewall.	9.6.1 One or more firewalls (or similar network device) have been installed on all of the boundaries of the organisations internal network(s)	Discussion was held with the Network officer during the field work who explained that the Trust had six firewalls which are situated at each internet breakout points. These firewalls comprise of two HSCN firewalls, two server firewalls and two INET firewalls. However, no network diagram was provided to confirm that the firewalls have been deployed at each of the Trust's ingress/egress point as per the Strengthening Assurance Framework Guidance.	**Low**	1.18

Ref	Assertion	Evidence Text	Finding	Priority	Recommendation ref
			Absence of assurance on the location of Trust firewalls may result in unauthorised access to the network.		
1.20	9.6 The organisation is protected by a well-managed firewall.	9.6.4 All inbound firewall rules (other than default deny) are documented with business justification and approval by the change management process. 9.6.5 Firewall rulesets are reviewed on a regular basis. Rulesets are removed/disabled when they are no longer required.	The process for making changes on Trust firewalls follows the change management process documented in the Change Advisory Group (CAG) Terms of Reference (TOR). However, no evidence was provided during the fieldwork stage of the audit of firewall ruleset changes to confirm that it was approved by one of the authorised individuals from the Change Advisory Group (CAG) Lack of regular review of firewall rulesets may imply that imply that unrequired permissions may still exist which can result to unauthorised access to the network.	**Low**	1.19
1.21	10.2 Basic due diligence has been undertaken against each supplier that handles personal information.	10.2.1 Your organisation ensures that any supplier of IT systems that could impact on the delivery of care, or process personal identifiable data, has the appropriate certification.	Through discussion with the Information Governance Team and a review of the contract log it confirmed that although there was a process in place to verify potential supplier certifications online there was no evidence documented to evidence these checks. Furthermore, there was no evidence of an annual review of supplier certifications undertaken.	**Low**	1.20

Ref	Assertion	Evidence Text	Finding	Priority	Recommendation ref
			There is a risk that supplier security controls may not be appropriate without assurance that sufficient standards have been met though formal security certifications.		

Appendix B – Recommendations

Ref	Recommendation	Priority	Accepted	Management Response	Target implementation	Manager Responsible
1.1	Implement a mechanism to provide assurance to the Trust on the completeness and accuracy of the ROPA in accordance with the requirements of GDPR. Formally document the process and monitor compliance.	**Medium**	Accepted	A SOP will be developed for a monthly review of the ROPA following Digital and Data Management Meeting at which DPIAs and ISAs are approved. A retrospective review of the ROPA will be conducted to ensure all DPIAs, ISAs and new information flows are documented. The ROPA and SOP will be presented to the CIO and SIRO for approval and sign-off.	30 June 2024	Andrea Shotton
1.2	Update the software asset register with designated asset owners and document the hardware asset register. Ensure that both registers are reviewed and approved by the SIRO.	**Medium**	Accepted in part	This activity is still a project. Evidence was provided describing the project - the timeframes - progress to date and the fact that it has organisational ownership and oversight. The SIRO sits on DPB and has ongoing oversight. We accept the recommendation which will be built into the outputs of the project.	30 June 2024	Steven Forster
1.3	Accept the risk of operating with several staff information security role vacancies until these are filled.	**Medium**	Accepted in part	The risk is being managed as it is recorded on the department's risk register and so there is organisational visibility and work to fill vacancies is ongoing (see screenshot attached below). Recently we have appointed Chief Information Officer and the Head of Technology Services who both now in post. Action implemented – evidence provided to AuditOne at report issue date.	N/A - Action implemented – evidence provided to AuditOne at report issue date.	Andrea Shotton

Ref	Recommendation	Priority	Accepted	Management Response	Target implementation	Manager Responsible
1.4	Ensure that the new Data Quality Working Group is formally established and is operating as intended and completed with an appropriate terms of reference.	**Low**	Accepted	The new post-CITO and post IIC Migration DQWG has not yet been stood back up and as such no new TOR has been agreed. Following the CITO go-live and initial embedding period, the appointment of the new CIO and with the imminent completion of the IIC Migration Project (due June 2024), we have arranged a meeting for 20/05/24 to discuss the monitoring of Data Quality issues & future of Data Quality Working Group.	30-Jun-24 (completion of IIC Migration Project) 12-Jul-24 (Approval of DQ approach)	Rachel Hobson
1.5	Seek assurance that granular reporting can be undertaken for the completion of data security and protection training.	**Low**	Accepted	At the time of audit, the IG team did not have sight of the granular reporting occurring within the business. Weekly updates are provided by the Corporate Performance Lead to the Trust's senior leaders which the Head of IG now has sight of. This includes uptake of appraisal, mandatory and data security & protection training (showing as Information Governance) broken down by directorate. Reports available through the IIC allow departments to self-govern. Achievement of Stat and Mand is managed at an organisation level by the Executive People and Culture Group.	N/A – Evidence of granular monitoring provided to AuditOne at report issue date.	Andrea Shotton
1.6	Ensure senior management attendance at events is recorded.	**Low**	Accepted	A cyber security awareness session will be held specifically for senior leaders. An awareness campaign is planned for the next 12 months which will include	30 June 2024	Steven Forster/Andrea Shotton

Ref	Recommendation	Priority	Accepted	Management Response	Target implementation	Manager Responsible
				training that is targeted specifically to senior leaders.		
1.7	Document the Business Impact Analysis (BIA) for all operational services along with the key dependencies, technologies and services their services rely on, the other dependencies and impact of loss of availability. Also, determine the frequency of review and update the document in accordance with the stated frequency in approved BIA.	High	Accepted	The Trust has implemented a Business Continuity Management System (BCMS) which is aligned to the international standards ISO 22301 and ISO 22313 and includes: A strategic overview via a survey and analysis process has been used to differentiate between critical and non-critical Trust services and systems • A review will be completed annually for each Business Impact Analysis (BIA) which underpins a business continuity plan. These will review service dependencies, customers and suppliers, identify potential risks or hazards which may impact service delivery against which strategies to mitigate impact will be developed. • Business Continuity Service Plans are in place for all critical services and systems in readiness for use in an incident to assist the Trust to continue to deliver its critical services at an acceptable pre-defined level. These are revised at least annually in line with the BIA reviews. Changes in the BIAs will be reflected in the relevant business continuity plans. • Command and Control function – Comprehensive Business Continuity Command and Control plans are in	30 June 2024	Simon Marshall

Ref	Recommendation	Priority	Accepted	Management Response	Target implementation	Manager Responsible
				place to enable a team to be established to efficiently manage an emergency or disruption impacting on Trust critical services • Risk Register – An Emergency Planning and Business Continuity Risk Register is in place which identifies Trust risks including those linked to the National and Community Risk Registers. High level risks are escalated to locality and Trust Risk Registers as appropriate. Due to a vacancy and operational pressures, the annual reviews of Business Impact Analysis have been delayed but a key part of that role is to support the relevant operational services review Business Impact Analysis against the local, regional and national risk profiles.		
1.8	Seek assurance that Business Continuity Plans have been documented for all services which include key dependencies. Where gaps are identified BCPs should be developed and approved.	**High**	Accepted	The Trust has a range of business continuity plans in place to ensure continued minimum service provision can be maintained. Plans are in place for all operational areas identified through the business impact analysis. Business continuity plans are available via the Trust Intranet with hard copies being help locally. Business continuity plans are available for Safeguarding, Clinical service delivery, estates, Hotel services, infection prevention and control,	31 May 2024	Simon Marshall

Ref	Recommendation	Priority	Accepted	Management Response	Target implementation	Manager Responsible
				finance, workforce information and recruitment, data centre, pharmacy, communications, information service desk, mental health act and the therapies staff group. The emergency planning manager post has been vacant for some time (now appointed) a key part of that role is to support the relevant operational service update their BCP's according to the changing landscape. It has been identified that due to the implementation of emerging technologies new business continuity arrangements are required for staff alarm system, safety door systems and the Oxehealth system. Action cards are currently being developed and will be added to existing BCP's. The transition from Paris to CITO required a new suite of action cards to be developed to support both the transition and any future outages. Examples of BCPs will be forwarded separately for audit purposes.		
1.9	Implement a process for software asset register review and document the outcomes of these reviews.	**Medium**	Accepted	This project is drawing to close. Findings will be reported via Digital Performance and Assurance Group. Unsupported software will be included as part of this activity and will be reported to the SIRO.	30 June 2024	Steven Forster, Craig Etherington
1.10	Carry out a risk assessment for unsupported software and document the corresponding remediation plan.	**Low**	Accepted	This project is drawing to close. Findings will be reported via Digital Performance and Assurance Group. Unsupported	30 June 2024	Steven Forster, Craig Etherington

Ref	Recommendation	Priority	Accepted	Management Response	Target implementation	Manager Responsible
				software will be included as part of this activity and will be reported to the SIRO.		
1.11	Implement the process for the end of support software while also ensuring that the SIRO approves mitigating controls or accepts risks for unsupported software being used by the Trust	**Low**	Accepted	This project is drawing to close. Findings will be reported via Digital Performance and Assurance Group. Unsupported software will be included as part of this activity and will be reported to the SIRO.	30 June 2024	Steven Forster, Craig Etherington
1.12	Investigate the reason for missing patches and install updated patches on all affected systems and bring these up to date or appropriately risk assess.	**High**	Accepted	Analysis of missing patches is underway to understand the associated risks which will be reported to DDMM on 30-May-24 and up to DPAG on 14-Jun-24	30 June 2024	Steven Forster
1.13	The SIRO should risk assess any risks associated with the systems with missing patches and accept the risk or approve the remedial action to be taken.	**Medium**	Accepted	The above report will be presented to the SIRO for signoff via Digital Performance and Assurance Group.	30 June 2024	Steven Forster
1.14	Ensure that network appliance passwords are tested as part of the annual penetration test.	**Low**	Accepted	Network appliance passwords are tested within the scope of standard penetration testing. Evidence will be provided separately.	31 May 2024	Steven Forster
1.15	Obtain retrospective approval of the previous penetration test report document and documented action plans from the SIRO and ensure that this process is continually followed for future penetrations tests undertaken.	**Medium**	Accepted	It's noted that the current SIRO hasn't formerly reviewed the last penetration test result. This is largely due to unusual circumstance around the CIO departing the Trust in 2023 which has caused some disruption. We will schedule a review in with SIRO in May 2024.	31 May 2024	Steven Forster
1.16	Review and update the Information Security Policy.	**Low**	Accepted	Work is in progress to complete this within the current toolkit reporting period.	30 June 2024	Andrea Shotton
1.17	Document a policy/procedure which identifies types of changes and the	**Low**	Accepted	The Change Advisory Group (CAG) procedure and the TOR have been	31 May 2024	Steven Forster

Ref	Recommendation	Priority	Accepted	Management Response	Target implementation	Manager Responsible
	process for requesting, risk assessing and approving system changes.			documented and approved and will be provided.		
1.18	Formally document the Trust's firewalls within a network diagram to seek assurance on coverage.	**Low**	Accepted	A network diagram will be produced for approval via Cyber Security Group.	30 June 2024	Steven Forster
1.19	Seek assurance that process to regularly review firewall rulesets is operating effectively and the outcome of reviews are documented.	**Low**	Accepted	The firewall rulesets are regularly reviewed as BAU. Evidence has been provided to AuditOne since the report was written.	N/A - Action complete.	Steven Forster
1.20	Formally document the verification of supplier security certifications to be requested and received prior to any new supplier onboarding. This should be reperformed on an annual basis.	**Low**	Accepted	The process will be documented. Verification will be completed by the end of May 2024 with a compliance confirmation report to be presented to Information Governance Group on 19th June 2024.	30 June 2024	Beverley Smith

Appendix C – Evidence Text Assessment Results

The following tables detail the mandatory evidence texts and the independent assessment results in-scope of the review.

National Data Guardian Standard 1: Personal Confidential Data

Assertion 1.1: The organisation has a framework in place to support Lawfulness, Fairness and Transparency

Overall confidence level in toolkit submission for assertions 1.1: **Medium**

Overall risk rating for assertion 1.1: **Medium**

Evidence Text Reference	Evidence Text or Category	Self-assessed by Trust	Assessed by AuditOne	Confidence level in veracity of self-assessment	Likelihood	Impact	Risk rating
1.1.1	State your organisation Information Commissioners Office (ICO) registration number	Met	Met	High	< 20%	Minor	Very low / insignificant
1.1.2	Your organisation has documented what personal data you hold, where it came from, who you share it with and what you do with it.	Met	Partially Met	Medium	60-80%	Major	Medium (See finding 1.1 appendix A)
1.1.3	Transparency information (e.g. your Privacy Notice and Rights for individuals) is published and available to the public	Met	Met	High	20-40%	Moderate	Low
1.1.4	Your business has identified, documented and classified its hardware and software assets and assigned ownership of protection responsibilities.	Met	Partially Met	Medium	60-80%	Major	Medium (See finding 1.2 appendix A)
1.1.5	List the names and job titles of your key staff with responsibility for data protection and/or security.	Met	Partially Met	Medium	60-80%	Major	Medium (See finding 1.3 appendix A)

Evidence Text Reference	Evidence Text or Category	Self-assessed by Trust	Assessed by AuditOne	Confidence level in veracity of self-assessment	Likelihood	Impact	Risk rating
1.1.6	Your organisation has reviewed how you ask for and record consent.	Met	Met	High	< 20%	Moderate	Low
1.1.7	Data quality metrics and reports are used to assess and improve data quality.	Met	Met	High	< 20%	Moderate	Low
1.1.8	A data quality forum monitors the effectiveness of data quality assurance processes	Met	Partially Met	Medium	20-40%	Moderate	Low (see finding 1.4 at Appendix A)

National Data Guardian Standard 2: Staff Responsibilities

Assertion 2.2: Staff contracts set out responsibilities for data security.

Overall confidence level in toolkit submission for assertions 2.2: **High**

Overall risk rating for assertion 2.2: **Low**

Evidence Text Reference	Evidence Text or Category	Self-assessed by Trust	Assessed by AuditOne	Confidence level in veracity of self-assessment	Likelihood	Impact	Risk rating
2.2.1	All employment contracts contain data security requirements	Met	Met	High	< 20%	Minor	Very low / insignificant

National Data Guardian Standard 3: Training

Assertion 3.1: Staff have appropriate understanding of information governance and cyber security, with an effective range of approaches taken to training and awareness
Overall confidence level in assertion 3.1: **High**

Overall risk rating for assertion 3.1: **Low**

Evidence Text Reference	Evidence Text or Category	Self-assessed by Trust	Assessed by AuditOne	Confidence level in veracity of self-assessment for this standard.	Likelihood	Impact	Risk Rating
3.1.1	Training and awareness activities form part of organisational mandatory training requirements, with a training and awareness needs analysis (covering all staff roles) that is formally endorsed and resourced by senior leadership.	Met	Met	High	< 20%	Minor	Low
3.1.2	Your organisations defined training and awareness activities are implemented for and followed by all staff.	Met	Partially Met	Medium	20-40%	Moderate	Low (see finding 1.5 at Appendix A)
3.1.3	Provide details of how you evaluate your training and awareness activities.	Met	Met	High	< 20%	Minor	Very low / insignificant

*The TNA was last reviewed and approved in June 2023 which was within the last 12 months at the time this assessment was undertaken. Next review was due for April 2024. See observation under key findings section of the report.

Assertion 3.2: Your organisation engages proactively and widely to improve data security and has an open and just culture for data security incidents.

Overall confidence level in assertion 3.2: **Medium**

Overall risk rating for assertion 3.2: **Low**

Evidence Text Reference	Evidence Text or Category	Self-assessed by Trust	Assessed by AuditOne	Confidence level in veracity of self-assessment for this standard.	Likelihood	Impact	Risk Rating
3.2.1	Information governance and cyber security matters are prioritised by the board or equivalent senior leaders	Met	Partially met	Medium	20-40%	Moderate	Low (see finding 1.6 in appendix A)

National Data Guardian Standard 4: Managing Data Access

Assertion 4.4: The organisation maintains a current record of staff and their roles.

Overall confidence level in assertion 4.4: **High**

Overall risk rating for assertion 4.4: **Low**

Evidence Text Reference	Evidence Text or Category	Self-assessed by Trust	Assessed by AuditOne	Confidence level in veracity of self-assessment for this standard.	Likelihood	Impact	Risk rating
4.4.1	The organisation ensures that logs, including privileged account use, are kept securely and only accessible to appropriate personnel. They are stored in a read only format, tamper proof and managed according to the organisation information life cycle policy with disposal as appropriate.	Met	Met	High	20-40%	Moderate	Low

Evidence Text Reference	Evidence Text or Category	Self-assessed by Trust	Assessed by AuditOne	Confidence level in veracity of self-assessment for this standard.	Likelihood	Impact	Risk rating
4.4.2	The organisation does not allow users with wide ranging or extensive system privilege to use their highly privileged accounts for high-risk functions, in particular email and web browsing.				20-40%	Moderate	Low

National Data Guardian Standard 5: Process Reviews

Assertion 5.1: Process reviews are held at least once per year where data security is put at risk and following data security incidents.

Overall confidence level in assertion 5.1: **High**

Overall risk rating for assertion 5.1: **Low**

Evidence Text Reference	Evidence Text or Category	Self-assessed by Trust	Assessed by AuditOne	Confidence level in veracity of self-assessment for this standard.	Likelihood	Impact	Risk rating
5.1.1	Root cause analysis is conducted routinely as a key part of your lessons learned activities following a data security incident, with findings acted upon.	Met	Met	High	20-40%	Moderate	Low

National Data Guardian Standard 6: Responding to Incidents

Assertion 6.2: All user devices are subject to anti-virus protections while email services benefit from spam filtering and protection deployed at the corporate gateway.

Overall confidence level in assertion 6.2: **High**

Overall risk rating for assertion 6.2: **Low**

Evidence Text Reference	Evidence Text or Category	Self-assessed by Trust	Assessed by AuditOne	Confidence level in veracity of self-assessment for this standard.	Likelihood	Impact	Risk rating
6.2.1	Antivirus/anti-malware software has been installed on all computers that are connected to, or are capable of connecting to the internet	Met	Met	High	20-40%	Moderate	Low
6.2.3	Antivirus/anti-malware is kept continually up to date.	Met	Met	High	40-60%	Moderate	Low
6.2.4	Antivirus/anti-malware software scans files automatically upon access.	Met	Met	High	20-40%	Moderate	Low
6.2.5	Connections to malicious websites on the internet are prevented	Met	Met	High	40-60%	Moderate	Low
6.2.8	You have implemented on your email, Domain-based Message Authentication Reporting and Conformance (DMARC). Domain Keys Identified Mail (DKIM) and Sender Policy Framework (SPF) for your organisations domains to make email spoofing difficult.	Not* applicable	Not* applicable	Not applicable*	Not applicable*	Not applicable	Not applicable*
6.2.9	You have implemented spam and malware filtering and enforced DMARC on inbound email.	Not* applicable	Not* applicable	Not applicable*	Not applicable*	Not applicable	Not applicable*

* The Trust advised that only NHS mail is used.

National Data Guardian Standard 7: Continuity Planning

Assertion 7.1: Organisations have a defined, planned and communicated response to Data security incidents that impact sensitive information or key operational services.

Overall confidence level in assertion 7.1: **Low**

Overall risk rating for assertion 7.1: **High**

Evidence Text Reference	Evidence Text or Category	Self-assessed by Trust	Assessed by AuditOne	Confidence level in veracity of self-assessment for this standard.	Likelihood	Impact	Risk rating
7.1.1	Your organisation understands the health care it provides	Met	Not met	Low	>80%	Major	High (See finding 1.7 at appendix A)
7.1.2	Your organisation has well defined processes in place to ensure the continuity of services in the event of a data security incident, failure or compromise.	Partially met	Not met	Low	>80%	Major	High (See finding 1.8 at appendix A)

The risk assessment tables for evidence texts 8.1, 8.2 and 8.3 are included to support the risk ratings of findings identified and have not been taken into consideration to form the overall assurance rating. These evidence texts were required in order to test evidence item 8.4.2 and their overall risk rating added up as the risk rating for 8.4.2

Evidence Text Reference	Evidence Text or Category	Self-assessed by Trust	Assessed by AuditOne	Confidence level in veracity of self-assessment for this standard.	Likelihood	Impact	Risk Rating
8.1.1	Provide evidence of how the organisation tracks and records all software assets and their configuration.	Met	Partially met	Medium	60-80%	Moderate	Medium (See finding 1.9 appendix A)
8.1.4	The organisation ensures that software is no longer within support or receiving security updates is uninstalled. Where this is practical, the endpoint	Met	Met	High	20-40%	Moderate	Low

Evidence Text Reference	Evidence Text or Category	Self-assessed by Trust	Assessed by AuditOne	Confidence level in veracity of self-assessment for this standard.	Likelihood	Impact	Risk Rating
	should be isolated and have limited connectivity to the network.						
8.2.1	List any unsupported software prioritised according to business risk, with remediation plan against each item.	Met	Met	High	20-40%	Moderate	Low (See finding 1.10 appendix A)
8.2.2	The SIRO confirms that the overall risks of using unsupported systems are being managed and the scale of unsupported software is reported to you board along with the plans to address.	Met	Met	High	20-40%	Moderate	Low (See finding 1.11 appendix A)
8.3.1	How do your systems receive updates and how often.	Met	Partially met	Medium	>80%	Major	High (See finding 1.12 at appendix A)
8.3.4	Where a security patch has been classed as critical or high-risk vulnerability it is applied within 14 days, or the risk has been assessed, documented, accepted and signed off by the SIRO with an auditor agreeing a robust risk management process has been applied.	Met	Partially met	Medium	60-80%	Moderate	Medium (See finding 1.13 appendix A)

National Data Guardian Standard 8: Unsupported Systems

Assertion 8.4: You manage known vulnerabilities in your network and information systems to prevent disruption of the essential service.

Overall confidence level in assertions 8.4: **High**

Overall risk rating for assertion 8.4: **High**

Evidence Text Reference	Evidence Text or Category	Self-assessed by Trust	Assessed by AuditOne	Confidence level in veracity of self-assessment for this standard.	Likelihood	Impact	Risk Rating
8.4.1	Your organisations infrastructure is protected from common cyber-attacks through secure configuration and patching.	Met	Met	High	20-40%	Moderate	Low
8.4.2	All infrastructure is running operating systems and software packages that are patched regularly, and as a minimum in vendor support.	Partially met	Partially met	High	60-80%	Major	High (See findings 1.9 to 13 at appendix A)
8.4.3	You maintain a current understanding of the exposure of your hardware and software to publicly-know vulnerabilities.	Met	Met	High	40-60%	Moderate	Low

National Data Guardian Standard 9: IT Protection

Assertion 9.2: A penetration test has been scoped and undertaken.

Overall confidence level in assertion 9.2: **Medium**

Overall risk rating for assertion 9.2: **Medium**

Evidence Text Reference	Evidence Text or Category	Self-assessed by Trust	Assessed by AuditOne	Confidence level in veracity of self-assessment for this standard.	Likelihood	Impact	Risk rating
9.2.1	The annual IT penetration testing is scoped in negotiation between the SIRO, business and testing team including a vulnerability scan and checking that all networking components have had their default passwords changed to a high strength password	Met	Met	High	40-60%	Moderate	Low (See finding 1.15 at appendix A)
9.2.3	The SIRO or equivalent senior role has reviewed the results of latest penetration testing, with an action plan for its findings.	Met	Partially met	Medium	60-80%	Moderate	Medium (See finding 1.16 appendix A)

Assertion 9.5: You securely configure the network and information systems that support the delivery of essential services.

Overall confidence level in assertion 9.5: **Medium**

Overall risk rating for assertion 9.5: **Low**

Evidence Text Reference	Evidence Text or Category	Self-assessed by Trust	Assessed by AuditOne	Confidence level in veracity of self-assessment for this standard.	Likelihood	Impact	Risk rating
9.5.1	All devices in your organisation have technical controls that manage the installation of software on the devices	Met	Met	High	20-40%	Moderate	Low
9.5.2	Confirm all data are encrypted at rest on all mobile devices and removable media and you have the	Met	Partially Met	Medium	20-40%	Moderate	Low

Evidence Text Reference	Evidence Text or Category	Self-assessed by Trust	Assessed by AuditOne	Confidence level in veracity of self-assessment for this standard.	Likelihood	Impact	Risk rating
	ability to remotely wipe and/or revoke access from an end user device.						(See finding 1.17 at Appendix A)
9.5.3	You closely and effectively manage changes in your environment, ensuring that network and system configuration are secure and documented.	Met	Partially Met	Medium	40-60%	Moderate	Low (See finding 1.18 at Appendix A)
9.5.5	End-user devices are built from a consistent and approved base image.	Met	Met	High	20-40%	Moderate	Low
9.5.6	End-user device security settings are managed and deployed centrally.	Met	Met	High	20-40%	Minor	Low
9.5.7	Auto-run is disabled.	Met	Met	High	20-40%	Moderate	Low
9.5.8	All remote access is authenticated.	Met	Met	High	20-40%	Moderate	Low
9.5.9	You have a plan for protecting devices that are natively unable to connect to the internet, and the risk has been assessed, documented, accepted, reviewed regularly and signed off by the SIRO.	Met	Met	High	20-40%	Moderate	Low

Assertion 9.6: The organisation is protected by a well-managed firewall.

Overall confidence level in assertion 9.6: **Medium**

Overall risk rating for assertion 9.6: **Low**

Evidence Text Reference	Evidence Text or Category	Self-assessed by Trust	Assessed by AuditOne	Confidence level in veracity of self-assessment for this standard.	Likelihood	Impact	Risk rating
9.6.1	The annual IT penetration testing is scoped in negotiation between the SIRO, business and testing team including a vulnerability scan and checking that all networking components have had their default passwords changed to a high strength password	Met	Partially Met	Medium	20-40%	Moderate	Low (See finding 1.19 at Appendix A)
9.6.2	The SIRO or equivalent senior role has reviewed the results of latest penetration testing, with an action plan for its findings.	Met	Met	High	20-40%	Moderate	Low
9.6.3	The organisation has checked and verified that firewall rules ensure that all unauthenticated inbound connections are blocked by default	Met	Met	High	20-40%	Moderate	Low
9.6.4	All inbound firewall rules (other than default deny) are documented with business justification and approval by the change management process.	Met	Partially Met	Medium	20-40%	Moderate	Low (See finding 1.20 at Appendix A)
9.6.5	Firewall rulesets are reviewed on a regular basis. Rulesets are removed/disabled when they are no longer required.	Met	Partially Met	Medium	40-60%	Moderate	Low (See finding 1.20 at Appendix A)
9.6.6	All of your organisations desktop and laptop computers have personal firewalls (or equivalent) enabled and configured to block unapproved connections by default.	Met	Met	High	20-40%	Moderate	Low

National Data Guardian Standard 10: Accountable Suppliers

Assertion 10.2: **Basic due diligence has been undertaken against each supplier that handles personal information.**

Overall confidence level in assertion 10.2: **Medium**

Overall risk rating for assertion 10.2**: Low**

Evidence Text Reference	Evidence Text or Category	Self-assessed by Trust	Assessed by AuditOne	Confidence level in veracity of self-assessment for this standard.	Likelihood	Impact	Risk Rating
10.2.1	The organisation has an up to date list of its suppliers, which enables it to identify suppliers that could potentially pose a data security or data protection risk to the organisation. The list includes which suppliers process personal data or provide IT services on which critical services rely, details on the product and services they deliver, contact details and contract duration.	Met	Partially met	Medium	40-60%	Moderate	Low (see finding 1.21 in appendix A)
10.2.4	Where services are outsourced (for example by use of cloud infrastructure or services), the organisation understands and accurately records which security related responsibilities remain with the organisation and which are the suppliers responsibility.	Met	Met	High	20-40-%	Moderate	Low

Appendix D: Evidence text and Assertion Risk Rating Assessment

Evidence texts are risk assessed on their likelihood and impact based on the assessment rationale in the impact table and likelihood tables below. This rating reflects the risk of the organisation being unable to meet the evidence text controls objective as a result of a control failing or the absence or ineffectiveness of a control. Professional judgement has been exercised to assign a risk rating at the assertion level. Knowledge of the importance of the controls in question and the mitigating controls in place; subject matter expertise; and observations made during the assessment have been used to assign each assertion a risk rating. A score has been assigned to each assertion using the reference table below. This score has been used in the overall calculation of risk for each NDG standard.

Impact Table

Impact rating	Assessment rationale
Catastrophic	A **Catastrophic Impact Finding** could apply to Health and Social Care organisations that use extremely complex technologies to deliver multiple services or process large volumes of patient data, including processing for other organisations. Many of the services are at the highest level of risk, including those offered to other organisations. New and emerging technologies are utilised across multiple delivery channels. The organisation is responsible for/ maintains nearly all connection types to transfer/store/process personal, patient identifiable and/or business-critical data with customers and third parties. A catastrophic finding that could have a: • Catastrophic impact on operational performance or the ability to deliver services / care; or • Catastrophic monetary or financial statement impact; or • Catastrophic breach in laws and regulations that could result in material fines or consequences; or • Catastrophic impact on the reputation or brand of the organisation which could threaten its future viability.
Major	A **Major Impact Finding** could apply to a Health and Social Care organisation that uses complex technology in terms of scope and sophistication. The organisation may offer high-risk products and services that may include emerging technologies. The organisation is responsible for/ maintains the largest proportion of connection types to transfer/store/process personal, patient identifiable or business-critical data with customers and third parties; other organisations and/or third-parties are responsible for/maintain a low proportion of connection types. A Significant finding that could have a: • Major impact on operational performance; or • Major monetary or financial statement impact; or • Major breach in laws and regulations resulting in large fines and consequences; or • Major impact on the reputation or brand of the organisation.
Moderate	A **Moderate Impact Finding** could apply to a Health and Social Care organisation that uses technology which may be somewhat complex in terms of volume and sophistication. The organisation is responsible for/maintains a some connection types to transfer/store/process personal, patient identifiable and/or business-critical data with customers and third parties; other organisations and/or third-parties are responsible for/maintain a most of the organisation's connection types. A Moderate finding that could have a: • Moderate impact on the organisation's operational performance; or • Moderate monetary or financial statement impact; or

Impact rating	Assessment rationale
	• Moderate breach in laws and regulations with moderate consequences; or • Moderate impact on the reputation of the organisation.
Minor	A **Minor Impact Finding** could apply to a Health and Social Care organisation with limited complexity in terms of the technology it uses. It offers a limited variety of less risky products and services. The institution primarily uses established technologies. It is responsible for/maintains minimal numbers of connection types to transfer/store/process personal, patient identifiable or business-critical data too customers and third parties; other organisations and/or third-parties are largely responsible for/maintain connection types. A Minor finding that could have a: • Minor impact on the organisation's operational performance; or • Minor monetary or financial statement impact; or • Minor breach in laws and regulations with limited consequences; or • Minor impact on the reputation of the organisation.
Very Low/ Insignificant	A **Low/Insignificant Impact Finding** could apply to a Health and Social Care organisation that has very limited use of technology. The variety of products and services are limited and the organisation has a small geographic footprint with few employees. It is responsible for/maintains no connection types to transfer/store/process personal, patient identifiable or business-critical data too customers and third parties. A Low finding that could have a: • Very low/ insignificant impact on the organisation's operational performance; or • Very low/ insignificant monetary or financial statement impact; or • Very low/ insignificant breach in laws and regulations with little consequence; or • Very low/ insignificant impact on the reputation of the organisation.

Likelihood table

Likelihood rating	Assessment Rationale
Almost certain	Almost certain to happen in the next 12 months (80% or more)
Likely	Likely to happen in the next 12 months (60-80%)
Moderate	Moderately likely to happen in the next 12 months (40-60%)
Unlikely	Unlikely to happen in the next 12 months (20-40%)
Rare	Very low likelihood to happen in the next 12 months (less than 20%)

The risk rating for each in-scope evidence text assessed has been calculated using a likelihood and impact rating prescribed in the NHSD Strengthening Assurance Guidance, using the following risk matrix.

Impact Rating

Likelihood rating (in next 12 months)	Insignificant	Minor	Moderate	Major	Catastrophic
Almost Certain	Low	Low	Medium	High	Extreme
Likely	Low	Low	Medium	Medium	High
Moderate	Low	Low	Low	Medium	Medium
Unlikely	Very low / insignificant	Low	Low	Low	Low
Rare	Very low / insignificant	Very low / insignificant	Low	Low	Low

The following reference tables have been used to determine the evidence text risk ratings and assign points for each assertion.

Points Corresponding to Assertion Risk Ratings

Rating	Points for each Assertion
Critical	40
High	10
Medium	3
Low	1

Determining the National Data Guardian (NDG) Standard Risk Rating

An aggregate score and classification has been assigned for each NDG standard. This is the overall NDG standard risk rating that appears in the executive summary of this report. The NDG standard risk rating has been determined by calculating the mean of the total number of assertion level points per NDG Standard and then referring to table below to assign a rating.

Calculation and Assignment of the NDG Standard Risk Ratings			<< Return to Risk and Confidence Evaluation workflow Rating Thresholds when **2 or more assertions** are in scope for each NDG Standard. Mean score is to be used (Total points divided by the number of in-scope assertions)
●	Substantial	1 or less	1 or less
●	Moderate	Greater than 1, less than 10	Greater than 1, less than 4
●	Limited	Greater than/equal to 10, less than 40	Greater than/equal to 4, less than 5.9
●	Unsatisfactory	40 and above	5.9 and above

Determining the overall risk rating

Once the risk rating for each National Data Guardian standard has been assigned, the following table has been used to allocate an overall risk rating.

Overall risk rating across all in-scope standards	
Unsatisfactory	1 or more Standards is rated as 'Unsatisfactory'
Limited	No standards are rated as 'Unsatisfactory', but 2 or more are rated as 'Limited'
Moderate	There are no standards rated as 'Unsatisfactory', and 1 or none rated as 'Limited'. However, not all standards are rated as 'Substantial'.
Substantial	All of the standards are rated as 'Substantial'

Determining the overall confidence-level in the veracity of the organisation's self-assessment and DSPT submission

Upon completion of the fieldwork and calculation of the ratings for assertions for each of the 10 National Data Guardian standards and the overall risk rating, the confidence-level in the veracity of the organisation's DSPT self-assessment submission has been determined by comparing the independent assessment findings against the latest DSPT submission. The following table has been used for aiding the decision of applying a confidence-level.

Level of deviation from the DSP Toolkit submission and assessment findings	Confidence-level	Suggested Assurance level (subject to the Independent Assessors judgement / knowledge, Independent Assessor to differentiate between Unsatisfactory and Limited)
High level of deviation - the organisation's self-assessment against the Toolkit differs significantly from the Independent Assessment For example, the organisation has declared as "Standards Met" or "Standards Exceeded" but the independent assessment has found individual NDG standards as 'Unsatisfactory' and the overall rating is 'Unsatisfactory'.	Low	Unsatisfactory OR Limited
Medium level of deviation - the organisation's self-assessment against the Toolkit differs somewhat from the Independent Assessment For example, the Independent Assessor has exercised professional judgement in comparing the self-assessment to their independent assessment and there is a non-trivial deviation or discord between the two.	Medium	Moderate
Low level of deviation- the organisation's self-assessment against the Toolkit does not differ / deviates only minimally from the Independent Assessment	High	Substantial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In each other and what we do
RESPECT
For one another and our clients
INNOVATION
Always looking to improve
QUALITY
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Appendix 2 – Final Assessment Action Plan

Evidence item	Recommendation ref	Rating	Action planned	Planned due date	Action owner
1.1.2	1.1	Medium	• Develop a SOP will be developed for a monthly review of the ROPA (Completed) • Conduct a retrospective review of the ROPA • Present the ROPA and SOP to the CIO and SIRO for approval and sign-off	30 June 2024 (Completed pending DPAG 27/06/24)	Andrea Shotton
1.1.4	1.2	Medium	• Complete ongoing work to document hardware assets within a hardware asset register. • Obtain independent review of the hardware asset register by the Senior Information Risk Owner (SIRO).	30 June 2024 (Completed pending DPAG 27/06/24)	Steven Forster
1.1.5	1.3	Medium	Action implemented since completion of the fieldwork	Completed	N/A
1.1.8	1.4	Low	• Complete IIC migration project • Approve data quality approach post Cito go-live	30 June 2024 12 July 2024 (on track)	Rachel Hodgson
3.1.2	1.5	Low	Action implemented since completion of the fieldwork	Completed	N/A
3.2.1	1.6	Low	• Provide cyber security awareness training to senior leaders. (Training issued via MetaCompliance 19/06/24 – pending training being completed) • Develop 12-month awareness campaign (completed)	30 June 2023 (partially completed – on track)	Steven Forster/ Andrea Shotton
7.1.1	1.7	High	On recruitment to Emergency Planner role, support operational services to review Business Impact Analysis against the local, regional and national risk profiles.	30 June 2024 (on track)	Simon Marshall
7.1.2	1.8	High	Emerging technologies such as Oxehealth and safety door systems, coupled with transition from Paris to CITO, require a new suite of action cards to be developed to support both the transition and any future outages.	31 May 2024 (on track for 30 June)	Simon Marshall
8.1.1	1.9	Medium	Provide report of centralised asset management project	30 June 2024	Steven

			findings to DPAG for SIRO sign-off.	(Completed pending DPAG 27/06/24)	Forster/ Craig Etherington
8.2.1	1.10	Low	Provide report of unsupported software to DPAG for SIRO sign-off.	30 June 2024 (Completed pending DPAG 27/06/24)	Steven Forster/ Craig Etherington
8.2.2	1.11	Low	Implement process for end of support software	30 June 2024 (Completed pending DPAG 27/06/24)	Steven Forster/ Craig Etherington
8.3.1	1.12	High	Complete analysis of missing patches to understand the associated risks which will be reported to DDMM on 04 June 24 and up to DPAG on 14 June 24	30 June 2024 (Completed pending DPAG 27/06/24)	Steven Forster
8.3.4	1.13	Medium	Present the analysis above to the SIRO for signoff via Digital Performance and Assurance Group	30 June 2024 (Completed pending DPAG 27/06/24)	Steven Forster
9.2.1	1.14	Low	Provide evidence that network appliance passwords are tested within the scope of standard penetration testing.	Completed pending Audit response	Steven Forster
9.2.3	1.15	Medium	Schedule a review of the last penetration test results with the SIRO.	31 May 2024 (on track for completion before 30 June 2024)	Steven Forster

9.5.2	1.16	Low	Review and update the Information Security Policy.	Completed	Andrea Shotton
9.5.3	1.17	Low	Provide a copy of the Change Advisory Group (CAG) procedure and Terms of Reference	Completed	Steven Forster
9.6.1	1.18	Low	Produce a network diagram will be produced for approval via Cyber Security Group (Completed pending CSG 20 June 2024)	30 June 2024 (Completed pending CSG 20/06/24)	Steven Forster
9.6.4 and 9.6.5	1.19	Low	Action implemented since completion of the fieldwork	Completed	N/A
10.2.1	1.20	Low	Verification of supplier certifications will be completed by the end of May 2024 with a compliance confirmation report to be presented to Information Governance Group (IGG) on 19th June 2024. (Completed pending IGG)	30 June 2024 (Completed pending IGG 19/06/24)	Beverley Smith

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