Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

Thursday 8 August 2024

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

AGENDA

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

Standard Items

1	Chair's welcome and introduction (verbal)	Chair	1.30pm
2	Apologies for absence (verbal)	Chair	
3	Declarations of interest (verbal)	All	
4	Minutes of the last meeting held on 13 June 2024	Chair	
5	Minutes of the extraordinary meeting held on 25 June 2024	Chair	
6	Board Action Log	Chair	
7	Chair's report	Chair	
8	Questions raised by Governors in relation to matters on the agenda (verbal) *(to be received by 1pm on 6 August 2024)*	Chair	

Strategic Items

9	Board Assurance Framework Summary Report	Co Sec	1.45pm
10	Chief Executive's Report	CEO	1.50pm
11	Integrated Performance Report	ACEO	2.05pm
12	Corporate Risk Register	CN	2.45pm

BREAK (3.00pm – 3.10pm)

13	Delivery Plan Quarter 1 March-June 2024, update	ACEO	3.10min

BAF RISK 1: Safe Staffing

14	Quarterly Report of the Guardian of Safe Working Hours for Postgraduate Doctors	Int. GoSW D Burke	3.25pm

BAF RISK 2: Demand
BAF RISK 3: Cocreation
BAF RISK 4: Quality of Care
BAF RISK 8: Quality Governance

15	Report of the Chair of Quality Assurance Committee	Cmt Chair	3.40pm
16	Learning from Deaths	EMD	3.50pm

Governance

17	Board Assurance Framework (verbal)	Chair	4.05pm

Matters for information

18	Feedback from Leadership Walkabouts	DoCA&I	-

Exclusion of the Public:

19	Exclusion of the public - the Chair to move: *"That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:* *Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office holder or applicant to become an office-holder under, the Trust.* *Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.* *Information which, if published would, or be likely to, inhibit –* *(a) the free and frank provision of advice, or* *(b) the free and frank exchange of views for the purposes of deliberation, or* *(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.*	Chair	4.15pm

BREAK (4.15pm-4.25pm)

Standard Items

20	Confidential minutes of the last meeting held on 14 June 2024	Chair	4.25pm
21	Confidential minutes of the extraordinary meeting held on 25 June 2024	Chair	
22	Confidential Action Log	Chair	

Strategic Items

23	Chief Executive's Confidential report	CEO	4.30pm
24	New government priorities	Chair	5.00pm
25	Reportable Issues Log	ECN	5.30pm
26	Report of the Chair of Audit and Risk Committee	Cmt Chair	5.45pm

BAF Risk 5: Digital
BAF Risk 6: Estate/Physical Infrastructure
BAF Risk 7: Cyber Security
BAF Risk 9: Partnerships and System Working
BAF Risk 12: Financial Sustainability

27	2024/25 Month 3 Finance report	DoFE&F	5.50pm

Governance

28	Report of the Chair of Board of Directors Nomination and Remuneration Committee	Cmt Chair	6.10pm
29	Board Assurance Framework	Co Sec	6.15pm
30	Board committee terms of reference	Co Sec	6.25pm

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

Matters for information

32	Minutes of meetings of board committees: a. Quality Assurance Committee, 6 June 2024	Co Sec	-

David Jennings
Chair
2 August 2024

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Tees, Esk and Wear Valleys
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS HELD ON THURSDAY 13 JUNE 2024 AT WEST PARK HOSPITAL, DARLINGTON AND VIA MSTEAMS, AT 1.30PM

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

In attendance:
P Bellas, Company Secretary
V Brinsley, Staff Raising Concerns Officer
K Christon, Deputy Company Secretary (minutes)
S Marshall, Business Manager

Observers:
M Bell, Trainee Clinical Psychologist
M Booth, Governor
H Griffiths, Governor
A McIntyre, Associate Director of Nursing and Quality, Secure Inpatient Services
S Theobald, Associate Director of Performance
E Thomas, Involvement and Engagement Member

24-25/29 CHAIR'S WELCOME AND INTRODUCTION

The Chair welcomed everyone to the meeting and commented on the powerful story the board had heard from a patient's family, prior to the meeting, and he welcomed their engagement with the Trust.

He reminded board members of pre-election guidance.

24-25/30 APOLOGIES FOR ABSENCE

Apologies for absence were received from R Barker, Non-Executive Director, J Murray, Non-Executive Director and A Bridges, Executive Director of Corporate Affairs and Involvement.

24-25/31 DECLARATIONS OF INTEREST

None.

24-25/32 MINUTES OF THE LAST MEETING HELD ON 11 APRIL 2024

The minutes of the meeting were agreed as an accurate record, subject to the following amendment:

'…and Section 5 *related to the holding powers of nurses and doctors…'* [para 24-25/15 refers].

24-25/33 BOARD ACTION LOG

Noted.

24-25/34 CHAIR'S REPORT

In discussion the following points were raised:

- It was proposed and agreed that H Crawford would attend Teesside University Graduation Dinner on behalf of the Chair/Trust.
- The Trust had been invited to participate in an equality and diversity event in November 2024 by Teesside University and would contribute information on work undertaken by the Trust, including in relation to the Gypsy, Roma and Traveller Community.
- The Chair noted his appointment to the board of NHS Providers, as one of three mental health Chair representatives in the country and one of three regional representatives.

24-25/35 QUESTIONS FROM GOVERNORS

None.

24-25/36 BOARD ASSURANCE FRAMEWORK

P Bellas presented the report, which provided information on risks included in the Board Assurance Framework, to support discussion at the meeting. In addition to that reported, he noted:

- Risks with the highest risk scores - safe staffing, financial sustainability and public confidence – and advised that the risk score for cyber risk would be determined once the risk profile had been assessed.
- Risks where the gap between target and risk was highest - safe staffing, gap of 10; public confidence, gap of 10; cocreation, gap of 8; and quality of care, gap of 7.
- As the Board Assurance Framework had recently been updated, it was not possible to comment on risk scores that had remained undiminished over the last six months.
- An analysis of risk scores versus the indicative controls assurance rating indicated that - public confidence, risk score 20/controls rating 50%; safe staffing, risk score 20/controls rating 54%; financial sustainability, risk score 20/controls rating 63%.
- The red/amber/green rating of the lines of defence would be discussed with executive directors as part of the refresh of the board assurance framework.

The Chair welcomed the development of the Board Assurance Framework as a means by which the board could review changes in the actual and target risk score over time. He also welcomed the opportunity to review the level of assurance on the first line of defence and for risk leads to red/amber/green rate the assurance they had that actions would mitigate the risk.

Action: Executive Director risk leads

He proposed the board re-consider the Board Assurance Framework following discussion of matters on the agenda.

24-25/37 CHIEF EXECUTIVE'S REPORT

B Kilmurray noted a number of matters that would be dealt with in confidential session, due to application of pre-election guidance. This included the Oxehealth Policy, the Niche assurance review, proposed terms of reference for the Transformation and Strategy Board, and updates in relation to national matters, collaborative arrangements and the Quality Board.

24-25/38 INTEGRATED PERFORMANCE REPORT

M Brierley presented the report, which proposed there was good assurance regarding the oversight of the quality of services delivered. In addition to that reported, he noted:

- NHS Providers had used the Trust's Integrated Performance Report as an example of good practice as part of their training on writing for assurance.
- Deep dives and Executive Directors Group 'walk the wall' arrangements that would give focus to key areas.
- The overall improvement in out of area bed days, albeit there had been a recent fluctuation.
- Continued focus on outcomes and unique caseloads where further analysis was required to fully understand the impact from the increase in people waiting to be seen.

Z Campbell reported from North Yorkshire, York and Selby Care Group and noted:

- Work underway in relation to adult and older person clinician and patient reported outcome measures. This included a review of a sample of patients to ensure outcome measures were completed at the start and end of the journey, work within teams to support understanding and improvement and discussion by the care group board on actions required.
- Work identified in the IPR in relation to unique caseloads, which included the introduction of a triage tool within the Perinatal Team to standardise and increase conversion of referrals to caseloads, as part of business continuity arrangements.
- Of the 17 breaches of the 72 hour follow up target, two had been genuine. 15 related to data quality issues and this would be explored by the care group.
- A performance improvement plan was in place for the Talking Therapies Service and an additional capacity and demand exercise had been completed to identify areas of improvement. Keep in touch arrangements were in place for those on the waiting list.
- The Early Intervention in Psychosis Service and the Specialist Perinatal Mental Health Service had moved into business continuity in March due to staffing challenges and recovery plans were in place. All other services in business continuity had action plans in place and weekly meetings provided enhanced support and monitored progress. Services were included on the care group risk register.
- Agency costs had reduced to the lowest level for two years.
- Triangle of care assessments provided valuable insight into what worked well and where further improvements could be made, and information would link to that provided through the cocreation board.
- Work that would be undertaken by the Cocreation Board to consider how it could provide assurance that there was robust involvement activity across all services to affect positive change.
- Establishment of a lived experience forum to support community mental health transformation work, which had created a strong partnership between services and their communities and would be broadened out more widely.

D Gardner reported from Durham, Tees Valley and Forensic Care Group and noted:

- The fluctuation in admissions and related out of area placements, which suggested that the Trust's ability to respond to small spikes in demand continued to be a challenge. Further work was required to build multiagency teams with local authorities and to review clinical models.
- A deep dive would be undertaken into children and young people outcome measures. For adult outcomes there would be a focus on treatment and intervention and hub teams. The care group would participate in the Clinical Outcomes Group, led by the Executive Medical Director.
- Caseloads had been driven by demand for children and adult neuro developmental services. For children services, work had been undertaken on a revised model of assessment, building on the success of the intensive screening process in Tees Valley. For adult services, options to support development of the clinical model, would be discussed with commissioners.
- Work would be undertaken to understand the success of the ADHD pilot and how learning could be rolled out to the rest of the care group. Also, if learning from the Sedgefield model could assist to ensure pre-assessment screening was more robust.
- There was weekly oversight of two health and justice teams who were in business continuity. It was expected that Roseberry Park Hospital would exit business continuity imminently and Durham and Darlington Crisis Team would exit business continuity in July.

In discussion the following points were raised:

1. In respect of people sent out of their area for treatment, B Murphy advised that she had sought assurance from care groups about the impact on quality and would present a report to Quality Assurance Committee in July.

2. B Reilly welcomed the inclusion of a glossary of terms and potential to roll out similar arrangements to other board reports.

3. Reflecting on feedback from the Deloitte governance review, B Reilly proposed that Quality Assurance Committee was well sighted on work underway by the care groups in relation to patient and clinician reported outcome measures and committee spent an appropriate amount of time seeking assurance on areas that required improvement.

4. B Reilly noted that Quality Assurance Committee had requested a piece of work to understand the impact on people who had waited to access services. C Carpenter also noted that Strategy and Resources Committee had also sought assurance and had been advised that work was underway to understand the position.

5. B Murphy advised that Executive Review of Quality Group and Quality Assurance Committee considered every case where the 72 hour follow up target had not been met, to review why and to establish the person was safe.

6. L Romaniak advised that the Trust had submitted the final Financial Plan for 2024/25 and this would be reported against once approved through NHS England and related system processes. She noted there had been no formal external reporting at month one, in recognition of the significant finance work still underway to finalise 2024/25 plan submissions and the accounts audit. Subsequent quality assurance work on the month one position, which had necessarily been produced outside the ledge due to deferred national planning and reporting, had identified two adjustments to the position reported

in the Integrated Performance Report. Whilst the net impact was that performance had improved by £170k, agency costs needed to be increased, meaning that the agency metric [25a] would be on plan, rather than better than plan, but would still be within 3.2% of the cost cap, representing 3.17% of the pay bill. This was a worse position than that outlined in the board report, albeit it was on plan.

7. B Kilmurray noted the interest of Council of Governors in mandatory and statutory training and appraisal targets and advised that Executive Directors Group had considered how any variation in services would be addressed.

8. Responding to a query, M Brierley advised that performance against national standards was reported over a rolling period, rather than year by year. He proposed that performance improvement plans would identify actions within the Trust's control and where wider support was required.

24-25/39 OUR JOURNEY TO CHANGE QUARTER 4 2023/24

M Brierley presented the report, which outlined the end of year position on the Trust's Our Journey to Change Delivery Plan for 2023/24. S Dexter-Smith noted an amendment to the report, that WorkPal had not been renamed.

In discussion the following points were noted:

1. B Murphy advised that of the two remaining cases from the serious incident backlog, one was subject to external review commissioned by NHS England the other would be considered at a panel that day. Over the past four weeks all patient safety incidents that required a review had been allocated on the day they had been identified.

2. C Carpenter welcomed the progress on Trust priorities despite a challenging year and reflected that capacity had impacted on delivery and would need to be considered when determining 2024/25 priorities. B Kilmurray proposed that the Transformation and Strategy Board would support that work and he placed on record his thanks to all staff for their support on delivery during the year.

3. In respect of delivery of autism projects, K Kale confirmed that autism training had been rolled out to all staff and was rated as green. M Brierley advised that the red/amber rating for neurodevelopmental services reflected that work was underway and timelines had been moved back.

   It was noted that a briefing on autism and ADHD assessment waiting times in Durham, Tees Valley and Forensics had been appended to the board action log.

4. L Romaniak advised that milestones for the Green Plan had not been achieved due to challenges in recruitment of the Energy and Sustainability Manger following a retirement in spring 2023 and inability to source interim capacity due to NHS limits on agency recruitment and absence of partner capacity to support. She confirmed that the position had now been filled by an existing energy manager from a partner Trust. Trust had also been successful in the appointment of a Deputy Director of Estates with significant experience of successfully decarbonising of the estate including through local authority partnerships.

The Chair welcomed the detail provided to support the board's discussion and echoed the need to use learning and the Board Assurance Framework, to focus on priorities. He also

welcomed the one page overview of the Clinical and Quality Journey's and proposed that consideration be given to how they could be shared with Council of Governors, given their particular interest in those areas.

Action: K Kale, B Murphy

24-25/40 OUR JOURNEY TO CHANGE DELIVERY PLAN 2024/25

M Brierley presented the report, which provided the draft Our Journey to Change Delivery Plan 2024/25 for agreement. In addition to that reported, he noted:

- Work proposed prior to launch of the delivery plan, to confirm prioritisation of activity.
- The role of the Transformation and Strategy Board in providing a view across all work programmes and prioritisation of capacity.

In discussion the following points were raised:

1. The Chair welcomed inclusion of the matrix 'how we will plan and deliver these priorities', which provided clarity on vertical transformation programmes, horizontal cross cutting priorities and challenges.

2. B Kilmurray acknowledged that the plan continued to be ambitious and provided assurance that executive directors would ensure there was a focus on and delivery of priorities.

3. K Kedar confirmed that co-creation was integral to the clinical networks, who contributed views via the Executive Clinical Leaders Subgroup – a group that included attendance of the Lived Experience Directors. As an example, he referenced work undertaken to develop the adult mental health clinical model. H Crawford echoed the comments made and noted work within learning disability network to support engagement.

   Commenting further, B Kilmurray proposed that cocreation was key to delivery of Our Journey to Change and responded to feedback from the Big Conversation. He proposed the trust would seek to achieve a balanced perspective, in the context of operating in a regulatory environment with resource constraints.

   The Chair reflected on feedback from the Our Journey to Change event and proposed that the triangle of care would mean views were considered equally, with clarity on the role of the accountable organisation/officer.

   Responding to a query, B Kilmurray advised that term co-creation had been carefully chosen and implied a continuum of involvement/engagement/coproduction across all areas of the organisation. He proposed that next Big Conversation, would provide further clarity.

   As examples of co-production at a strategic level, B Murphy and K Kale commented on co-production of the Trust's quality priorities for 2024/25, priorities linked to use of restrictive interventions and the hub model in communities.

Agreed: *that the Our Journey to Change Delivery Plan 2024/25 be approved.*

24-25/41 REPORT OF THE CHAIR OF PEOPLE, CULTURE AND DIVERSITY COMMITTEE

S Dexter-Smith presented the report, which outlined matters arising from the meeting held on 30 May 2024. She commented on the inspiring staff story provided at the meeting and noted:

- The positive position across a number of indicators, which if sustainable may support a review/reduction in the risk score in 3-4 months' time.
- Work that would be undertaken to understand the data behind the spike in violence and aggression towards staff and to ensure the process of multidisciplinary review and escalation was in place. This work would focus on Psychiatric Intensive Care Units and Bankfields Court.

In discussion B Reilly advised that Quality Assurance Committee had expressed concern about increased violence and aggression towards staff and queried if there was a clear understanding of the position, if data should be published and if the board should receive a detailed report to provide clarity on the position.

In response, S Dexter-Smith confirmed that work was underway to understand the position, including the impact on staff wellbeing. She proposed to present a report to People, Culture and Diversity Committee, prior to Board.

The Chair noted a recent article by local media on an A&E department, which had highlighted violence and aggression towards staff and reflected that there may be a similar opportunity for the Trust through development of the communications plan.

24-25/42 GUARDIAN OF SAFEWORKING ANNUAL REPORT

Apologies were received from D Burke, Interim Guardian of Safe Working and K Kale presented the report on this behalf. In addition to that reported, he noted that work was underway to consider alternative options to non-residential on call rotas.

Responding to a query, he advised that fines levied against the Trust were paid into a wellbeing fund for junior doctors.

24-25/43 FREEDOM TO SPEAK UP REPORT

V Brinsley presented the report, which provided an overview of freedom to speak up activity for quarters 3 and 4 of 2023/24, and which proposed there was good assurance that the control was operating effectively. In addition to that reported, she noted:

- Concerns related to worker wellbeing may be an indication of job satisfaction, increased stress, high staff turnover and reduced productivity, and addressing those concerns would be important to maintain a healthy working environment, ensure staff satisfaction, improve patient care and improve employee retention.
- Concerns reported as 'other' related to staff seeking advice on wellbeing, policies or procedures or information on the freedom to speak up process.
- The ambassador role had been relaunched and training had been provided to 12 new/existing ambassadors. Work would continue to encourage more staff to volunteer.

In discussion the following points were raised:

1. V Brinsley advised that six staff had provided feedback on their experience of the service and cases would not be closed if the member of staff were not satisfied. S Dexter-Smith confirmed that to be the position.

2. A query was raised on the ethnicity of those who had spoken up and if that suggested other ethnic groups were less inclined to speak up. In response, V Brinsley noted that the data reported related to quarter 4 only and would be more representative over a longer period.

   S Dexter-Smith provided assurance that other ethnic groups had accessed the freedom to speak up process and commented on work that would be undertaken with Show Racism the Red Card, Unison and the BAME network to encourage honest feedback.

24-25/44 REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

B Reilly, Chair of Quality Assurance Committee, presented the report, which outlined matters arising from the meetings held on 2 May 2024 and 6 June 2024. In addition to that reported, she drew attention to:

- Concerns raised by committee in relation to positive and safe and the intention to have a substantive item at the next meeting in order to provide assurance to the board.
- The decision not to approve the request to extend the deadline for the CQC recommendation 'support for staff to attend reflective practice and wellbeing opportunities in secure inpatient services'.
- Assurance received that the shift at Foss Park, which had been 100% staffed by agency staff, was legally compliant.
- Concern about the increase in violence and aggression and the psychological impact on staff.
- Delayed discharges due to lack of personalised placements and concerns that the health of those patients may deteriorate as a result.
- Attendance at the meeting by the Integrated Care Board and positive feedback received. K Kale went on to note that the ICB had indicated that they intended to implement similar arrangements.

B Murphy noted an amendment to the report, to read 'there was no prone restraint, mechanical restraint or the use of tear proof clothing in *North Yorkshire, York and Selby* [page 171 refers].

In discussion the following points were raised:

1. B Murphy advised that the Trust had received positive feedback from the CQC lead inspector's visit to Bankfields Court.

2. B Kilmurray advised that site visits for the CQC inspection of crisis and liaison services, including 136 suites had been completed and initial feedback had not raised any areas of concern. Focus groups would be held the following week and the Trust would continue to respond to requests for information.

3. Responding to a query on data in the national learning from lives and deaths report, K Kale confirmed that the reported avoidable deaths for people with a learning disability at 42%, was a national figure and largely physical health related.

B Kilmurray noted the Trust's development of a physical care health care delivery plan, which would be considered by Quality Assurance Committee in July.

24-25/45 LEARNING FROM DEATHS REPORT

K Kale presented the report, which outlined information from the learning from the deaths dashboard and proposed there was good assurance of reporting and learning in line with national guidance.

In discussion the following points were raised:

1. B Reilly, Chair of Quality Assurance Committee, proposed that committee would and undertake a deep dive on the report, prior to board.

2. B Kilmurray noted there would be a review of the Trust's meeting structure to ensure the timely flow of information into a committee and the board, in response to feedback from Deloitte.

3. Assurance was sought that learning was fed into the Trust's quality and safety approach and in response K Kale advised that learning – triangulated with themes from patient safety incidents, complaints and mortality reviews – would feed into a number of groups and predominantly the Organisational Learning Group, from which information would be cascaded to clinical networks.

4. B Murphy welcomed the development of the report and K Kale commented on further improvements and the proposal to develop an advanced dashboard for learning.

24-25/46 REPORT OF THE CHAIR OF MENTAL HEALTH LEGISLATION COMMITTEE

K Kale presented the report, which outlined matters arising from the meeting held on 13 May 2024. He proposed the report provided good assurance and noted:

- Patients discharged without their rights been read represented 1% of total detentions during the period and included those who had been discharged on the first day of detention. Further work would be undertaken through the Fundamental Standards Group to ensure rights were read in a timely way.
- A number of questions had arisen from the individual case study and the results of the After Action Review would be presented at the next committee meeting.
- Overall, compliance with Mental Capacity Act training was higher than the Trust's standard and further work would be undertaken in areas where compliance varied.

24-25/47 COMPLIANCE AGAINST THE NHS CORE STANDARDS FOR EMERGENCY PREPARDNESS, RESILIENCE AND RESPONSE

S Marshall presented the report, which provided the results of the annual emergency preparedness, resilience and response self-assessment and proposed that there was assurance that the Trust was able to demonstrate that it could respond to emergency planning and business continuity incidents, whilst still maintaining provision to service users. He noted:

- The change in process with self-assessments now reviewed by NHS England. As a result all provider organisations in Humber and North Yorkshire, North East and North Cumbria and the North West had moved from compliant to non-compliant.

- Although the Trust was now non-complaint due to the change in definitions used in the self-assessment, its position had not changed from previous years and its ability to respond to incidents remained thorough and had been tested on a number of occasions.
- The North East and North Cumbia Integrated Care Board would work with all non-complaint providers through 2024 in order that a higher degree of compliance would be reported in the 2024/25 self-assessment.

In discussion the following points were raised:

1. S Marshall confirmed the Trust was fully compliant on 30 standards, partially compliant on 28 standards and had no areas of non-compliance. Assurance rating thresholds were: 100% fully compliant, 89-99% substantially complaint, 77-88% particularly compliant and 76% and less non-compliant.

2. J Maddison, Chair of Audit and Risk Committee, advised that committee had considered the report, and a follow-up report had been requested for September for committee to review progress against the gap analysis.

   Z Campbell noted that an action plan was in place, in addition to work that would be completed more broadly across the integrated care system and B Kilmurray welcomed an update to a future board meeting. **Action: Z Campbell**

3. There had been a significant change in compliance across all providers as a result of the change in process, with compliance now at 49%.

4. It was noted that a correction was required to the report in respect of the difference in reported compliance, as this differed between the appended self-assessment and cover report.

24-25/48 BOARD OF DIRECTORS REGISTER OF INTERESTS

P Bellas introduced the report, which provided an updated register of interests prior to publication on the Trust website. He invited the board to notify him of final changes by 19 June 2024.

The following updates/amendments were provided:
- B Murphy - membership of the Mental Health Learning Disability Nursing Directors Forum.
- C Carpenter – Independent Chair of the North of Tyne Bus Improvement Partnership.

24-25/49 BOARD ASSURANCE FRAMEWORK

It was agreed that there were no matters arising from the discussing during the meeting that changed the position outlined in the Board Assurance Framework.

24-25/50 LEADERSHIP WALKABOUTS

Noted

24-25/51 USE OF THE TRUST'S SEAL

In addition to that reported, P Bell as advised that the Trust had recently signed the renewal of the lease for Windsor House in Harrogate.

Following discussion of matters on the agenda, it was noted that a Governor observer had raised a question in the MSTeams chat facility, and it was agreed that this would be reviewed outside of meeting.

24-25/52 EXCLUSION OF THE PUBLIC

Agreed: *that representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution.*

Following consideration of confidential matters, the meeting concluded at 5.30pm.

Tees, Esk and Wear Valleys
NHS Foundation Trust

MINUTES OF THE SPECIAL MEETING OF THE BOARD OF DIRECTORS HELD ON TUESDAY 25 JUNE 2024 VIA MSTEAMS

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

In attendance:
P Bellas, Company Secretary
K Christon, Deputy Company Secretary (minutes)
Tolu Olusoga, North Yorkshire and York Care Group Medical Director (attending on behalf of Z Campbell)

Observers:
H Griffiths, Governor

24-25/64 WELCOME AND INTRODUCTION

The Chair welcomed everyone to the meeting and confirmed all board members had received the papers in advance.

24-25/65 APOLOGIES FOR ABSENCE

Apologies for absence were received from R Barker, Non-Executive Director, C Carpenter, Non-Executive Director and Z Campbell, Managing Director North Yorkshire and York Care Group.

24-25/66 DECLARATIONS OF INTEREST

None.

24-25/67 REPORT OF THE CHAIR OF AUDIT AND RISK COMMITTEE (VERBAL)

J Maddison, Chair of Audit and Risk Committee, provided a verbal update from recent meetings of the committee and commented on:

- The internal auditor's report from AuditOne, which had been updated to include additional information on the assurance status from final audits completed, additional rationale in respect of domains considered by the Head of Internal audit, beyond audits themselves, and provided confidence to support the Head of Internal Audit Opinion as 'good'.

- The external auditor's report from Forvis Mazars LLP and management letter on subsequent changes, where he noted: the removal of value for money risks related to previous CQC inspections; adjusted accounts misstatements related to prior year lease accounting values and application of the new accounting standard; and an unadjusted item valued at £1.6m.
- Evidence of good cooperation, communication and liaison with the external auditor.
- The detailed review of the Annual Report undertaken by committee at a seminar and consideration of the Annual Governance Statement and the Remuneration Report.
- Consideration of the Quality Account, which no longer required external auditor assurance, where committee had taken assurance from work undertaken by Quality Assurance Committee through the year and their review of the report.
- Consideration of the Data Security and Protection Toolkit and assurance committee had received on progress.

He placed on record his thanks to L Romaniak, P Bellas and staff for preparation of the Annual Report and Accounts within required timescales.

In discussion the following points were raised:

1. L Romaniak confirmed that the final external auditor's report would be received to allow the Trust to complete its submissions on time.

2. P Bellas advised that points raised by Audit and Risk Committee in relation to the Quality Account had been reflected in the final document.

24-25/68 NHS FOUNDATION TRUST ANNUAL REPORT AND ACCOUNTS 2023/24

P Bellas introduced the Annual Report and Accounts 2023/24 for approval, and drew attention to the letter from Mazars in follow-up to the Audit Completion Report 2023/24, as circulated prior to the meeting.

Approved:

i. The Annual Report and Accounts 2023/24
ii. The Letter of Representation
iii. The signing of:
  a. The Annual Report
  b. The Performance Report
  c. The Remuneration Report
  d. The Annual Governance Statement
  e. The Statement on the Accounting Officer's Responsibilities
  f. The Foreword to the Accounts
  g. The Statement of the Financial Position
  h. The Letter of Representation
iv. The submission of the Annual report and Accounts 2023/24 to NHS England/ Improvement and Parliament.

24-25/69 QUALITY ACCOUNT 2023/24

B Murphy presented the Quality Account 2023/24 for approval. She noted the report had been endorsed by Quality Assurance Committee and advised that progress on delivery of quality priorities and development of priorities for 2024/25 had been reported to Quality Assurance Committee throughout the year to ensure consistent oversight.

In discussion P Bellas noted the receipt of a stakeholder letter from Hartlepool Borough Council that morning, which would be included in the final report.

No further late submissions were expected, but – as the Trust was open and receptive to feedback - they would be incorporated if timescales permitted.

Approved: *The Quality Account 2023/24 and its publication on the Trust website by 30 June 2024.*

24-25/70 DATA SECURITY AND PROTECTION TOOLKIT 2024/25

M Brierley presented the annual report for approval, which provided an overview of the Trust's self-assessment of performance against the National Data guardian's 10 data security standards. He commented on the areas of recommendation and the related action plan, which included a requirement for board members to complete cyber awareness training, and development of the toolkit for 2025/26 to align to the cyber assurance framework.

In discussion the following points were raised:

1. M Brierley advised that the report provided an assessment of the Trust's position at that point and the Digital Performance and Assurance Group would monitor progress against the action plan and report to Audit and Risk Committee and Resources and Planning Committee.

2. J Maddison noted that the internal audit plan included capacity for AuditOne to complete an independent evaluation. L Romaniak clarified that this internal audit was scheduled as advisory prior to final submission, the timing of which had moved in recent years into quarter one of the new financial year to reflect an assessment against standards that had changed during the year and support corrective action plans ahead of final submission.

3. The Chair commented on the importance of data security and protection and proposed that a report be provided to the board should there be any barriers to delivery of the action plan.

Agreed: *Board notes the content of the report, and the aim to achieve all recommendations as outlined.*

24-25/71 EXCLUSION OF THE PUBLIC

Agreed: *that representatives of the press and other members of the public be excluded from the remainder of the meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 of the Constitution.*

Following conclusion of confidential matters, the meeting ended at 5.36pm.

Board of Directors
Public Action Log

RAG Ratings:	
Completed	Action completed
	Action due/Matter due for consideration at the meeting.
	Action outstanding but no timescale set by the Board.
	Action outstanding and the timescale set by the Board having passed.
	Action superseded
	Date for completion of action not yet reached

Changes since the last board meeting are provided in bold

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
11/01/24	23-24/136	Patient outcomes	Timescales to be provided for completion of current work to improve the reporting of patient outcomes.	EMD	Jul-24		Board seminar held 11 July 2024
11/04/24	24-25/11	Corporate Risk Register	Committees to consider corporate risks that had remained static for 12 months and review target dates	Committee Chairs			
13/06/24	**24-25/36**	**Board Assurance Framework**	**Risk leads to red/amber/green rate the assurance they had that actions would mitigate the risk**	**Executive Leads**	**Oct-24**		**Discussion on the BAF to be held at Executive Directors Group on 13/08/24**
13/06/24	**24-25/39**	**Our Journey to Change 2425**	**Consideration be given to how the one page overviews of the clinical and quality journey's could be shared with the Council of Governors, given their particular interest in those priorities.**	**K Kale, B Murphy**	**Oct-24**		**next Council of Governmers meeting 24/10/24**
13/06/24	**24-25/47**	**Emergency prepardness, resilience and response**	**Board update to be provided on progress against the NHS core standards, following discussion at Audit & Risk Committee in September.**	**Z Campbell**	**Oct-24**		

Agenda Item 6

Chair's Report: 13th June – 8th August 2024.

Headlines:

External:

- Meeting Cumbria, Northumberland and Tyne & Wear Mental Health Trust Chair
- NHS Providers Board meeting & induction
- NHS Providers Nomination & Remuneration Committee : process for appointing a new Chair
- NHS Confederation briefing on the new Government : Matthew Taylor
- North East & North Cumbria Chairs & ICS meeting
- Humber & North Yorkshire ICS Chairs meeting
- CQC Review : 121 meeting with the Chief Executive and the review lead, and also wider participation in both private roundtable events
- Durham Central ICP quarterly meeting
- Teesside University : meeting with Chair of Governors
- Stakeholder Panel – NHSE new Regional Director appointment.

Council of Governors (CoG)

- 2 x Nomination & Remuneration Committees : Non-Executive Director (NED), NED appraisal, and Chair's appraisal
- Governor Development Day
- New Governor Induction event

Internal

- Special Board of Directors : approval of Annual Report & Annual Governance Statement
- Board Nomination & Remuneration Committee : executive pay awards
- Meetings connected with the Chief Executives appraisal, executive and NED appraisals
- Regular NED meeting
- Various 121 meetings with Execs : People, Therapies, Finance, Digital
- Leadership Walkabouts : South Durham & Darlington Acute Psychiatry Liaison Team
- 121 meeting Mark Allan : Peer Support Lead for TEWV
- Meetings with all the Interim Managing Director candidates.

Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of: **Board of Directors**
Date: **8 August 2024**
Title: **Chief Executive's Public Report**
Executive Sponsor(s): **Brent Kilmurray, Chief Executive**
Author(s): **Brent Kilmurray**

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

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

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

Strategic Risks relating to this report:

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

Executive Summary:

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

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

Overview: A Range of topics to update the board

Prior Consideration and Feedback n/a

Implications: No additional implications.

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

York Hub

The York Mental Health Partnership submitted a bid to NHS England for funding for a pilot 24/7 mental health hub in May 2024. This is for two-year funding totalling approximately £2.4m. Bids from across the Country were submitted. The York bid was successfully shortlisted for a site visit from NHS England in June 2024 (nine shortlisted, five have been successful) and we have now been informed that this bid was successful.

The Expression of Interest builds on the work done to develop a York hub model as part of the Connecting our City project. Our York hub model is strongly influenced by services in Trieste - with whom we established a learning agreement and supported visits by staff, service users and carers. The “Connecting our City” project became York’s version of Trieste, involving an extended programme of community engagement and coproduction.

See Appendix 1 for further details.

GP Collective Action

Following a ballot which closed on Monday 29th July 2024 GP’s in England will be participating in collective action (this has been likened to ‘work to rule’). The action is likely to commence from 1st August.

The action will be across the whole practice team and could see ‘GPs prioritising their patients’ needs over local NHS system wants’.

The BMA will be asking GP contractors/partner BMA members to determine the actions they are to take – there will be no coordinated action. Actions taken may differ from one practice team to another. They may also differ day to day. This means we may have to respond differently to each GP’s actions and may even have to tailor our responses on a daily basis if GPs chose to enact different actions each day.

LMCs may advise and coordinate local members.

There are 9 areas of proposed actions:

1. Limit daily patient contacts per clinician to the UEMO recommended safe maximum of 25.Divert patients to local urgent care settings once daily maximum capacity has been reached.
2. Stop engaging with the e-Referral Advice & Guidance pathway - unless it is a timely and clinically helpful process for you in your professional role.
3. Stop supporting the system at the expense of your business and staff - serve notice on any voluntary services currently undertaken that plug local commissioning gaps.
4. Stop rationing referrals, investigations, and admissions.
    - Refer, investigate or admit your patient for specialist care when it is clinically appropriate to do so.
    - Refer via eRS for two week wait (2WW) appointments, but outside of that write a professional referral letter where this is preferable. It is not contractual to use a local referral form/proforma.
5. Switch off GPConnect functionality to permit the entry of coding into the GP clinical record by third-party providers.
6. Withdraw permission for data sharing agreements which exclusively use data for secondary purposes (i.e. not direct care).

7. Freeze sign-up to any new data sharing agreements or local system data sharing platforms.
8. Switch off Medicines Optimisation Software embedded by the local ICB for the purposes of system financial savings and/or rationing, rather than the clinical benefit of your patients.
9. Practices should defer signing declarations of completion for “better digital telephony” and “simpler online requests” until further GPC England guidance.
    - Defer signing off”Better digital telephony”: do not agree yet to share your call volume data metrics with NHS England.
    - Defer signing off “Simpler online requests”: do not agree yet to keep your online triage tools on throughout core practice opening hours, even when you have reached your maximum safe capacity.

An internal team that included input from Digital, Pharmacy, Medics, EPRR, Planning/Commissioning and Nursing, have been involved in highlighting which of the proposed actions would impact on us and how they would impact.

Proposal 1 may impact our crisis services if patients are unable to obtain timely GP appointments, relevant General Managers are including this possibility in their planning.

Proposal 2 may impact but it is unlikely (we believe engagement with us falls under “timely and clinically helpful”).

Proposal 3 has been assessed as being the highest risk to us as it would impact on ‘shared care’ arrangements and would involve things such as blood tests and ECGs.

Proposal 4 has been assessed as potentially being able to cause some level of disruption where we have referral proforma’s that we expect GPs to complete for example around memory clinics and MHSOP pathways.

This team is now working with GMs to develop our mitigations. Due to the nature of the proposed actions, i.e. they may be different for each GP practice team and may change on a daily basis; we are developing a ‘suite’ of responses which local teams will select from according to the action in their area/on a particular day.

The group are scheduled to meet again on the 9 August to review the Trust responses as the position that GPs are taking becomes clearer.

LD Transformation – NENC

The trust continues to engage with the NENC ICB around improvements to care for those with a Learning Disability. This includes us taking a lead role in a newly established regional Transforming Care Executive Group that has been instigated in support of progressing priorities that help us to move toward our system ambitions of more care, housing and support in communities for those with a Learning disability, avoiding unnecessary stays in hospital and to help people live more fulfilling lives. As a trust we continue to make progress toward these goals through a number of priority schemes:

- Implementation of an Adult Learning Disability Intensive Support Team (IST) across Durham and Tees Valley

- Development and revision of our core community clinical model and working closely with local authority colleagues in Durham to scope and pilot alternative models of bed-based support as an alternative to admission in crisis.
- Continuing to deliver improvements within our inpatient environments, including sustained improvement to reducing restrictive interventions.
- Working closely with Local Authority Partners in Teesside and the ICB on a joint bid for NHSE capital monies to enable development of new supported living accommodation within the Tees Valley in order to enable transformed future models of care and support those in our communities to live well at home.

New Government Priorities

New Government, appointments and MPs

Following the General Election on 4 July 2024 and new Labour Government came into power. They moved swiftly to announce Cabinet and parliamentary appointments, most notably (for TEWV) the announcement of the Rt Hon Wes Streeting, Labour MP for Ilforth North, as Secretary of State for Health and Social Care.

There was significant change in seats in the area served by TEWV – 12 of the 22 MPs representing constituencies wholly or partly are new. There are now 15 Labour, 6 Conservative and 1 Lib Dem MPs sitting for constituencies that are wholly or partially within TEWV. Well known mental health campaigner Kevan Jones did not stand for election, however Liz Twist MP for Blaydon and Consett, who co-chaired the all-parliamentary group on suicide and self-harm prevention, now covers Consett and other parts of north west County Durham in addition to the Blaydon area of Gateshead. Ms Twist has been an MP since 2017.These do not include any Cabinet members (although Bridget Philipson, Rachel Reeves, Hilary Benn, Yvette Cooper and Ed Miliband represent constituencies in adjoining Trusts' areas). Northallerton and Richmond MP Rishi Sunak is now Leader of the Opposition but only until 4 November 2024 when a new Conservative leader will be announced.

We have written to all new MPs introducing TEWV and extending an invitation for an early meeting, as well as reaching out to the new Health Secretary and Chancellor to meet at the earliest opportunity.

Manifesto commitments and recent announcements.

The new Government's manifesto contained some specific pledges around mental health, and the King's Speech confirmed that the long-anticipated Mental Health Bill will be included in the legislative programme which we will need to respond to.

The new Health Secretary, Wes Streeting MP, wasted no time in meeting with junior doctors on their ongoing industrial action on day 3 of his tenure. His first speech the following day was clear - 'the NHS was broken'. More recently there has been criticism of the CQC and the reform required, as well as the notion of a 'neighbourhood health service' focused on improving access to GPs and community care – it's not clear what that means for community mental health services.

The Department for Health and Social Care (DHSC) and NHS England have been given an instruction to collectively work together and explore how they pool their resources, which chimes with some of the announcements made by Chancellor earlier this week where departments were asked to make efficiencies in back office costs and to 'absorb as much as possible.

He also announced the Darzi review, and investigation to be led by Lord Darzi which is expected to reaffirm the importance of moving resource into primary care which is due to report by September 2024. This will feed into a new 10-year plan which expected in the spring or summer of 2025, and that this plan would be a 'health' plan not just for the NHS, feeding more broadly into the Government's commitment around economic growth.

In the meantime, DHSC has:

- Reaffirmed its commitment to expanding the mental health workforce.
- Maintained its commitment to 100% coverage of mental health support teams for schools), and to children's mental health hubs, with a focus on children at risk of being involved in crime.
- Continued to support work to define waiting time standards and publicise performance against these.

Wes Streeting, as the new Health Secretary has already met Claire Murdoch and reportedly shown his commitment to and interest in mental health issues.

The junior minister with responsibility for mental health is Baroness (Gillian) Merron. Her full title is Parliamentary Under-Secretary of State for Patient Safety, Women's Health and Mental Health. She was MP for Lincoln and held junior ministerial appointments in the 1997-2010 Labour Government, including Public Health.

Chancellor's Statement – 29 July 2024

The Chancellor, Rt Hon Rachel Reeves MP, made a significant speech to the House of Commons this week on 29 July. In it she:

- Revealed the findings of a Treasury spending audit which identified £22 billion of unfunded pledges inherited from the previous Government this year.
- Outlined "difficult decisions" to find £5.5 billion of savings this year and £8.1 billion next year.
- Announced a set of non-negotiable fiscal rules will be confirmed at Budget on 30 October 2024, alongside further difficult decisions on tax and spending.
- Finalised departmental budgets for this financial year and the next will be confirmed in October, and a multi-year Spending Review will conclude in Spring 2025 to embed mission-led Government and transform public services.
- Announced a review of investment in the New Hospital Programme albeit this may not lead to project cancellations.
- Confirmed that the Government will honour the public sector pay awards recommended by pay review bodies. It is not yet clear what mechanism will be used to support providers with increased costs, however if contract uplift follows past rules,

then mental health trusts may not receive sufficient funds to cover wage increases. These include:

  - Junior doctors being offered 22% increase to resolve pay dispute (subject to members' ballot).
  - 5.5% rise in Agenda for Change staff (honouring Pay Review Body proposals).
  - 5% for senior NHS managers.

- In addition, ICBs (including Humber North Yorkshire ICB) have been described as being of "significant concern" due to financial deficits and asked to "take immediate action" to bring down their spending. This is a risk due to the significant amount of uncommitted mental health / learning disability funding.

The Executive Team will continue to closely monitor developments and provide updates to the Board on the implications and impact of these announcement.

Parliament is now in summer recess and will resume on 7 September 2024, straight into party conference season.

NHSE Team Changes

National and Regional Chief Nurse changes

Chief Nursing Officer for England

Following the announcement in April that Dame Ruth May would retire from her role as Chief Nursing Officer for England NHS England have announced that Duncan Burton has been appointed as Chief Nursing Officer for England with the appointment taking immediate effect. Duncan was most recently Deputy Chief Nursing Officer. As Chief Nursing Officer for England Duncan will lead the nursing profession as the government's most senior advisor on nursing matters. The full announcement can be found on the link below.

NHS England » New chief nursing officer for England announced

North East and Yorkshire Regional Chief Nursing Officer

Since Margaret Kitching's retirement the role of Chief Nursing Officer has been held jointly by Julie Clennell and Gill Hunt on an interim basis. NHS England has announced that David Purdue has been appointed as the Chief Nurse for NE&Y and will take up post in October 2024. David is currently the Chief Nursing Officer for the North East and North East Cumbria Integrated Care Board and has worked productively with TEWV in this role. We wish David well in his new appointment and look forward to continuing our positive working relationship with him.

Sam Allen NENC ICB CEO will lead the recruitment to the NENC CNO which we will support as needed. In the interim Sam has asked Deputy Chief Nurse, Ann Fox, to provide Interim cover following David's departure.

York Expression of Interest for a 24/7 Mental Health Hub: Briefing Note

Context

The York Mental Health Partnership submitted a bid to NHS England for funding for a pilot 24/7 mental health hub in May 2024. This is for two-year funding totalling approximately £2.4m. Bids from across the Country were submitted. The York bid was successfully shortlisted for a site visit from NHS England in June 2024 (nine shortlisted, five have been successful) and we have now been informed that this bid was successful.

The Expression of Interest builds on the work done to develop a York hub model as part of the Connecting our City project. Our York hub model is strongly influenced by services in Trieste - with whom we established a learning agreement and supported visits by staff, service users and carers. The “Connecting our City” project became York’s version of Trieste, involving an extended programme of community engagement and coproduction.

The 24/7 Hub

The 24/7 centre team will offer time, compassion, and a trauma-informed approach.

It will be based within the Acomb/Holgate/Westfield wards. Premises are yet to be confirmed but options include a building adjacent to Energise Leisure centre and Acomb Garth health centre (further discussion planned with CYC colleagues to identify alternative premises).

It will be an open access 24/7 neighbourhood mental health centre, building on the principles and learning from our successful prototype community mental health hub that was piloted at 30 Clarence Street in York, in 2023.

In addition to the multidisciplinary and multiagency team operating during core hours (8am-9pm), we will provide personalised support on an overnight basis, including for those in significant distress. There will be at least 2 members of staff present overnight, closely supported by both Crisis and Liaison services operated by the mental health trust, as well as support workers from VCSE providers.

We do not envisage repurposing premises for the inclusion of beds, but aim to have calm, comfortable spaces where people can be appropriately supported at all times of the day or night.

The 24/7 centre will be codesigned and codeveloped in collaboration with people with lived experience, local residents and those with community connections.

Proposed timeline

Phase 1 (first 6 months) – Co-design with Innovation Unit support and input of the coproduction champion. The groundwork for engagement and codesign is a crucial part of phase 1. Establishment of the 24/7 centre team via recruitment and secondment where appropriate. Options for the 24/7 centre location further appraised and approved as part of codesign.

Phase 2 (3 – 6 months) – The 24/7 centre staff team orientation; ongoing team training and development for 24/7 delivery and maintenance; linking with community and other teams and services, and completion of recruitment to 24/7 centre roles. Identify needs of current clients and those waiting, to ensure that open access does not disadvantage them further. Communications regarding launch and commencement of delivery of model within existing community resources.

Phase 3 (6 months onwards) – The 24/7 centre becomes fully operational. Consolidation of working practices and 24/7 support offers. Support required is kept under close review. Six-month review of delivery, with subsequent tracking of pilot delivery and outcomes, in liaison with NHSE colleagues. Networking, engagement and sharing of good practice and solution focussed approaches to ongoing 24/7 centre development. Communication of 24/7 activity and outcomes to the wider system and communities. Ongoing staff development and CPD.

Costings

The proposal totals £2,448,856 over 2 years.

This includes staffing costs of just over £2m. Staffing is a multi-disciplinary approach mirroring the current hub model with the addition of a crisis clinician and psychiatry input. The staffing base includes clinicians, a team manager, social worker, recovery workers, peer supporters, social prescriber, and carer support. The bid also includes some costs for estates (£230,000) and for the Innovation unit to provide consultancy support in year 1.

Communications Dashboard

June-July 2024

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

These months we...

- Celebrated Pride month, Volunteers week and Carers week
- Officially launched the Star Awards 2024 and opened nominations
- Signed up to the NHS sexual safety charter
- Celebrated Co-production week
- Received national recognition for two staff members from TEWV at the 2024 Learning Disability & Autism awards
- Launched the Big Conversation
- Opened up a new wellbeing hub for Stockton-on-Tees residents
- Had TEWV staff member Jo Smith, interviewed by the BBC Look North for a year-long research project where people with severe mental illness created and produced Jenny's pasta - a ready-meal that was made available in social supermarkets and eco shops in Middlesbrough.

Highlights

Our volunteers were interviewed by BBC Look North for Volunteers Week

Two of our staff received national recognition at the 2024 Learning Disabilities and Autism Awards for their STOMP project

A new Wellbeing Hub opened up in Stockton-on-Tees in Wellington Square

Carers Week was celebrated across the trust to highlight the dedication of all the carers within our Trust

Our Early Intervention in Psychosis teams played a game of rounders in the lead up to their Voyage to recovery

Jo Smith discussed her year-long project on BBC Look North. Jenny's pasta is available is available in eco shops in Middlesbrough

Media and online

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

13
Media enquiries handled by the team

8
Media releases issued

72
Total pieces of coverage across online news, TV, and radio

News stories

- **Jenny's pasta aims to tackle food insecurity** - *Fuse, Teesside Live*
- **TEWV celebrates volunteers week with a special thanks to therapy dogs and their handlers** *– Teesside Live*
- **'Kind, caring man' found dead at new flat days after leaving MH hospital** - *Northern Echo online*
- **TEWV boss says organisation is 'now very different' after deaths of teenage girls** - *Teesside Live*
- **Concern raised as TEWV fails to send representation to face scrutiny panel** - *Yahoo! News UK & Ireland*
- **Stokesley TEWV worker goes from stutter to strength during life-changing India trip** - *Teesside Live*

Our website

109,989
page views

Top three visited pages

1. Careers
2. Services
3. Locations

Staff intranet

2,499,159
page views

Top staff intranet news stories

1. Autism mandatory training
2. Ridgeway fun fair
3. Working carers recognition
4. Couch to 5k for a CAMHS manager
5. Poem by Trust patient wins national acclaim
6. Learning Disability Week newsletter

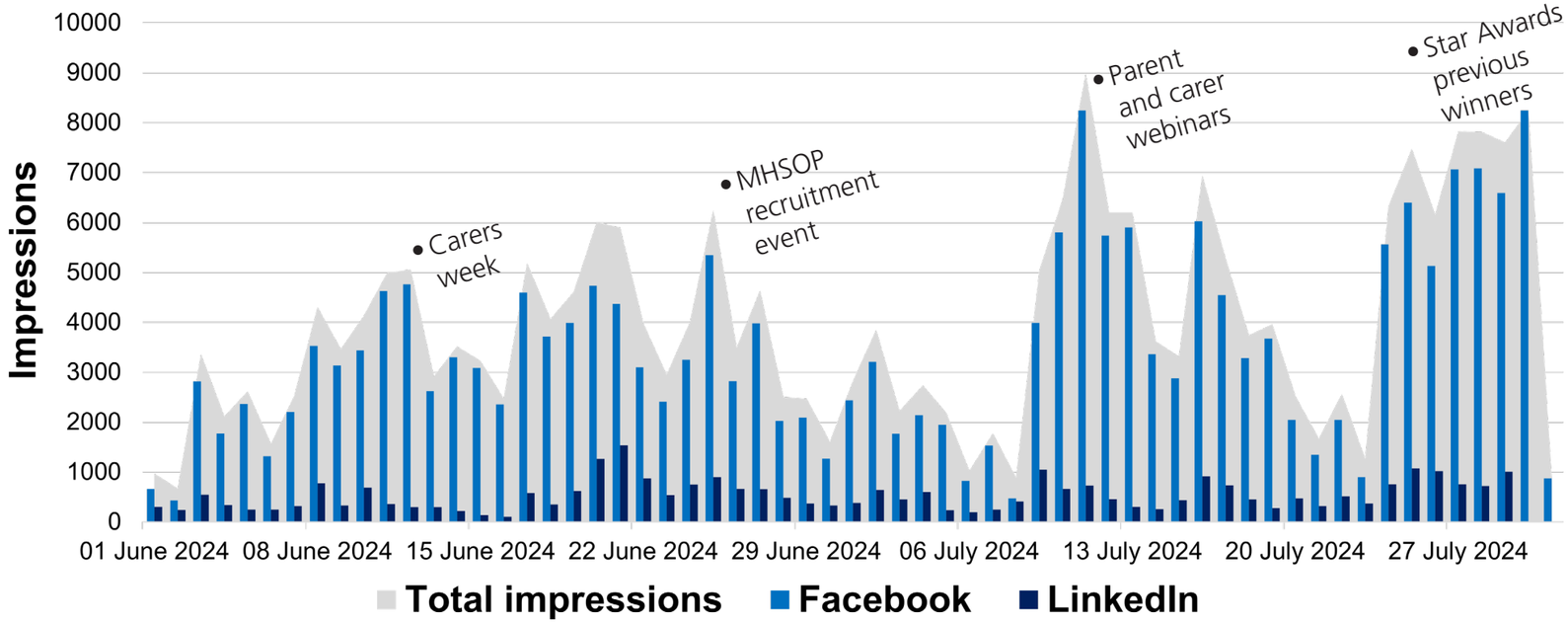
Social Media

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

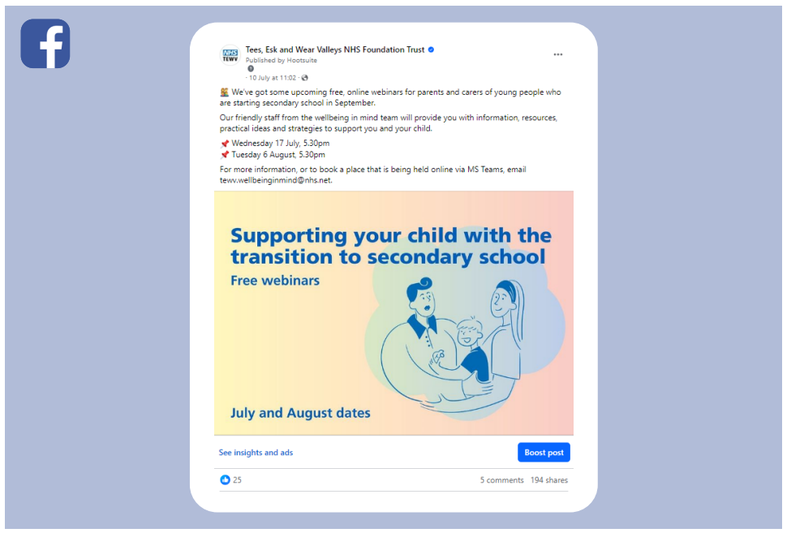
Our audience

26,972 Total followers	**285** New followers
293,547 People who saw our content - impressions	**209** Total posts

Daily impressions

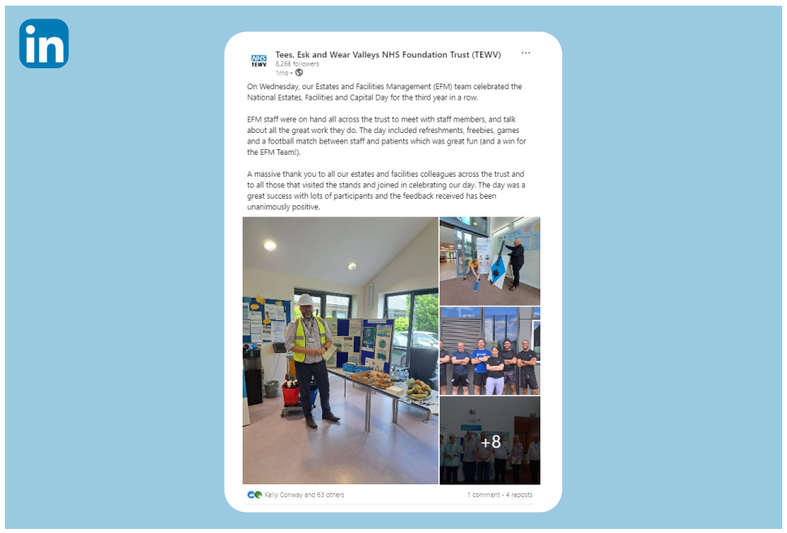


Top posts



Impressions 26,044 - Engagement 703

Impressions 3,372 - Engagement 40



Impressions 3,026 - Engagement 1,908

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**8th August 2024**
Title:	**Board Integrated Performance Report as 30th June 2024**
Executive Sponsor(s):	**Mike Brierley, Assistant Chief Executive**
Author(s):	**Ashleigh Lyons, Head of Performance**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
1	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.
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.
3	Co-Creation	**There is a risk** that if we do not fully embed a shared co-creation framework **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 Our Journey To Change.
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.
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 Our Journey To Change goals today and for the future.
6	Estates & 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.
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.
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.
9	Partnerships & 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 Integrated Care Systems and multiple local authorities **limits** our ability to influence service transformation and improve the health of the communities we serve.
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
11	Roseberry Park	**There is a risk that** the necessary Programme of rectification works at Roseberry Park, limited access to capital funding, and associated Private Finance Initiative (PFI) termination legal case **could adversely affect** our service quality, safety, financial, and regulatory standing.
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
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.

Executive Summary:

Purpose:

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

Proposal:

The Executive Directors Group is proposing that Board of Directors receives this report with:

- **Good controls assurance** regarding the oversight of the quality of services being delivered and the corrective actions/mitigations in place to address any gaps or negative assurances.
- **Good performance assurance** regarding the Integrated Performance Dashboard (IPD)
- **Reasonable performance assurance** regarding the National and Local Quality Requirements

Overview:

Controls Assurance

The overall **good** level of **controls assurance** has been determined based on the Performance Management Framework we have in place which includes an agreed information and governance flow; dashboards/data at various levels via the Integrated Information Centre; the use of Statistical Process Control charts to support analysis; Performance Improvement Plans to support improvement; a Performance and Controls Assurance Framework and a data quality assessment for the IPD (supplemented by annual audits for a small number of measures by Audit One); and a dedicated Corporate Performance Team within the Assistant Chief Executives portfolio to support the organisation with performance management.

Performance Assurance

The overall **good** level of **performance assurance** for the IPD has been determined based on the following information which is underpinned by the Performance and Controls Assurance Framework:

- There are only 3 measures (from 31) within the Integrated Performance Dashboard (IPD) with **limited performance assurance** and **negative controls assurance.**
- There are 4 measures within the IPD demonstrating **improved performance and/or controls assurance.**
- There are corrective actions/mitigations in place to address the risks and issues identified.

The overall **reasonable** level of **performance assurance** for the National and Local Quality Requirements has been determined based on the following information:

- There are 6 National Quality Requirements within the IPR at sub ICB level and we are failing 13 individual targets (from a total of 24)
- There are 8 Local Quality Requirements within the IPR at sub ICB level and we are failing 19 individual targets (from a total of 32)
- There are corrective actions/mitigations in place to address the risks and issues identified.

Whilst there are measures with limited performance assurance, including those where we are failing targets, there are corrective actions/mitigations in place to address these which are outlined in the IPR. An assessment on the impact of these actions/mitigations will be undertaken in August (data ending July 24).

Positive Assurances

We have positive assurances in the following:

- ✓ Outcomes: CYP and Adults/Older Persons showing measurable improvement following treatment (clinician reported)
- ✓ Inappropriate OAP bed days and Inappropriate Active OAPs
- ✓ Talking Therapies: Waiting Times 6 & 18 weeks
- ✓ Incidents of moderate or severe harm
- ✓ Staff Leaver Rate and Staff in post with a current appraisal
- ✓ Finance: CRES Performance – Non Recurrent, Capital Expenditure (Capital Allocation) and Cash balances (actual compared to plan)

Key Changes

We have identified several National and Local Quality Requirements that have failed target for 3 consecutive months in this current financial year to date; therefore, EDG have agreed the development of Performance Improvement Plans for those areas starting with deep dives to inform the required actions for the next report.

Other Information

Following a review of the standard for the *Percentage of inpatients reporting that they feel safe whilst in our care* measure the Quality Assurance Committee are recommending to the Board of Directors we maintain the current standard of 75%.

The latest Data Quality Assessment has been undertaken in June; all changes are noted on the relevant slides.

Prior Consideration and Feedback

The individual Care Group IPRs have been discussed and approved by the Care Group Boards and Executive Directors Group have approved the Trust IPR prior to Board of Directors.

Implications:

The Integrated Performance Report (IPR) is a fundamental component of our Board Assurance Framework. The implications of those measures with limited performance assurance and negative controls assurance and those where we are failing to achieve National and Local Quality Requirements impact on:

- Safe Staffing
- Demand
- Estates/Physical
- Quality of care
- Quality Governance
- Partnership & System Working
- Regulatory Compliance
- Financial Sustainability
- Public Confidence

They could also affect the Trust's ability to manage relevant risks to target level in accordance with agreed trajectories.

Recommendations:

Board of Directors is asked to:

- note the good controls assurance on the operation of the Performance Management Framework; good performance assurance on the IPD and reasonable performance assurance on the National and Local Quality requirements,
- note the corrective actions/mitigations that have been/are being put in place to address the risks and issues identified and confirms it is assured on the actions being taken to improve performance in the required areas, and
- approve the maintenance of the 75% standard for the *Percentage of inpatients reporting that they feel safe whilst in our care* measure.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

As at 30th June 2024

Report produced by: Amy Walford, Performance Lead (Corporate) and Ashleigh Lyons, Head of Performance
Date the report was produced: 16th July 2024

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journey to change

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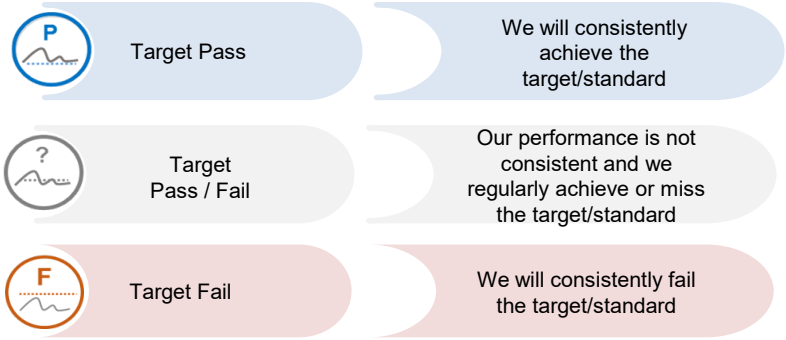
Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys NHS Foundation Trust

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

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

Assurance: is the standard achievable?



Please note assurance on whether the standard/plan is achievable is now included for a number of measures. Standards for the remaining ones will be progressed, where required.

Our Approach to Data Quality and Action

Tees, Esk and Wear Valleys NHS Foundation Trust

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

The latest assessment has been completed in June 2024 and results have been incorporated in this report.

Note: The development of the local audit/assurance framework to support the assessment has been further delayed due to capacity issues within Business Intelligence who have been supporting the implementation of CITO. This will now be completed in quarter 2 2024/25 with the first assessment of this element in quarter 3 2024/25.

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

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

Data Quality Assessment status

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

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

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

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

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

Glossary of Terms

ADHD	Attention deficit hyperactivity disorder
ALD	Adult Learning Disabilities
AMH	Adult Mental Health
ASD	Autism Spectrum Disorder
CRES	Cash Release Efficiency Savings
CROM	Clinician Reported Outcome Measure
CYP	Children & Young People
CYPS	Children and Young People Services
DTOC	Delayed transfers of care
DTVFCG	Durham Tees Valley and Forensic Care Group
EDG	Executive Directors Group
EIP	Early Intervention in Psychosis
ICB	Integrated Care Board
IPD	Integrated Performance Dashboard
MHSOP	Mental Health Services for Older People
MoJ	Ministry of Justice
NYYSCG	North Yorkshire, York & Selby Care Group
Neuro	Neurodevelopmental services
OAP	Out of Area Placement
PIP	Performance Improvement Plan
PIpA	Purposeful Inpatient Admission
PMH	Specialist Community Perinatal Mental Health
PROM	Patient Reported Outcome Measure
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Framework
SMART	Specific, measurable, achievable, relevant, time-bound
SOCI	Statement of comprehensive income
SPC	Statistical Process Control
STEIS	Strategic Executive Information System
UoRR	Use of Resources Rating

Board Integrated Performance Dashboard Headlines

Headlines

- **Patient and Carer Experience:** no significant change for patients rating their recent experience as good or very good and for inpatients feeling safe, and both are achieving standard in June. Cause for concern for carer involvement and below standard. There is no significant change in the responses received for any of the measures.
- **Outcomes:** CYP no significant change and below standard for the PROM; however, special cause improvement for the CROM and above standard. AMH/MHSOP special cause concern and below standard for the PROM; however, special cause improvement but below standard for the CROM.
- **Bed Pressures:** no significant change in bed occupancy; however, special cause improvement for the inappropriate out of area bed days.
- **Patient Safety:** special cause improvement for patient safety incident investigations and incidents of moderate of severe harm. No significant change for Restrictive interventions and medication errors; however, there was 1 unexpected Inpatient unnatural death reported on STEIS during June.
- **Uses of Mental Health Act** no significant change.
- **Staff:** We have special cause improvement for leaver rate and appraisal, and no significant change for sickness and mandatory training, and we are achieving the standards in June for mandatory training and appraisals.
- **Demand** no significant change in referrals however, special cause concern continues for caseload.
- **Finance** The Trust's final 2024/25 financial plan targets delivery of a break-even position. The year-to-date plan at Month 3 reflected a £0.796m deficit, with actual performance being a deficit of £0.650m; or £0.146m favourable variance to plan. Whilst overall performance is marginally ahead of plan, CRES targets are more heavily weighted to deliver reduced costs in the second half of the year, requiring an ongoing focus on grip and control actions.

Risks / Issues

Of most concern:
- Unique Caseload
- Agency price cap compliance
- CRES Performance - Recurrent

Of concern:
- Carer Experience
- Adults and Older Persons PROM

Positive Assurance

Significant improvement seen in:
- Children and Young Persons CROM
- Adults and Older Persons CROM
- Inappropriate OAP bed days
- Incidents of moderate or severe harm
- Staff Leaver Rate
- Staff in post with a current appraisal

Positive assurance for:
- CRES Performance – Non Recurrent
- Capital Expenditure (Capital Allocation)
- Cash balances (actual compared to plan)

Board Integrated Performance Dashboard Headlines

Mitigations

Caseload

- DTVFCG CYPS are developing a Recovery Plan to address the long waiting times within CYPS Neurodevelopmental teams (this will replace the original PIP); which will need system-wide support. The remaining action within the PIP for AMH services was to implement a revised assessment process within Sedgefield teams for ADHD and ASD pathways working with Primary Care colleagues. It was anticipated this would increase assessment and reduce 80% of referrals coming into intervention teams by June 2024. **(Complete)** The implementation is slower than anticipated and visible impact is expected by the end of September 2024 (October report). The focused deep dive on AMH active caseload will be completed by end of August 24, which will inform further PIP actions.
- NYYSCG CYPS have completed the two identified pieces of work that were required before being able to identify SMART actions; a full day event will be held in July 2024 to agree the next steps. The HNY ICB led a Memory Re-Design Event in April 2024; outputs from this event are expected from the ICB in September following engagement with key partners.
- Corporately, a series of focused deep dives will be undertaken to better understand any other areas of concern. The first deep dive will focus on CYP services and will be completed by the end of August 2024. Findings will be shared with EDG in September 2024.

Carer Experience

There is special cause concern for Carer Experience at Trust level and for Durham, Tees Valley & Forensic Care Group. This is attributable to a reduction in positive responses in June compared to May, across all specialties. Whilst we would not identify any specific actions based on one month's non-achievement, we recognise the concern and the performance below standard, and this is being monitored closely by the services.

AMH/MHSOP PROM

A Board seminar was held early July 2024 to support understanding in our outcome measures, which received positive feedback. The resource pack for clinical services has now been developed and discussions are taking place with communications colleagues on how best to share this. The monthly "Walk the Wall" performance discussion at EDG continues covering the remaining measure in July. Business Intelligence continue to offer training and support to clinical services to support understanding, including how to capture timely, paired scores, how to monitor this, and how to use the data to understand those patients not demonstrating improvement in order to identify possible future actions. NYYSCG MHSOP have now developed their PIP and actions are to ensure that outcomes are taken at the start and end of every patient journey and to review a sample of patients not achieving measurable improvement to identify any specific issues and required improvement actions by the end of August 2024. Both AMH services continue to progress their individual PIPs, acknowledging the wider programme of work.

Finance To support improved compliance, the Executive Workforce and Resources Group are overseeing a Performance Improvement Plan to ensure optimal rosters. The first meeting of the Efficiency Hub that will oversee delivery of CRES took place on 26th June where changes and additions to the ToR, as well as the content and format of the scheme tracker were agreed. Trackers will be completed and brought back to the next meeting in July. In addition to CRES schemes, ongoing grip and control measures are required to deliver the 2023/24 exit run-rates based 2024/25 plan.

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

Durham Tees Valley & Forensic Care Group IPD Headlines

Headlines

- **Patient and Carer Experience:** no significant change for patients rating their recent experience as good or very good or for inpatients feeling safe; however, achieving standard in June. Cause of concern for carer involvement and performance is below standard. There is no significant change in the responses received for any of the measures.
- **Outcomes:** CYP special cause concern and below standard for the PROM; however, special cause improvement for the CROM although also below standard. AMH/MHSOP no significant change in the PROM and special cause improvement in the CROM. Below standard for the PROM and CROM.
- **Bed Pressures –**no significant change in bed occupancy; however, special cause improvement for the inappropriate out of area bed days.
- **Patient Safety**. Special cause Improvement for patient safety incident investigations. No significant change for and incidents of moderate of severe harm, Restrictive interventions, medication errors and unexpected inpatient unnatural deaths. There was 0 unexpected Inpatient unnatural death reported on STEIS during June.
- **Uses of Mental Health Act** no significant change.
- **Staff.** For recommending the Trust as a place to work we achieved 51.48% and for staff feeling able to make improvements we achieved 54.75%. Special cause Improvement in appraisal and no significant change in mandatory and statutory training or sickness.
- **Demand** no significant change in referrals; however special cause concern in caseload driven by Adult Mental Health and Children and Young Peoples services.
- **Finance The DTVF Care Group**, planned to spend £65.1m as at June, and actual spend was £64.9m, which is £0.211m less than planned. The improvement is as a result of reduced levels of Independent sectors beds. As at M3 CRES delivery was achieved.

Risks / Issues*

Of most concern:

- Unique Caseload
- Financial Plan: Surplus/Deficit

Of concern:

- Carer involvement
- Children and Young Peoples PROM
- Agency price cap compliance
- Agency Spend

Positive Assurance

Significant improvement seen in:

- Children and Young Peoples CROM
- Adult Mental Health/Older Peoples CROM
- Inappropriate OAP bed days
- Incidents of moderate or severe harm
- Staff Leaver Rate.
- Appraisal

Durham Tees Valley & Forensic Care Group IPD Headlines

Mitigations

CYP PROM
The Care Group revised their Performance Improvement Plan (PIP) as the original actions did not have the desired impact. The services are undertaking a patient level deep dive into patients discharged with a paired outcome measure that are not demonstrating an improvement. This was due to be completed by the end of June 2024 but has been delayed and an extension is requested to the end of July. . The service will also focus efforts to ensure the agreed outcome measures are recorded at the start and end of the patient's journey and for services to review a sample of patients not achieving measurable improvement to understand the reason(s) why. It is anticipated we will see improved collection of outcome measures from August (July data). The measure will be revised to include Parent Rated outcomes and the new assessment tools by the end of August 24.

AMH/MHSOP PROM and CROM
We have developed a programme of work to support understanding and improvement in our outcome measures. To date, a resource pack for clinical services including key information on data available, where to access this and how it should be used has been developed and will be distributed during July 2024. The Care Group have reviewed their PIP and have added an action for the team and service managers to facilitate a session with the Section Head of Research & Statistics by the end of July 2024 to understand how to use the new caseload report to monitor timely outcome recording

Caseload
CYPS are developing a Recovery Plan to address the long waiting times within CYPS Neurodevelopmental teams (this will replace the original PIP); which will need system-wide support. A PIP for AMH services includes pilot work within Sedgefield teams to implement a revised assessment process for ADHD and ASD pathways working with Primary Care colleagues It is anticipated this action will increase assessment and reduce 80% of referrals coming into intervention teams by June 2024 (July report). This action has not yet had the desired impact and is now expected by the end of Quarter 2. In addition, a focused deep dive on active caseload is to be completed by end of August 24, which will inform further PIP actions.

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

Headlines

- **Patient and Carer Experience:** No significant change in either of the measures or in the number of carer responses, with the exception of patient who have responded to their experience which is showing special cause improvement.
- **Inpatients Feeling Safe:** No significant change and in the number of responses to this measure. MHSOP are reporting special cause concern, however this is due to low numbers, they are achieving standard.
- **Outcomes:** CYP PROM are reporting no significant change with some improvement. CYP CROM are reporting special cause improvement, AMH/MHSOP PROM are reporting special cause concern, AMH/MHSOP CROM are reporting no significant change with some improvement.
- **Bed Pressures:** No significant change in Care Group both AMH and MHSOP for bed occupancy and now above the mean; inappropriate out of area beds days continues to report special cause improvement
- **Patient Safety:** No significant change across all measures with the exception of Incidents of moderate or severe harm which is now reporting special cause improvement at care group level and Adult Learning Disabilities and Children and Young People
- **Uses of Mental Health Act:** no significant change
- **Staff:** For recommending the Trust as a place to work we achieved 40.76% and for staff feeling able to make improvements we achieved 54.78%. **Staff leaver** is special cause improvement (low). **Sickness** no significant change and continues to improve**, Mandatory Training and Appraisals** is special cause improvement.
- **Demand:** no significant change in referrals and caseload
- **Finance** significant challenges in relation to financial recovery to achieve breakeven by the end of the year.

Risks / Issues

Of most concern:

- Adults and Older Persons Patient reported Outcome Measure
- Number of unexpected inpatient unnatural deaths
- Financial Plan: Agency expenditure

Of concern:

- Financial Plan: Surplus/Deficit
- Agency price cap compliance

Positive Assurance

Improvement seen in:

- Children and Young Persons Clinician Reported Outcome Measures
- Inappropriate OAP
- Number of incidents of moderate or severe harm
- reported on STEIS
- Staff Leaver Rate
- Mandatory & Statutory Training
- Appraisals

Mitigations

AMH/MHSOP PROM and CROM

We have developed a programme of work to support understanding and improvement in our outcome measures. This includes: a monthly "Walk the Wall" performance discussion at Executive Directors Group, the development of a comprehensive resource pack for clinical services by the end of June 2024, a Business Intelligence training and support offer to clinical services to support understanding, including how to capture timely, paired scores, how to monitor this, and how to use the data to understand those children and young people not demonstrating improvement in order to identify possible future actions

AMH is reviewing their PIPs to take into account this wider programme of work and this will be completed by the end of Juy 2024.

MHSOP agreed actions are to ensure staff complete the agreed outcome measures at the start and the end of the patient's journey to ensure they are timely and paired with a timescale of 31st August 2024, but it must be noted that this will not show improvement in the denominator until September 2024.

To review a sample of patients who are not achieving measurable improvement to understand the reasons why which will allow for specific issues to be identified and align new actions with a timescale of 31st August 2024.

Caseload

CYPS have completed the two identified pieces of work that were required before being able to identify SMART actions; a full day event will be held in July 2024 to agree the next steps. The HNY ICB led a Memory Re-Design Event in April 2024; outputs from this event are expected from the ICB in September following engagement with key partners.

Finance

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

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

Performance & Controls Assurance Overview

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

Board Integrated Performance Dashboard

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC		?	92.00%	92.89%	92.00%
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	QAC	L	?	75.00%	71.60%	75.00%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC		?	75.00%	79.54%	75.00%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC		F	35.00%	23.53%	35.00%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L	F	55.00%	43.51%	55.00%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	F	50.00%	50.00%	50.00%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	H	F	30.00%	22.71%	30.00%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC				100.25%	
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	L			44	
10)	The number of Patient Safety Incident Investigations reported on STEIS	QAC				9	
11)	The number of Incidents of moderate or severe harm	QAC	L			143	
12)	The number of Restrictive Interventions Used	QAC				2,999	
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				1	
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				2	
15)	The number of uses of the Mental Health Act	MHLC				1,036	

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
16)	Percentage of staff recommending the Trust as a place to work	PC&D				44.11% (Apr - 2024)	
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				50.56% (Apr - 2024)	
18)	Staff Leaver Rate	PC&D	L	F	11.00%	11.41%	11.00%
19)	Percentage Sickness Absence Rate (month behind)	PC&D		?	5.50%	5.81%	5.50%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D		?	85.00%	87.55%	85.00%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	H	F	85.00%	87.64%	85.00%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
22)	Number of new unique patients referred	S&RC				23,718	
23)	Unique Caseload (snapshot)	S&RC	H			67,887	

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	796,000	650,106
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	3,273,072	3,039,379
25b)	Agency price cap compliance	S&RC	67.00%	62.96%
26)	Use of Resources Rating - overall score	S&RC	3	2
27)	CRES Performance - Recurrent	S&RC	4,718,240	4,097,000
28)	CRES Performance - Non-Recurrent	S&RC	400,000	523,000
29)	Capital Expenditure (CDEL)	S&RC	2,242,000	2,109,180
30)	Cash against plan	S&RC	55,137,000	58,491,556

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

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

What does the chart show/context:
During June 1016 patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **955 (94.00%)** scored "very good" or "good".

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

The latest National Benchmarking data (April 2024) shows the England average (including Independent Sector Providers) was **85**% and we were ranked **12** (1 being the best with the highest ratings) out of 68 mental health trusts. We were also ranked highest for the total number of responses received.

Underlying issues:
Electronic tablets used within inpatient areas do not always connect to the Trust Wi-Fi and a number of community areas have electronic tablets that cannot be configured to enable connection; therefore, we are not capturing all patient experience within this measure.

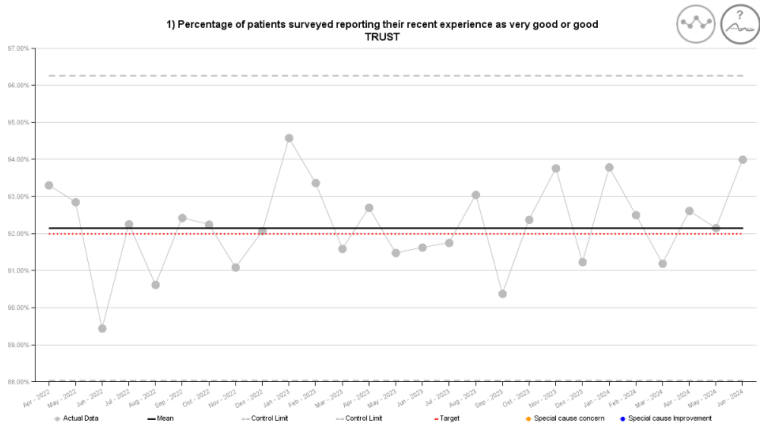
Actions:
- A task and finish group is being established with service user and carer membership to understand the performance of each individual team and what key 5 things they might look for. The key 5 priorities will be agreed by the end of September 2024.
- Quality Improvement Team to undertake some focused work with the top 10 and bottom 10 teams regarding response rates, to learn from and share best practice. This work will be completed by the end August 2024.
- Digital & Data Services are working proactively with services to resolve any issues identified on existing tablets in a timely manner and are liaising with our system supplier, Meridian, and NHS Digital on issues outside Trust control.

No significant change in the data during the reporting period shown

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

DQ ★ 93%

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



Actions continued:
- The Head of Technology is managing a Trust-wide project to improve WiFi provision, which will improve connections within our inpatient areas and may mitigate some of the issues currently impacting use of the electronic tablets. This is a long-term project that will be undertaken through 2024/25.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

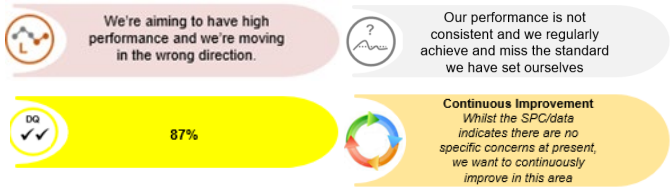
What does the chart show/context:
During June, **382** carers responded to the question in the carer survey: Question: "Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?". Of those, **247 (64.66%)** scored "yes, always".

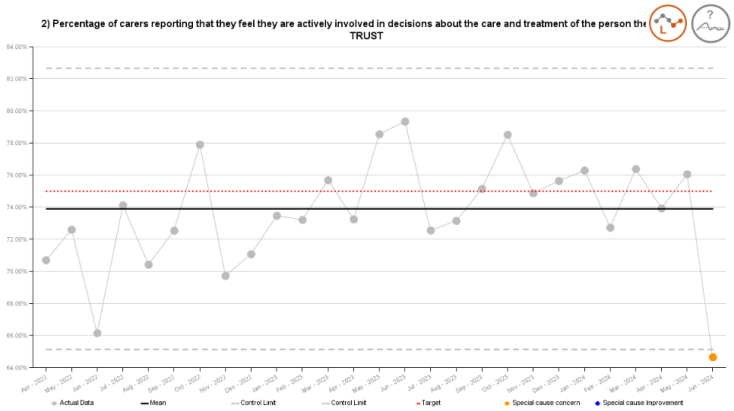
There is special cause concern visible at Trust level and for Durham, Tees Valley & Forensic Care Group for the reporting period. There is no significant change in the number of patients who have responded to this question. There is no significant change for North Yorkshire, York & Selby Care Group and all underlying specialties within the Trust.

The two-star rating for Triangle of Care has been maintained for 2024/25.

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

Actions:
- The Patient & Carer Experience Team are continuing to work with the Recovery College to develop an e-learning package to deliver the Carer Awareness training and are continuing to deliver face to face training with an increased number of sessions. The draft proposal will be presented to the Carers Group by the end of August 2024.
- Deep dive work has taken place to review the Triangle of Care assessments and the Quality Improvement Team are to undertake some focused work with the top 10 and bottom 10 teams regarding response rates, to understand whether these barriers remain a concern and to identify any new and emerging themes for improvement. This work will be completed by the end August 2024.
- A Carers Plan has been developed and shared with Quality Assurance Committee and Patient Experience and Carers Group. This incorporates a programme of work focusing on the involvement of carers. This includes, but is not limited to:
    - co-delivered training to Trust staff





Actions continued:
- the cocreation of E-Learning Carer Awareness Training which will be available within the online recovery programmes
- proactive working with carers to identify opportunities for the ongoing development of further carer forums
- the development of a carer pathway on Cito, to record all information provided and discussed with carers
- The use of visual display boards in teams where carers are identified to ensure regular contact is made
- improved links with volunteers undertaking "Check and Chat" calls with carers.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

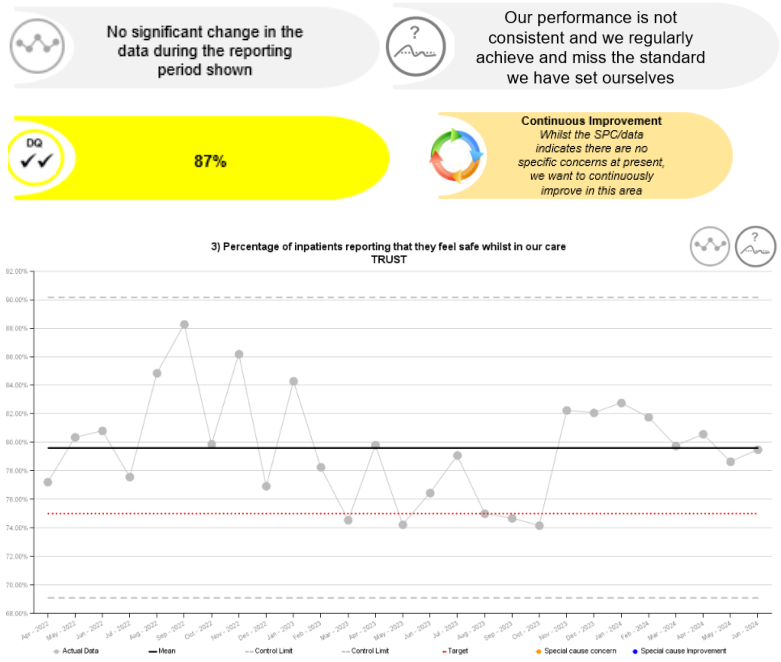
Background / standard description:
We are aiming for 75%* of inpatients reporting, they feel safe whilst in our care (**pending approval by Board of Directors*)

What does the chart show/context:
During June195 patients responded to the overall experience question in the patient survey: "During your stay, did you feel safe?". Of those, 155 (79.49%) scored "yes, always" and "quite a lot".

There is no significant change at Trust and Care Group level in the reporting period and in the number of inpatients who have responded to the question. However, special cause concern is visible for North Yorkshire, York & Selby Mental Health Services for Older People, whilst special cause improvement is visible for Secure Inpatient Services in Durham, Tees Valley & Forensic.

Underlying issues:
- There are several factors that can influence whether a patient feels safe, e.g. staffing levels, other patients, environment, the acuity of other patients and violence & aggression on wards.
- Self-Harm in inpatient settings can cause other patients to feel unsafe
- The use of restrictive interventions on wards can cause other patients to feel unsafe.

Actions:
- Durham Tees Valley & Forensic Care Group have a Performance Improvement Plan (PIP). Actions are for Peer Workers and Patients to create their own Leaflets outlining, what would they want other patients to know when they arrive, what would help them feel safe; suggestion boxes on wards to support people to raise questions or concerns about feeling safe in an anonymous/less intrusive way and a monthly checklist to explore how many patients attended the Mutual Help Activities and psycho-social sessions etc, so activities can be tailored to suit the cohort of patients. It is anticipated that the impact of these improvement actions should be seen by May 2024 (June report) with a 5% increase in inpatients reporting they feel safe. **(Not completed)** The Care Group have submitted a request to stand down the PIP following sustained improvement in performance.



Actions continued:
- The Patient & Carer Experience Team in collaboration with the Lived Experience Directors will review the "standard" for this measure following the expansion to include "quite a lot". A proposal will go to the Executive Review of Quality in April 2024. (**Completed**) The proposal went to the Executive Review of Quality in June 2024 to retain the 75% standard for the feeling safe measure and was supported by the Quality Assurance Committee early July 2024.
- DTVFCG Lived Experience Director to develop a Trust-wide Reducing Restrictive Practice Strategy. This will be completed by end of July 2024.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

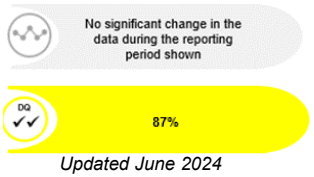
What does the chart show/context:
For the 3-month rolling period ending June **648** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 159 (24.54%)** made a measurable improvement.

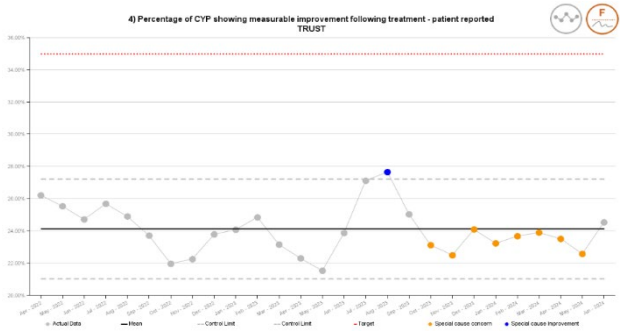
There is no significant change at Trust level and for North Yorkshire, York & Selby Care Group in the reporting period. There is special cause concern is for Durham Tees Valley & Forensic Care Group.

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

Underlying issues:
There are a range of issues currently impacting this measure.
- This measure currently does not include Parent Rated outcomes (which is valid) and the full suite of patient-related outcomes.
- We are not capturing timely, paired outcome measures for all of our patients that are discharged; therefore, this is not a comprehensive picture. One contributory factor is the length of time taken to record an outcome measure on Cito.
- We do not fully understand the reasons why our children and young people are not demonstrating measurable improvement.

Actions:
- The Business Intelligence Team are updating this measure to include Parent Rated outcomes and the new assessment tools. The existing parent-rated outcomes and the additional assessment tool for Eating Disorders will be included within this measure by the end of July 2024 (August report). Further work is required on the remaining assessment tools to confirm the inclusion criteria.
- We have a programme of work to support understanding and improvement in our outcome measures. This includes:
  - A monthly "Walk the Wall" performance discussion at Executive Directors Group (rotating one outcome measure per month).





Actions continued:
- We are developing a comprehensive resource pack for clinical services which will include key information on the data available, where to access this and how this should be used. This will include training videos to support the use of the resources available and links to educational material. This will be completed by the end of June 2024 and communicated throughout the organisation. **(Completed)**
- Training and support is being offered to clinical services by Business Intelligence colleagues to support understanding, including how to capture timely, paired scores, how to monitor this, and how to use the data to understand those children and young people not demonstrating improvement in order to identify possible future actions.
- A Board seminar in July 2024 on the current Trust outcome measures. **(Completed)**
- DTVFCG are reviewing their PIP to take into account the wider programme of work. This will be completed by the end of June 2024. (**Not completed)** A request has been submitted to EDG to review the actions and extend timescales to the end of July 2024.
- Additional training is being provided by the Child Outcomes Research Consortium (CORC) on the 1st August 2024 to NYYSCG.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

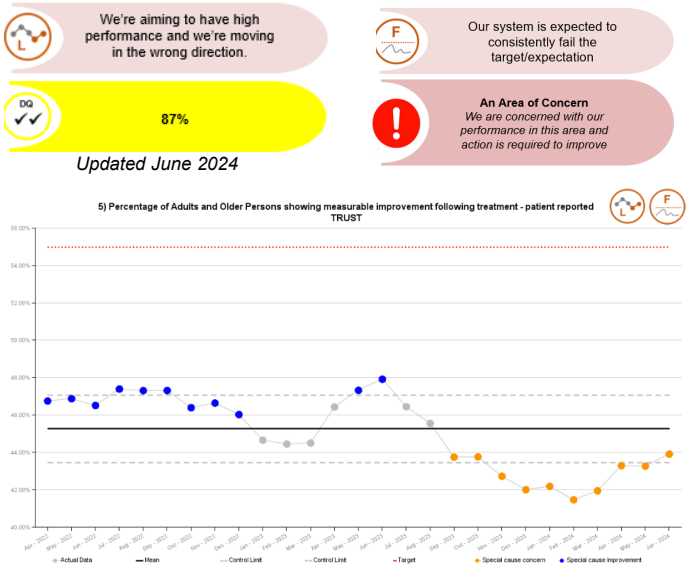
What does the chart show/context:
For the 3-month rolling period ending June **1546** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 679 (43.92%)** made a measurable improvement.

There is special cause concern at Trust level and for North Yorkshire, York & Selby Care Group, with special cause concern and a deteriorating position visible for Adult Mental Health. There is no significant change for Durham, Tees Valley & Forensic Care Group with an increasing position visible for Adult Mental Health.

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

Underlying issues:
- We believe we are not capturing timely, paired outcome measures for all of our patients that are discharged.
- We do not fully understand the reasons why our adult and older persons patients are not demonstrating measurable improvement.

Actions:
We have a programme of work to support understanding and improvement in our outcome measures. This includes:
- A monthly "Walk the Wall" performance discussion at Executive Directors Group (rotating one outcome measure per month).*
- We are developing a comprehensive resource pack for clinical services which will include key information on the data available, where to access this and how this should be used. This will include training videos to support the use of the resources available and links to educational material. This will be completed by the end of June 2024 and communicated throughout the organisation. **(Completed)**
- Training and support is being offered to clinical services by Business Intelligence colleagues to support understanding, including how to capture timely, paired scores, how to monitor this, and how to use the data to understand those patients not demonstrating improvement in order to identify possible future actions.



Actions continued:
- A Board seminar in July 2024 on the current Trust outcome measures. **(Completed)**
- DTVFCG are reviewing their PIP to take into account the outstanding actions and the wider programme of work. This will be completed by the end of June 2024.**(Completed)** Team and service managers to facilitate a session with the Section Head of Research & Statistics by the end of July 2024 to understand how to use the caseload report to monitor timely outcome recording.
- NYYSCG AMH services are reviewing their PIP as the original actions did not have the desired impact and will take into account the wider programme of work. This will be completed by the end of July 2024.
- NYYSCG MHSOP are developing their PIP, which will be developed by the end of June 2024. (**Completed)** Agreed actions are to ensure outcomes are taken at the start and the end of every patient journey and to review a sample of patients to identify any specific issues and improvement actions by the end of August 2024.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
For the 3-month rolling period ending June **639** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 327 (51.17%)** made a measurable improvement.

There is special cause improvement at Trust level and for both Care Groups in the reporting period. Performance is above standard for the Trust and North Yorkshire, York & Selby Care Group.

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

Underlying issues:
There are two key issues currently impacting this measure.

- We are not capturing timely, paired outcome measures for all of our patients that are discharged; therefore, this is not a comprehensive picture. However, this will be the focus of the July EDG Walk the Wall (*see below**)
- We do not fully understand the reasons why our children and young people are not demonstrating measurable improvement.
- Within DTFVCG different outcome tools are being used throughout patient journeys and HoNOSCA is not being updated at discharge.

Actions:
We have a programme of work to support understanding and improvement in our outcome measures. This includes:

- A monthly "Walk the Wall" performance discussion at Executive Directors Group (rotating one outcome measure per month).
- We are developing a comprehensive resource pack for clinical services which will include key information on the data available, where to access this and how this should be used. This will include training videos to support the use of the resources available and links to educational material. This will be completed by the end of June 2024 and communicated throughout the organisation. **(Completed)**

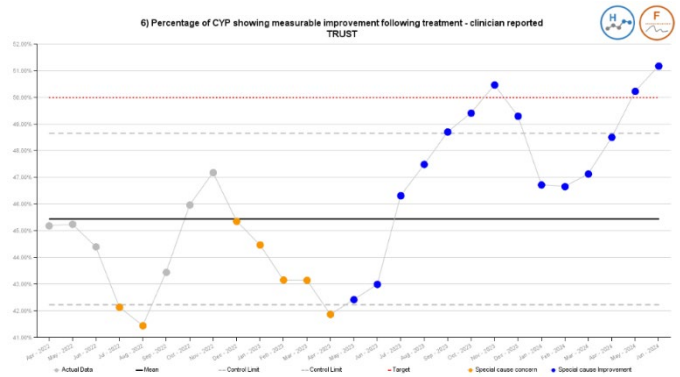
We're aiming to have high performance and we're moving in the right direction.

87%

Our system is expected to consistently fail the target/expectation

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

Updated June 2024



Actions continued:

- Training and support is being offered to clinical services by Business Intelligence colleagues to support understanding, including how to capture timely, paired scores, how to monitor this, and how to use the data to understand those children and young people not demonstrating improvement in order to identify possible future actions.
- A Board seminar in July 2024 on the current Trust outcome measures. **(Completed)**

- DTVFCG are undertaking a patient level review to identify any root causes and required improvement actions. A request has been submitted to EDG to extend the timescales to the end of June 2024. (**Completed)** (*See Underlying Issues*). General Manager to meet with the Head of Research & Statistics by the end of July to talk through the findings and develop some further actions.
- Additional training is being provided by the Child Outcomes Research Consortium (CORC) during June and July 2024 to NYYSCG.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
For the 3-month rolling period ending June **2405** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 589 (24.49%)** made a measurable improvement.

There is special cause improvement at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period, with both underlying specialties reporting special cause improvement. There is no significant change for North Yorkshire, York & Selby Care Group. Mental Health Services for Older People in both Care Groups continues to be a concern (around 10-13% improvement) despite showing improvement in DTVFCG and no significant change in NYYSCG.

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

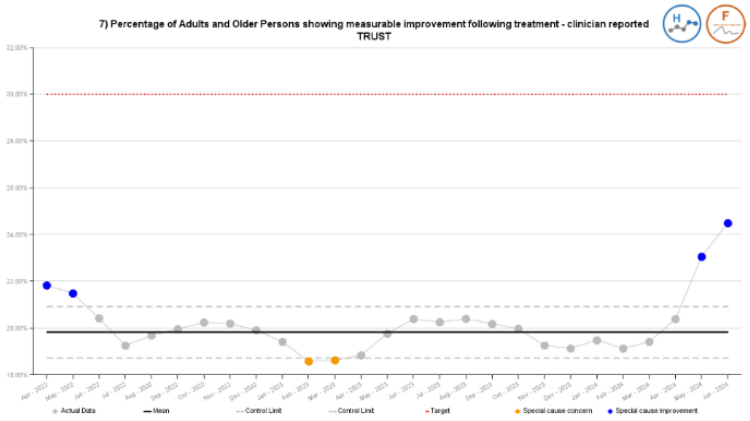
Underlying issues:
There are a range of issues currently impacting this measure.

- We are not capturing timely, paired outcome measures for all of our patients that are discharged; therefore, this is not a comprehensive picture.
- We do not fully understand the reasons why our adult and older persons patients are not demonstrating measurable improvement.

Actions:
We have a programme of work to support understanding and improvement in our outcome measures. This includes:

- A monthly "Walk the Wall" performance discussion at Executive Directors Group (rotating one outcome measure per month).

Updated June 2024



Actions continued:

- Training and support is being offered to clinical services by Business Intelligence colleagues to support understanding, including how to capture timely, paired scores, how to monitor this, and how to use the data to understand those patients not demonstrating improvement in order to identify possible future actions.
- A Board seminar in July 2024 on the current Trust outcome measures. **(Completed)**
- Care Group specific actions which are also applicable for this measure are contained within Measure 5.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
During June, **10,500** daily beds were available for patients; of those, **10,696 (101.87%)** were occupied. Overall occupancy including independent sector beds was **102.20%**

There is no significant change at Trust and Care Group level in the reporting period, with increasing bed occupancy visible. There is special cause concern for Durham, Tees Valley & Forensic Care Group Adult Mental Health Services, but no significant change for all other services. However, an increasing position is visible for Mental Health Services for Older People in both Care Groups.

Underlying issues:
- Clinically Ready for Discharge – specifically around accommodation. There is special cause concern in relation to delayed transfers of care (DTOC) for AMH services within Durham, Tees Valley & Forensic Care Group (12.2% DTOC during June). ***At Trust level (both Care Groups) patients classified as clinically read for discharge equated to an average of 32.8 Adult and 17 Older Adult beds in June 2024, with an associated cost of c £1.312m (including £311k independent sector bed costs) and £450k year to date respectively for each speciality.**
- Patient flow and adherence to PIPA process
- Length of stay (linked to above issues)
- Greenlight admissions
- Ministry of Justice (MoJ) patients

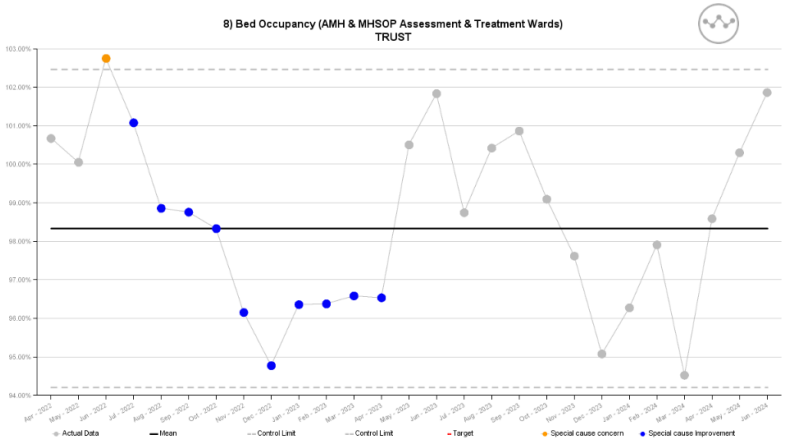
Actions:
Durham Tees Valley & Forensic Care Group have a Performance Improvement Plan (PIP). Remaining actions are to:
- Identify best practice across other NHS trusts to support the review of our discharge policy. The policy was expected to be implemented by end of April 2024. It is anticipated that the impact of this action should be a reduction in length of stay to an average of 30 days. **(Not yet completed)** The Care Group have requested a further extension to the PIP with a revised date of the end of July 2024.
- Develop a form to define the purpose of admission and how this is used to support discharge. It is anticipated that 100% of patients will have a defined purpose of admission to hospital. This will be completed by end of June 2024. **(Completed)** Dates are to be arranged for the go-live on Cito.

No significant change in the data during the reporting period shown

DQ 80%

Updated June 2024

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



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

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming to have no out of area bed days by the end of March 2024.

What does the chart show/context:
For the 3-month rolling period ending June **44 days** were spent by patients in beds away from their closest hospital.

There is special cause improvement at Trust level and for North Yorkshire, York & Selby in the reporting period. Whilst there is no significant change for Durham, Tees Valley & Forensic Care Group Adult Mental Health Services, a reducing position is visible.

Update:
Previously the inappropriate OAPs metric used in planning was the number of inappropriate OAP bed days; in 2024/25 this was replaced by the total number of active inappropriate OAPs, to focus more on the number of patients subject to inappropriate OAPs.

There was 1 active OAP placement as at 30th June 2024 (North Yorkshire SICBL).

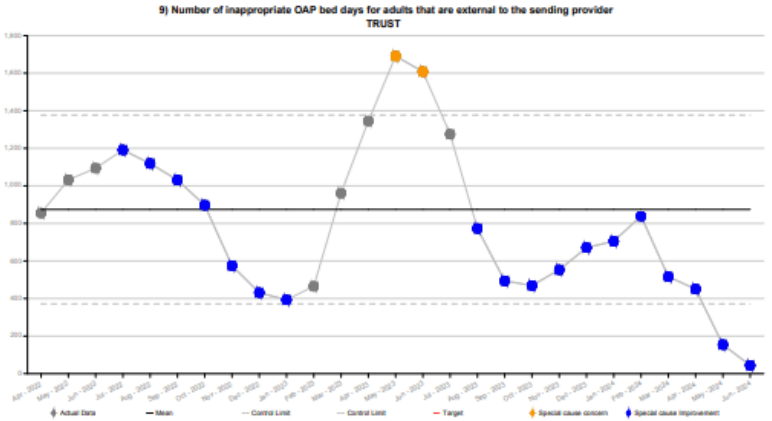
Underlying issues:
Bed Occupancy is impacting on our ability to admit patients to our beds

Actions:
See measure 8) Bed Occupancy

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

DQ 73%

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



ICB Trajectories versus actual performance for Active Inappropriate Adult Acute Mental Health Out of Areas Placements (OAPs)

Active inappropriate adult acute mental health out of areas placements (OAPs)		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trust	Plan	10	10	8	7	6	4	4	4	2	2	1	0
	Actual	1	1	1									
North East & North Cumbria ICB	Plan	7	7	6	5	4	3	3	3	2	2	1	0
	Actual	0	0	0									
Humber & North Yorkshire ICB	Plan	3	3	2	2	2	1	1	1	0	0	0	0
	Actual	1	1	1									

10) The number of Patient Safety Incident Investigations reported on STEIS

Tees, Esk and Wear Valleys NHS Foundation Trust

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

There is no significant change at Trust level and for North Yorkshire, York & Selby Care Group. There is special cause improvement for Durham, Tees Valley & Forensic Care Group, Adult Mental Health Services, Mental Health Services for Older People and Secure Inpatient Services within that care group, and for Children & Young Peoples Services and Mental Health Services for Older People in North Yorkshire, York & Selby Care Group.

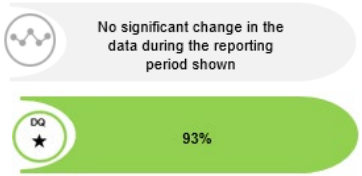
This is not necessarily an actual improvement, as there was a change in process late January 2024, when we Trust transitioned to the National Patient Safety Incident Framework (PSIRF). This new framework advocates a more proportionate approach to investigations.

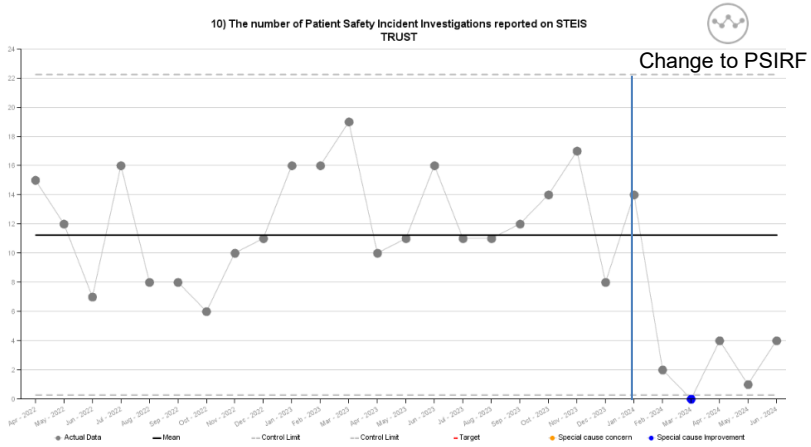
NB. The full investigations (closest equivalent to Serious Incidents previously reported) are now referred to as Patient Safety Incident Investigations (PSII).

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.





11) The number of Incidents of moderate or severe harm

Tees, Esk and Wear Valleys NHS Foundation Trust

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

There is special case improvement at Trust level and for North Yorkshire, York & Selby Care Group. There is no significant change for Durham, Tees Valley & Forensic Care Group. There is special cause improvement for Adult Learning Disabilities and Children & Young Peoples Services in North Yorkshire, York & Selby Care Group.

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

Underlying issues:
- As incidents are reviewed, the severity could be reduced or increased (severity is usually reduced).

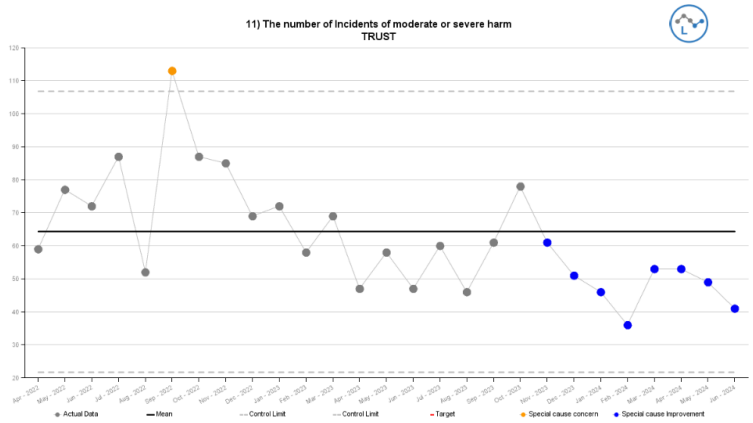
Actions:
- The learning from incidents will be collated and themed by the Patient Safety Team and shared with the Organisational Learning Group and subsequently reported to Quality Assurance Committee. A current focus within the group is record keeping.

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

DQ ★ 93%

Updated June 2024

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



12) The number of Restrictive Intervention Used

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:

1,013 types of Restrictive Interventions were used during June.

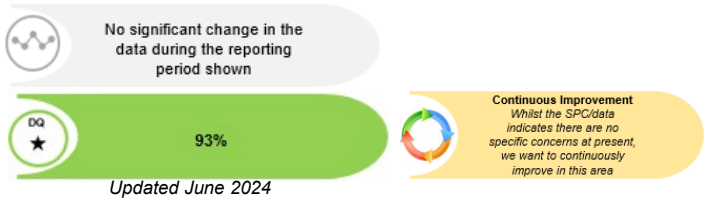
There is no significant change at Trust and Care Group level. Whilst there is special cause concern for Durham, Tees Valley & Forensic Adult Mental Health Services, there is special cause improvement for Adult Learning Disabilities and Children & Young Peoples Services in both Care Groups.

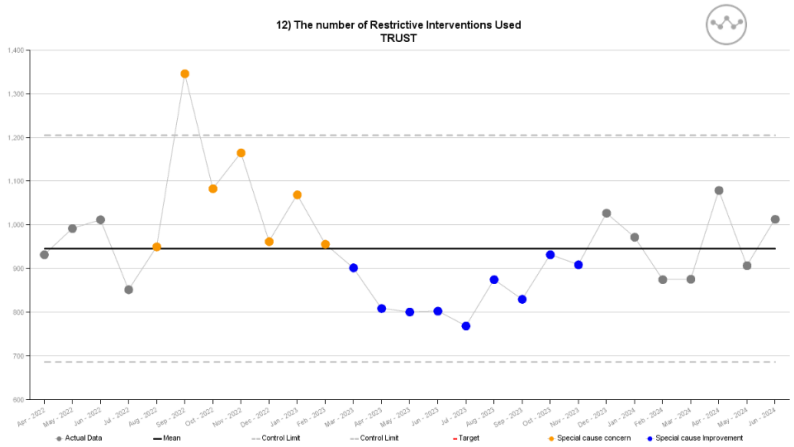
Underlying issues:

- Concerns remain in Overdale (latter small number of complex female patients) and high number on Cedar (PICU) within AMH services in Durham Tees Valley & Forensic Care Group
- Whilst special cause improvement is shown for DTVFCG ALD, there are significant concerns noted in that service due to the complexity of the patients.

Actions

- There are several actions to support improvement to the wards identified above, which include:
  - the Inpatient Lead Psychologist and additional leadership supporting Cedar Ward as part of a wider action plan, which includes clinically appropriate discharge.
  - Specialist Practitioner for Positive & Safe working with the teams to review the use of restrictive interventions and to provide education.
  - due to the nature of the patient group, the Trust-wide Autism Team providing additional support into Cedar ward.
- Within DTVF AMH, where required, all female patients have plans in place to ensure that where interventions are required, they are the least restrictive and most appropriate for that individuals care.
- Additional training is being provided to the DTVFCG ALD services and increased support is being provided by the leadership team, SIS and AMH services.





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

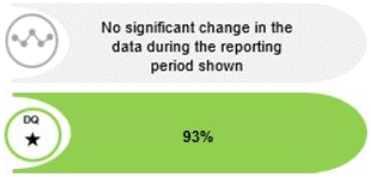
Tees, Esk and Wear Valleys NHS Foundation Trust

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

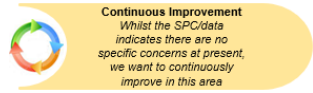
There is no significant change at Trust and Care Group level in the reporting period.

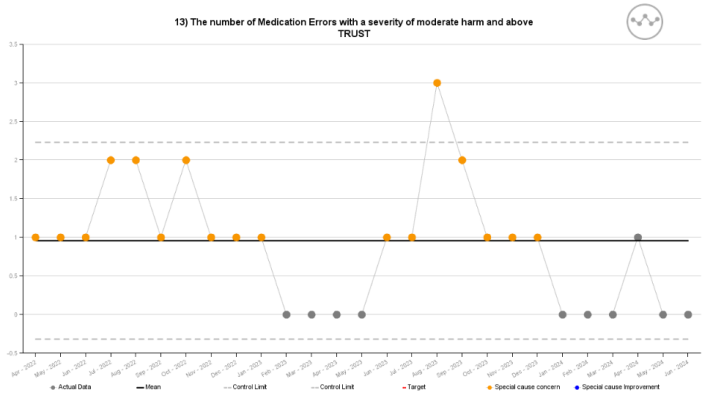
Underlying issues:
- EPMA (electronic prescribing & medicines administration) will enable more timely prescribing and administration of medication to patients and will reduce the risk of some errors once embedded.
- As incidents are reviewed, the severity could be reduced or increased (early indications are that severity is usually reduced).

Actions:
- The rollout of EPMA to community services has been impacted by a delay in the software release from our system suppliers. The rollout to clozapine and depot clinics will be completed by March 2025; further completion dates are to be confirmed at a later stage.



Updated June 2024





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

Tees, Esk and Wear Valleys NHS Foundation Trust

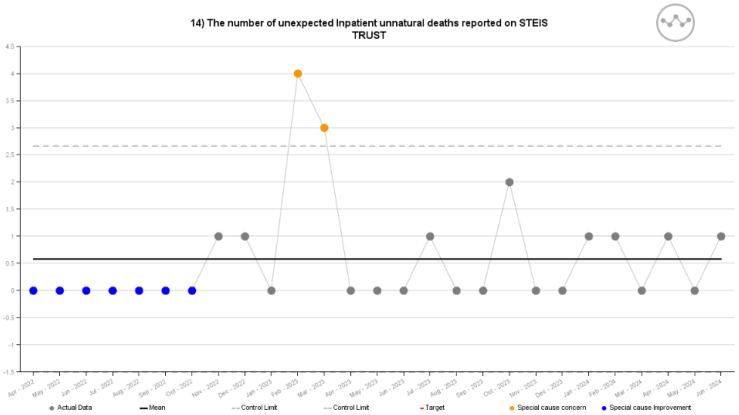
What does the chart show/context:
1 unexpected Inpatient unnatural death was reported on the Strategic Executive Information System (STEIS) during April.

Underlying issues:
All unexpected deaths in inpatient wards are immediately reported in this data; once the cause of death is confirmed the data is cleansed to ensure accurate reporting of deaths that are unexpected and unnatural. The cause of death can be delayed, this data is currently being cleansed to ensure it is accurate. It is indicated that this is an OVER reporting of unnatural unexpected deaths.

Actions:
- A comprehensive multi-disciplinary after-action review has been completed and in line with the National Patient Safety Incident Framework, a full Patient Safety Incident Investigation will be completed.
- Business Intelligence to refresh all historic data to ensure accurate reporting, This will be completed by August 2024 (July report).

No significant change in the data during the reporting period shown

DQ ✓✓ 87%



15) The number of uses of the Mental Health Act

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
There were **320** uses of the Mental Health Act during June .

There is no significant change at Trust and Care Group level in the reporting period; however, special cause concern for Secure Inpatient Services in Durham, Tees Valley & Forensic Care Group.

Underlying issues:
Whilst statistical concern is shown for Secure Inpatient Services in Durham, Tees Valley & Forensic Care Group, the Care Group has confirmed there are no underlying issues to report.

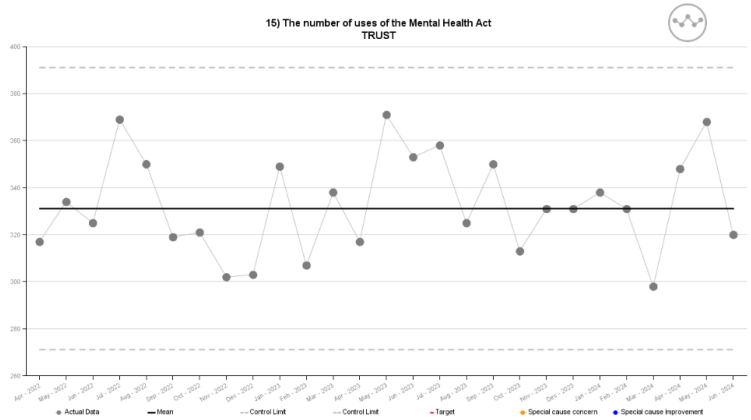
Actions:
There are no specific improvement actions required

No significant change in the data during the reporting period shown

DQ 87%

Updated June 2024

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



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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:

We previously identified that the number of responses being used in the calculation was not consistent. We have now agreed the additional data required with the external provider and this should be available to us by the end of July 2024.

977 staff responded to the April 2024 Pulse Survey. In relation to the question "I would recommend my organisation as a place to work", **431 (44.11%)** responded either "Strongly Agree" or "Agree". We recognise this is the lowest data point to date and will continue to monitor this as part of the actions outlined below.

The NHS Staff Survey Benchmarking report 2023, shows the "best result" was 75.43% and the "average result" was 65.59% for similar organisations.

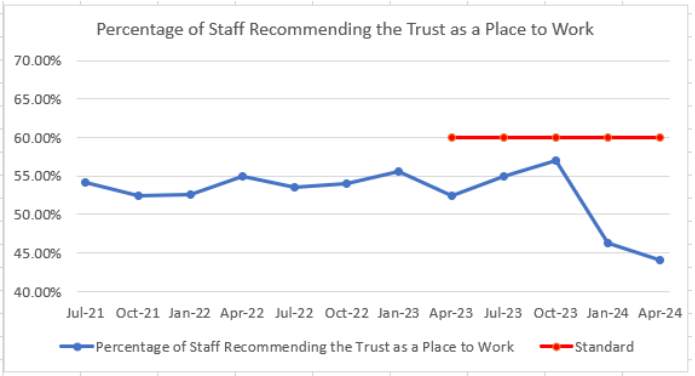
Underlying issues:
We currently have limited data on the percentage of staff recommending the Trust as a place to work therefore we are unable to deploy a Statistical Process Control Chart for analysis of real change.

Actions:
- We have a programme of work within the Safer Staffing Group which is focusing on retention. This includes flexible working opportunities; an extensive health and wellbeing offer covering Employee Support Services, Employee Psychological services, financial resilience, Intention to leave interviews/focus groups and a wide range of career development opportunities including development posts.
- In addition to the programme of work, People and Culture triangulate various data sources including staff survey, Organisational Development interventions, Freedom to Speak Up, to identify key themes for targeted action plans.

DQ

80%

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



** Please note the survey is only undertaken once a quarter . The National Staff Survey (annual) is October each year; the National Quarterly Pulse Survey is the months of January, April and July*

Actions continued:
- The Organisational Development Team and People Partners will provide advice and guidance to support the Services to develop targeted action plans over the next 6 months (September 24) and report into Executive People Culture and Diversity and People Culture & Diversity Committee. Engagement events will then take place over September/October 24 to update staff on what we have heard and what action is being taken.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:

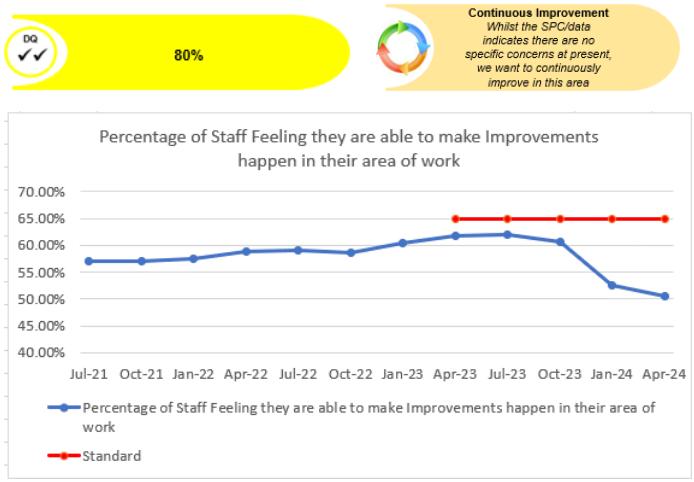
We previously identified that the number of responses being used in the calculation was not consistent. We have now agreed the additional data required with the external provider and this should be available to us by the end of July 2024.

977 staff responded to the April 2024 Staff Survey. In relation to the question "I am able to make improvements happen in my area of work", **494 (50.56%)** responded either "Strongly Agree" or "Agree". We recognise this is the lowest data point to date and will continue to monitor this as part of the actions outlined below.

The NHS Staff Survey Benchmarking report 2023, shows the "best result" as 67.81% and the "average result" as 61.37% for similar organisations.

Underlying issues:
We currently have limited data on the percentage of staff feeling they are able to make improvements happen in their area of work therefore we are unable to deploy a Statistical Process Control Chart for analysis of real change .

Actions:
- The Trust has embarked on a 5-year (November 2027) stepped approach to Quality Improvement (QI) Training support staff to identify where improvements can be made and to feel empowered to suggest and develop those improvements.
- Our Journey To Change focuses on our cultural development through a wide range of engagement, communication and learning opportunities to enable and empower our staff to make changes in their area of work.
- The Organisational Development Team and People Partners will provide advice and guidance to support the Services to develop targeted action plans over the next 6 months (September 24) and report into Executive People Culture and Diversity and People Culture and Diversity Committee. Engagement events will then take place over September/October 24 to update staff on what we have heard and what action is being taken.



** Please note the survey is only undertaken once a quarter . The National Staff Survey (annual) is October each year; the National Quarterly Pulse Survey is the months of January, April and July*

18) Staff Leaver Rate

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Background / standard description:
We are aiming for our staff leaver rate to be no more than 11% (agreed June 2024).

What does the chart show/context:
From a total of **7,240.08** staff in post, **826.19 (11.41%)** had left the Trust in the 12-month period ending June 2024.

There is special cause improvement at Trust level and for most areas in the reporting period. However, there is special cause concern for the Assistant Chief Executive Directorate and Health & Justice and Mental Health Services for Older People within Durham Tees Valley & Forensic Care Group. Whilst there is no significant change and special cause improvement respectively, increasing positions are noted in Nursing & Governance and North Yorkshire, York & Selby Care Group Adult Learning Disabilities.

The latest (February 2024) National Benchmarking for NHS Staff Leaver Rate published on NHS England NHS Oversight Framework Dashboard shows we were ranked 14 (previously ranked 11) of 71 Trusts Mental Health & Learning Disability Trusts (1 being the best with the lowest leaver rate) and are placed in the highest performing quartile range.

Underlying issues (*for those who do leave and tell us why):
- Staff wanting a new challenge
- Promotion
- Role not being as expected
- Work-life balance/wellbeing
- Management/team relationships

Actions:
- We have a programme of work within the Safer Staffing Group which is focusing on retention. This includes flexible working opportunities; an extensive health and wellbeing offer covering Employee Support Services, Employee Psychological services, financial resilience, Intention to leave interviews and a wide range of career development opportunities.
- The revised PIP for e-Roster effectiveness focuses on having 80% of rotas published in line with the Trust target and 80% of teams achieving target for annual leave level loading by the 1st July 2024. We have achieved 83% of rotas published which is better than the Trust target of 80%. However, the action on annual leave level loading has not been completed and an extension has been requested from EDG. 66

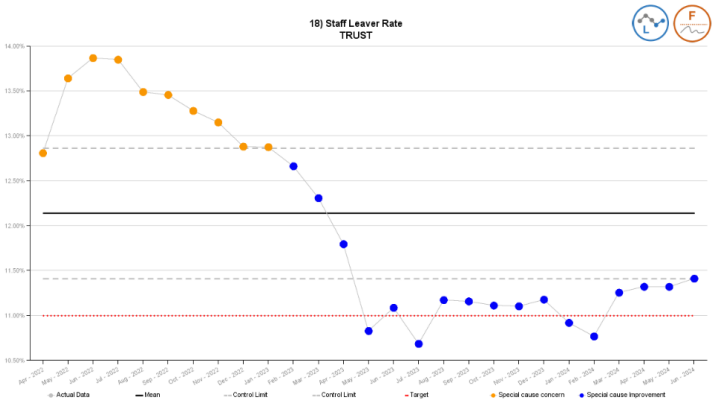
We're aiming to have low performance and we're moving in the right direction.

Our system is expected to consistently fail the target/expectation

87%

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

Updated June 2024



Actions continued:
- A cross-referencing exercise is to be undertaken against our Intention to Leave data and ESR data to identify trends and ensure that exit interviews are being undertaken in a timely manner. Findings will be shared with services by the end of June 2024. **(Completed)** Initial analysis has been undertaken and the findings have been shared. Ongoing analysis will continue to ensure we understand reasons staff leave the organisation.

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
There were **230,487.29** working days available for all staff during June (reported month behind); of those, **13,367.05 (5.80%)** days were lost due to sickness.

There is no significant change at Trust and for most directorates in the reporting period; however, there is special cause concern for Digital & Data Services and Mental Health Services for Older People within Durham, Tees Valley & Forensic Care Group. Whilst there is no significant change, increasing positions are visible in Medical and DTVFCG Adult Learning Disabilities.

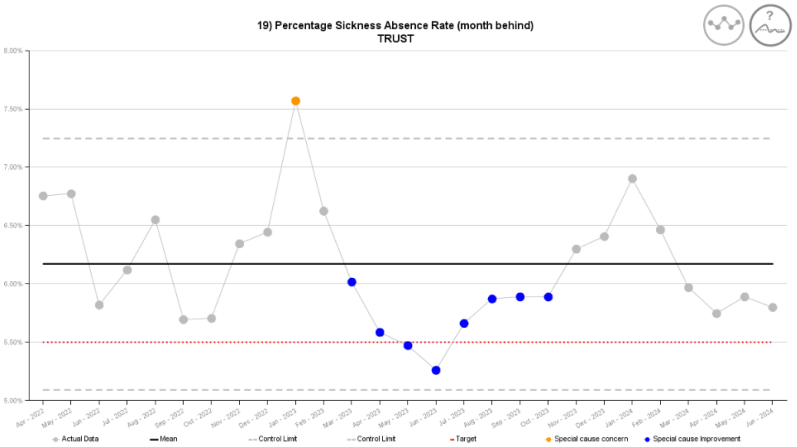
National Benchmarking for NHS Sickness Absence Rates published 27th June 2024 (data ending February 2024) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is 5.59**%** compared to the Trust mean of **6.14%**, with the Trust ranked 34 of 48 Mental Health Trusts (1 being the best with the lowest sickness rate).

Underlying issues:
- Anxiety/stress/depression is the main reason of sickness absence
- Impact of organisational processes on sickness (eg disciplinary process)

Actions:
- People & Culture are focusing on the health, wellbeing and resilience of our staff. This includes flexible working opportunities, Employee Support Services, Employee Psychological services and Health & Wellbeing Champions. There is also an engagement programme including monthly health and wellbeing meetings, guest speakers and newsletters for staff.
- A rolling programme of sickness audits in both Care Groups will be undertaken from May 2024 by People & Culture colleagues to understand whether sickness absence is being managed in line with procedures. Findings from the DTVF audits were shared with Care Group in April 2024. Audits in NYYS will commence in May 2024, with initial findings available by the end of July 2024.

67

Updated June 2024



Actions continued:
- DTVF People Partners to work with the services in each of their areas to develop sickness support plans by the end of June 2024. **(Not Completed)** People Partners have a draft sickness absence support plan which they are sharing with services to agree a specific plan by the 1st August 2024.
- Principle People Partners to monitor causes of long-term sickness to identify the impact of organisational processes. Initial investigations will be completed by the end of June 2024. **(Not completed)** Monitoring processes have been established to enable analysis from 1st August 2024. Initial draft will be completed by the 31st August 2024.

20) Percentage compliance with ALL mandatory and statutory training

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

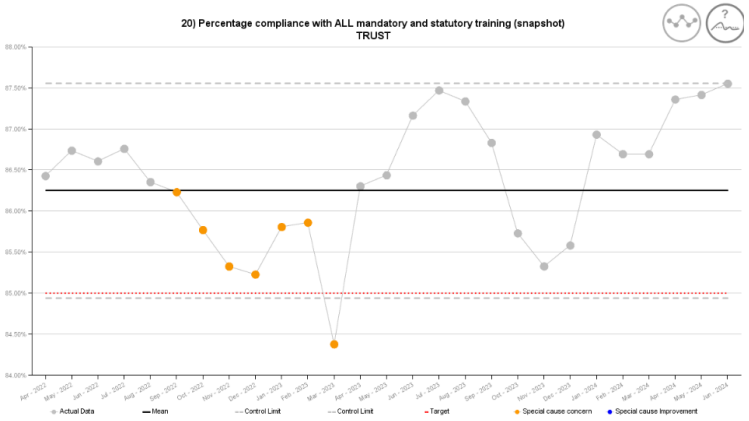
What does the chart show/context:
180,012 training courses were due to be completed for all staff in post by the end of June. Of those, **157,605 (87.55%)** were completed.

There is no significant change at Trust level and for most areas in the reporting period, with several areas showing special cause improvement: Assistant Chief Executive, Company Secretary, Digital & Data Services, North Yorkshire, York & Selby Care Group, Nursing & Governance, People & Culture, ALD, CYP, H&J, MHSOP and SIS in Durham, Tees Valley & Forensic Care Group and ALD, CYP and MHSOP in North Yorkshire, York & Selby Care Group.

As at the 30th June 2024, only Nursing and Governance are below the 85% standard (1658 compliant from 1954 – 84.85%).

Underlying issues:
- Staff unable to be released to attend training (high DNA rate)
- Lack of capacity for Positive & Safe training courses
- Lack of suitable training rooms
- Misalignment of competencies and staff on ESR
- There are currently 20 training courses with compliance below 85%

Actions:
- Training Department are actively following up all staff who DNA
- The training portfolio for Positive & Safe has been reviewed in line with capacity and demand and the Trust Welcome. Implementation date end of September 2024.
- We are constantly reviewing the availability of training rooms across trust premises. Refurbishment work is to be undertaken at Flatts Lane to provide increased space for Positive & Safe Training . This will be completed by the end of July 2024. During this time, all training scheduled at Flatts Lane has been moved to an external venue.
- Workstreams have been agreed following the Quality Improvement Event to review Mandatory Training requirements – implementation date end of September 2024.
- We will now focus on the lowest 5 compliance level (as indicated overleaf) by identifying SMART actions at the EDG monthly “Walk the Wall” in July 2024.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

Mandatory and statutory training

As at the 30th June 2024, by exception compliance levels below 85% are as follows for the following courses sorted by lowest performance:

	Number Compliant	Total Number	% Compliant
1) Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year*	377	886	42.55%
2) Positive and Safe Care Level 2 Update*	1023	1675	61.07%
3) Resuscitation - Level 1 - 1 Year*	1615	2505	64.47%
4) Positive & Safe Care Level 1*	2963	4343	68.22%
5) Resuscitation - Level 2 - Adult Basic Life Support - 1 Year*	1513	2088	72.46%
6) Face to Face Medication Assessment	1669	2291	72.85%
7) Rapid Tranquilisation 1	210	284	73.94%
8) Medicines Management Annual Module	470	627	74.96%
9) Moving and Handling - Level 2 - 2 Years*	715	927	77.13%
10) Safe Prescribing	215	274	78.47%
11) Fire Safety - 2 Years**	6246	7853	79.54%
12) Annual Medicines Optimisation Module	1776	2205	80.54%
13) Patient Safety Level 2	4705	5806	81.04%
14) Safeguarding Level 3**	3201	3925	81.55%
15) Mental Health Act Level 2	3146	3851	81.69%
16) Infection Prevention and Control - Level 2 - 1 Year	5015	6091	82.33%
17) Rapid Tranquilisation 2	492	588	83.67%
18) MCA - MCA and Young People Aged 16/17	721	858	84.03%
19) MCA - Restraint	3446	4083	84.40%
20) MCA - Relationship Between MCA and MHA	3452	4083	84.55%

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

Please note: *From 1st April 24 –Immediate Life Support (ILS) becomes the require competency for Inpatient Registered Nurses.*

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
Of the **6,779** eligible staff in post at the end of June; 5,941 (87.64%)had an up-to-date appraisal.

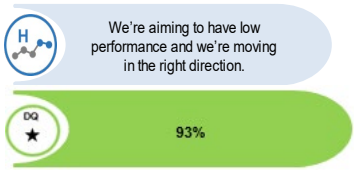
There is special cause improvement at Trust level and for several areas in the reporting period: Company Secretary, Digital & Data Services, Durham, Tees Valley & Forensic Care Group, North Yorkshire York & Selby Care Group, Nursing & Governance, People & Culture, all specialties with the exception of H&J within DTVF, and ALD and MHSOP within NYYS. Whilst there is no significant change, a decreasing trend is visible for Estates & Facilities Management.

As at the 30th June 2024, by exception compliance levels below 85% are as follows:

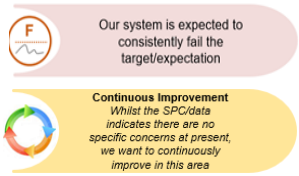
	Number Compliant	Total Number	% Compliant
1) THERAPIES	29	39	74.36%
2) FINANCE	38	49	77.55%
3) NORTH YORKSHIRE, YORK AND SELBY	1341	1581	84.82%

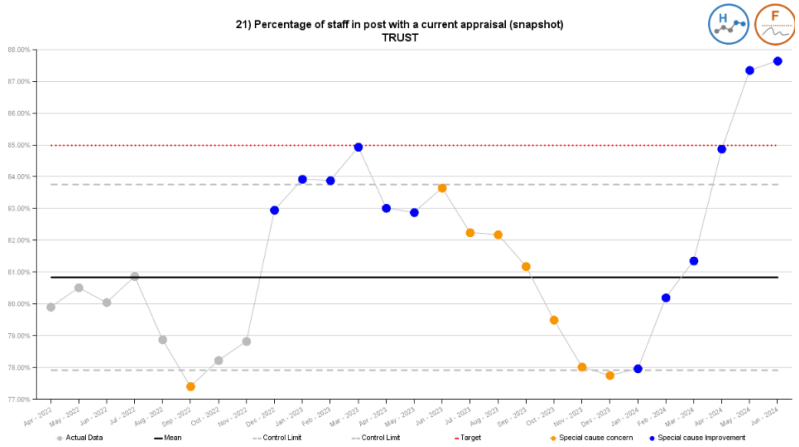
Underlying issues:
- Some supervisors are not correctly recording appraisals on ESR
- Staff Sickness of both staff and managers
- Staff not being aligned correctly on ESR

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



Updated June 2024





Actions continued:
- Actions in the revised PIP include ensuring outstanding appraisals are booked in, ensuring all appraisals are recorded on the Electronic Staff Record (ESR), establishing weekly monitoring, training to be provided to supervisors where appropriate/required to ensure appraisals are reported correctly, and ensuring that any staff aligned to incorrect teams are addressed with Workforce and Finance. All actions should be completed by the end of July 2024 with 85% compliance achieved in all directorates from July (August report). A request to stand down the PIP following sustained improvement in performance has been submitted to EDG.

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
7,334 patients referred in June that are not currently open to an existing Trust service.

There is no significant change at Trust/Care Group level in the reporting period; however, we are showing a number of unexpected level of variation. There are shifts of low referrals for Adult Learning Disabilities, Children & Young Peoples Services and Health & Justice within Durham Tees Valley & Forensic Care Group and a continued shift of high referrals for Children & Young People Services within North Yorkshire, York & Selby Care Group.

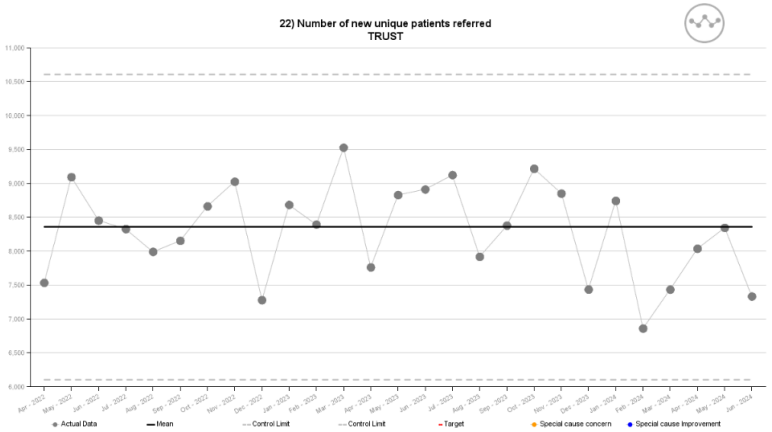
Underlying issues:
Whilst there is an unexpected level of variation shown for a number of areas, the Care Groups have confirmed there are no underlying issues to report.

Actions:
There are no specific improvement actions required

No significant change in the data during the reporting period shown

DQ ★ 93%

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



23) Unique Caseload (snapshot)

Tees, Esk and Wear Valleys NHS Foundation Trust

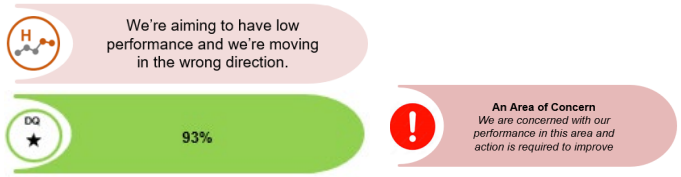
What does the chart show/context:
67,887 cases were open, including those waiting to be seen, as at the end of June 2024.

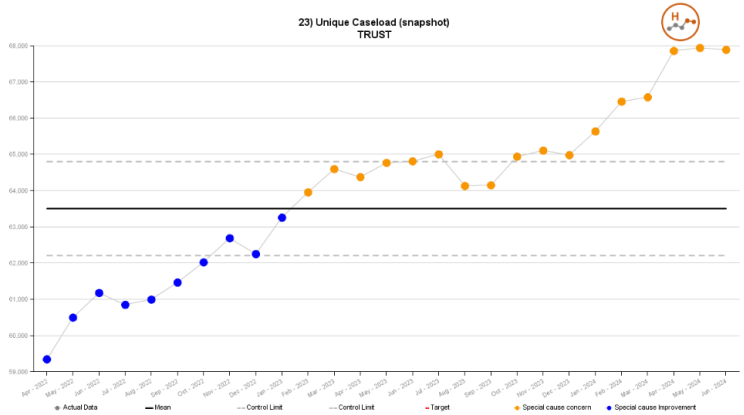
There is special cause concern at Trust and for Durham, Tees Valley & Forensic Care Group in the reporting period (including in ALD, AMH, CYP, H&J and SIS and in MHSOP within North Yorkshire, York & Selby Care Group). There is no significant change for North Yorkshire, York & Selby Care Group. It should be noted there is special cause improvement in MHSOP within Durham, Tees Valley & Forensic Care Group and ALD in North Yorkshire, York & Selby Care Group.

However, we know from the detailed analysis undertaken and reported to EDG in May 2024 that this is impacted by the increase in patients **waiting** for a first contact.

Underlying issues:
- We have had an 83% increase in the number of children and young people waiting for neurodevelopmental assessment between May 2022 and June 2024. There has also been an increase in AMH services within DDTVFCG. We have approximately 20k neuro diverse patients waiting to be seen which equates to 30% of the caseload.

Actions:
- DTVFCG CYPS are developing a Recovery Plan to address the long waiting times within CYPS Neurodevelopmental teams (this will replace the original PIP); which will need system-wide support.
- The remaining action within the PIP for AMH services was to implement a revised assessment process within Sedgefield teams for ADHD and ASD pathways working with Primary Care colleagues. It was anticipated this would increase assessment and reduce 80% of referrals coming into intervention teams by June 2024. **(Completed)** The implementation is slower than anticipated and visible impact is expected by the end of September 2024 (October report). The focused deep dive on AMH active caseload will be completed by end of August 24, which will inform further PIP actions.
- NYYSCG CYPS have completed the two identified pieces of work that were required before being able to identify SMART actions; a full day event will be held in July 2024 to agree the next steps.
- The HNY ICB is leading a Memory Re-Design Event 22-24 April 2024. **(Completed)** Outputs from this event are expected from the ICB in September following engagement with key partners.





Actions continued:
- Corporately, a series of focused deep dives will be undertaken to better understand any other areas of concern. The first deep dive will focus on CYP services and will be completed by the end of August 2024. Findings will be shared with EDG in September 2024.

24) Financial Plan: SOCI – Financial Performance – (Surplus)/Deficit

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

The financial position to 30th June 2024 is a deficit position of **£0.650m which amounts to a £0.146m favourable variance against plan**. The Trust submitted a final breakeven plan in a national submission on 12th June 2024. Plans for 2024/25 assume delivery of challenging 4.5% or £21.78m Cash Releasing Efficiency Scheme (CRES) Plans to achieve this.

- **Agency expenditure** in the period ending 30th June 2024 was £3.04m, which is £0.23m below plan. The value in June was £0.94m and is slightly below the previous month's run rates. Plans for 2024/25 assume agency costs are below the national cap of 3.2% of paybill. A reducing run rate trend since April 2023 reflects sustained impacts from actions to exit non-clinical agency assignments, reducing costs relating to complex care packages for a small number of adults with a learning disability, and reduced inpatient agency headcount. Ongoing usage includes high premia rate locum costs for cover of medical vacancies, residual inpatient agency headcount including linked to occupancy and acuity, and costs within Health and Justice. The trust had **no off-framework agency assignments** in month.
- **Independent sector beds** - the Trust used 86 non-Trust bed days in month (33 in May) which represented a increase of 53 bed days from the previous month and cost £0.96m (£0.311m year to date) including estimates for unvalidated periods of occupancy and average observation levels pending billing. The YTD expenditure includes a prudent assumption that Trust will be responsible for a patient in NYYS, however this is not included in the bed days. This remains a key area of volatility, and consequently clinical and management focus including through the Urgent Care Programme Board (chaired by the Managing Director for DTVF) is required. Bed pressures, including from elevated numbers of those who are clinically ready for discharge, mean that sustaining low (and delivering nil targeted) independent sectors bed utilisation remains very challenging.
- **Taxis and Secure Patient Transport** costs were £0.654m in the period ending 30th June compared to 2023/24 run rate based planned costs of £0.535m, a £119k adverse variance to plan. (Annual costs for 2023/24 were £2.675m, which was £1.0m higher than plan, and equated to a monthly average run rate of £223k). As 2024/25 is based on 2023/24 actual this shows a consistently increasing use of transport. A quality improvement event was held in 2023 which recommended grip and control actions and development of a new policy. Results remain subject to review and oversight due to limited sustained impact**.** The Chief Nurse is overseeing actions to ensure robust governance around Secure Transport and a procurement is expected to reduce unit costs in 2024/25.
- 2024/25 plans assume delivery of 4.5% £21.78m **Cash Releasing Efficiency Savings (CRES)** for the year, with £15.7m being recurrent and £6.055m non–recurrent (including costs of £1.485m reducing the in-year benefit from recurrent CRES). Currently £2.06m of the non-recurrent target remains unidentified. So far YTD CRES is £0.498m behind plan, with recurrent being £0.621m behind plan and non recurrent being £0.123m ahead of plan.

F — Our system is not hitting the target/expectation

DQ ★ — 93%

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

24) Financial Plan: SOCI – Financial Performance – (Surplus)/Deficit

Underlying issues:

- We need to reduce bed occupancy including through reduced lengths of stay to reduce reliance on independent sector beds. This will require support from local authority system partners, including due to rising and sustained high levels of patients who are clinically ready for discharge.
- We recognise that agency expenditure and safe staffing levels are significantly impacting our financial plan due to numbers of staffing above funded levels and including agency premia rates (including some above price cap).
- We need to deliver CRES schemes to achieve our financial plan and deliver recurrent programmes to address our underlying financial pressures.

Actions:

- Please see actions within measures 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider.
- The revised PIP for e-Roster effectiveness focuses on having 80% of rotas published in line with the Trust target and 80% of teams achieving target for annual leave level loading by the 1st July 2024. We have achieved 83% of rotas published which is better than the Trust target of 80%. However, the action on annual leave level loading has not been completed and an extension has been requested from EDG.
- Following discussion with Executive Directors the Agency Reduction PIP has been revised and has been submitted to EDG for approval. Actions include; the cessation of paying accommodation costs for 6 agency workers; identifying agency usage for each DTVFCG service with a view to stopping the outsourcing to agency within those services with less than 10 shifts filled in a 6-week period; targeted internal recruitment; and reviewing the outsourcing timeframes. All actions to be completed by the 30th September 2024. An additional action to re-negotiate rates of pay with framework agencies for Health & Justice registered nurses and all new H&J registered nurses onboarded to be within cap rates will be completed in a phased approached, by the 31st January 2025.
- Terms of Reference for an Efficiency Hub have been agreed and is now in place to oversee delivery of CRES and to provide support to Care Groups / Directorates, however PMO support has not yet been identified.
- In addition to delivery of identified in year CRES, the Efficiency Hub will provide support to enable focus on key strategic financial recovery actions including to manage and reduce over-establishments, track benefits from International Recruitment, ensure the efficient rostering of inpatient staffing and linked to inpatient occupancy, flow and Out of Area Placements. It will also support the transformation programmes to identify and realise associated benefit.
- Information on workforce spend (both financial and WTE) has been enhanced and will be available for all relevant managers to view and analyse in terms of driving efficiency.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

YTD agency expenditure of £3.04m is £0.23m below plan. Month 3 expenditure of £0.94m is £114k below plan. NHS planning guidance for 2023/24 introduced system agency cost caps of 3.70% pay bill, reducing to 3.2% pay bill for the 2024/25 financial year. YTD actual agency costs are 3.07% of pay bill, having reduced from around 4.5% on average through 2023/24 and 6% on average through 2022/23.

Reducing agency shifts and premia paid above national price caps remains a key focus. The Trust has achieved agency reductions equivalent to 125 worked Whole Time Equivalent (WTE) from April 2023 (240 worked WTE) to May 2024 (115 worked WTE), and the related annualised premia has reduced from £4.9m in March 2023 to £3.1m in May 2024 (£1.0m reduction), demonstrating a positive impact from actions taken to date and the benefit from sustained focus, including through framework usage and WTE reduced reliance.

The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to management of sickness absence, but equally to net new recruitment (including to medical, qualified nursing, inpatient, and health and justice hot spots) and securing alternative whole system models of care for specialist adult learning disability packages of care and reducing occupancy linked to increasing levels of patients who are clinically ready for discharge and require support to effect discharge.

We recognise that volume pressures and rate premia associated with agency expenditure are significantly impacting our financial plan. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance (Please see measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit).

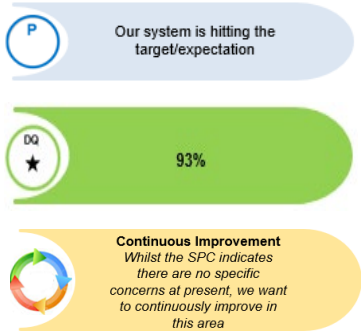
Underlying issues:

We need to continue to ensure a sustainable permanent workforce, including in key shortage professions including medical and nursing, to tackle high occupancy levels in inpatient wards (including with system collaboration) and to use temporary staffing more optimally including through improved rostering and regularly reviewing our safer staffing levels relative to clinical need.

Actions:

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

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



25b) Agency price cap compliance

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

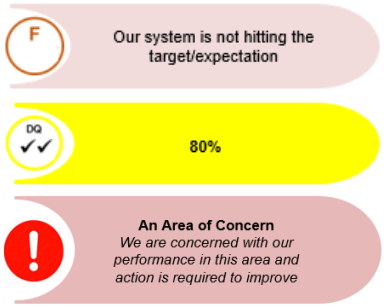
2,206 agency shifts were worked in June 2024, with **1,389 shifts compliant (63%)** and 817 non-compliant (37%) (prior month 1,432 shifts compliant or 63% and 819 non-compliant or 37%) **with national price caps**.

There were **45 fewer overall shifts worked this month** compared to last, with shifts worked being equivalent to **approximately 74 shifts per day** (73 shifts per day in May).

- The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to management of sickness absence but equally to net new recruitment (including to medical, qualified nursing, inpatient, and health and justice hot spots) and securing alternative whole system models of care for specialist adult learning disability packages of care and reducing occupancy linked to increasing levels of patients who are clinically ready for discharge and require support to effect discharge. Other key areas of focus include actions to ensure optimal roster efficiency.
- Further refinement of shift data relating to the above takes place up to the point that NHSE Temporary Staffing data is submitted mid-month, which may result in minor differences between reported data.
- We recognise that volume pressures and rate premia associated with agency expenditure are significantly impacting our financial plan. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance (Please see measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit).

Underlying issues:
Particular persistent challenges relate to levels of medical staffing vacancies requiring cover from premia rate locum assignments which breach price caps.

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



26) Use of Resources Rating - overall score

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

The overall rating for the trust is a **2** for the period ending 30th June.
The **Use of Resources Rating** (UoRR) was impacted by Covid-19 with national monitoring suspended. The Trust has continued to assess the UoRR based on plan submissions compared to actual performance.

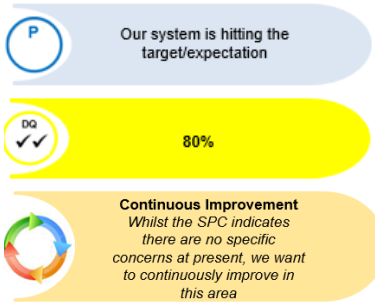
- The **capital service capacity metric** assesses the level of operating surplus generated, to ensure Trusts can cover all debt repayments due in the reporting period. The Trust has a capital service capacity rating of **3**.
- The **liquidity metric** assesses the number of days' operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric is rated as **1.**
- The Income and Expenditure **(I&E) margin metric** assesses the level of surplus or deficit against turnover. The Trust has an I&E margin of -0.59% which is a **rating of 3**.
- The Income and Expenditure **(I&E)** margin distance from plan is 0.6% which is a **rating of 1.**
- **The agency expenditure metric** assesses agency expenditure against a 3.2% cap (set by NHSE) on agency spend as a proportion of pay. Costs of £3.04m below plan and would be **rated as a 1.** The Trust's year to date agency costs were 3.07% of pay bill.

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

The Trust's financial performance results in an **overall UORR** of **2** for the period ending 30th June.

Underlying issues:
There are no additional underlying issues to report. As recovery actions are identified to support delivery of the Trust's planned breakeven position and improved agency compliance are targeted and progressed these will support achievement of the associated individual UoRR metrics and overall UoRR rating.

Actions:
There are no specific improvement actions required.



27) Cash Releasing Efficiency Savings (CRES) Performance - Recurrent

Tees, Esk and Wear Valleys NHS Foundation Trust

Update:

Recurrent CRES performance for the period ending 30th June was £4.10m which was below plan by 0.62m. 2024/25 financial plans assume delivery of 4.5% £21.78m Cash Releasing Efficiency Savings for the year. We plan to deliver **£15.7m recurrent** Cash-Releasing Efficiency Savings (CRES) for the year.

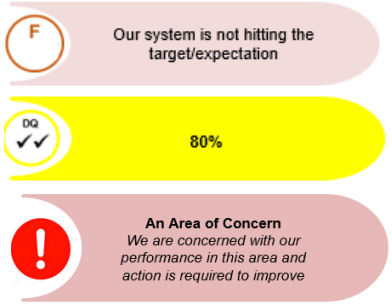
Following the submission of our financial plan, confirmed recurrent CRES plan key areas include:

- **Pay schemes** include actions to sustain Agency reductions in Inpatient and other clinical areas including from improved rostering, recruitment (including International), to aim to reduce Medical Locum (high premia rate) usage and to address over spending due to over establishments in both Care Groups.
- **Non Pay schemes** including actions to eliminate Independent Sector bed reliance by Quarter 4 as well as savings from LED Light installation, IT licences, mobile phones, printing, the appraisal system and Taxi usage.

- The Over Establishment Target (inc Surge) has overperformed YTD by £0.13m. However this is being offset by schemes that are underperforming such as International Nurse recruitment (behind by £0.28m) and MHSOP permitted expenditure - agency reduction (behind by £0.12m).

Underlying issues:
We need to deliver recurrent CRES schemes to achieve our in-year financial plan and improve our underlying financial sustainability. Delivery of CRES non-recurrently increases the CRES requirement the following year.

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



28) Cash Releasing Efficiency Savings (CRES) Performance – Non-Recurrent

Tees, Esk and Wear Valleys NHS Foundation Trust

Update:
Non Recurrent CRES performance was reported as being ahead of plan by £0.12m for the period ending 30th June, with £0.52m being achieved.

2024/25 plans assume delivery of 4.5% £21.78m Cash Releasing Efficiency Savings for the year.

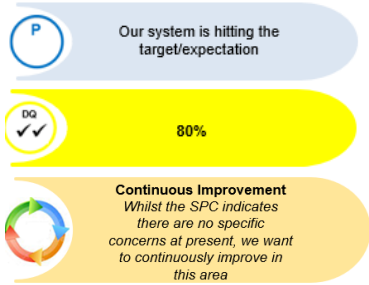
We plan to deliver **£6.055m of non-recurrent** Cash-Releasing Efficiency Savings (CRES) for the year.

£4.0m of non-recurrent CRES have been identified in the plan, but with a residual £2.055m remaining unidentified presently and a key focus.

The overachievement YTD of £123k is due to substantive underspend on MHSOP in NYYS which is mitigating under delivery on the recurrent agency CRES scheme.

Underlying issues:
It has been essential to target non-recurrent CRES to aim to target a broadly break even plan, however reliance on non-recurrent schemes leave an underlying unmitigated financial challenge moving ahead beyond 2024/25.

Actions:
Financial Planning activities will confirm the extent to which the same actions can be delivered recurrently (or non-recurrently) and any other scope to deliver new non-recurrent CRES in 2025/26 to mitigate underlying financial pressures.



29) Capital Expenditure (Capital Allocation)

Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:

Capital expenditure was **£2.1m** at the end of June and **marginally behind allocation**.

£8.5m 2024/25 capital schemes have been approved for funding from nationally allocated capital delegated via North East and North Cumbria Integrated Care Board (ICB).

The Trust has secured £1.8m of additional cash-backed central funding in 2024/25 to improve Information systems and assist creating our Mental Health hub in North Yorkshire. This is not included in performance measurement against the £8.5m capital allocated to the Trust through North East and North Cumbria ICB.

This means the Trust's **aggregate capital programme for 2024/25 is £10.7m**.

Underlying issues:
There are no underlying issues to report in year, however reducing liquidity and the availability of Trust cash and increasingly constrained national and regional capital allocations relative to need are of concern going forward.

Actions:
A key focus is on the milestone tracking of Programmes, including for sensor door installation and the procurement for phase 2 rectification works at Roseberry Park. Any anticipated delays to planned inpatient environment schemes are communicated to the Environmental Risk Group to manage any associated risks.

30) Cash balances (actual compared to plan)

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:

The Trust had cash balances of **£58.49m** at the end of June 2024 against a planned cash balance of **£55.14m** which was a **£3.36m positive variance** to plan.

- This was mainly due to capital payables and deferred income balances being higher than planned and debtor balances being lover than planned but is expected outturn in line with plan for 2024/25.
- The Trust has narrowly failed to achieve the 95.0% Better Payment Practice Code (BPPC) target compliance for the prompt payment suppliers, achieving a combined year to date BPPC of 94.9%. We continue to support the use of Cardea to make processes as efficient as possible, and to ensure suppliers are paid promptly.
- The value of debt outstanding as at 30th June 2024 was £1.86m, with debts exceeding 90 days amounting to £0.38m (excluding amounts being paid via instalments and PIPS loan repayments) Three public sector organisations account for £0.30m of debt exceeding 90 days overdue. Progress continues to be made to receive payment for older debts. No outstanding debts have been formally challenged.

Underlying issues:

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

Actions:

See actions at measure 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit.

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	Measure	Goal 1 - To Co-Create a great experience for our patients, carers and families	Goal 2 - To Co-Create a great Experience for our Colleagues	Goal 3 - To be a great partner
1	Percentage of Patients surveyed reporting their recent experience as very good or good	√	√	
2	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	√	√	
3	Percentage of inpatients reporting that they feel safe whilst in our care	√	√	
4	Percentage of CYP showing measurable improvement following treatment - patient reported	√		
5	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	√		
6	Percentage of CYP showing measurable improvement following treatment - clinician reported	√	√	
7	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	√	√	
8	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	√	√	√
9	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider	√		
10	The number of Patient Safety Incident Investigations reported on STEIS	√	√	
11	The number of Incidents of moderate or severe harm	√		
12	The number of Restrictive Intervention Used	√	√	
13	The number of Medication Errors with a severity of moderate harm and above	√		
14	The number of unexpected Inpatient unnatural deaths reported on STEIS	√		√
15	The number of uses of the Mental Health Act	√		
16	Percentage of staff recommending the Trust as a place to work	√	√	√
17	Percentage of staff feeling they are able to make improvements happen in their area of work	√	√	√
18	Staff Leaver Rate	√	√	√
19	Percentage Sickness Absence Rate	√	√	√
20	Percentage compliance with ALL mandatory and statutory training	√	√	√
21	Percentage of staff in post with a current appraisal	√	√	√
22	Number of new unique patients referred	√	√	√
23	Unique Caseload (snapshot)	√	√	
24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit			
25	Financial Plan: Agency expenditure compared to agency target			
26	Agency price cap compliance			
27	Use of Resources Rating - overall score			
28	CRES Performance - Recurrent			
29	CRES Performance - Non-Recurrent			
30	Capital Expenditure (CDEL)			
31	Cash balances (actual compared to plan)			

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	Measure	1. Safe Staffing	2. Demand	3. Co-Creation	4. Quality of Care	5. Digital	6. Estate / Physical	7. Cyber Security	8. Quality Governance	9. Partnerships and System	10.Regulatory compliance	11. Roseberry Park	12. Financial Sustainability	13. Public confidence
1	Percentage of Patients surveyed reporting their recent experience as very good or good	√	√	√	√									√
2	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	√		√	√									√
3	Percentage of inpatients reporting that they feel safe whilst in our care	√		√	√									√
4	Percentage of CYP showing measurable improvement following treatment - patient reported	√	√		√	√			√	√			√	√
5	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	√	√		√	√			√	√			√	√
6	Percentage of CYP showing measurable improvement following treatment - clinician reported	√	√		√	√			√	√			√	√
7	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	√	√		√	√			√	√			√	√
8	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	√	√		√				√				√	√
9	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider	√	√		√				√				√	√
10	The number of Patient Safety Incident Investigations reported on STEIS	√		√	√		√				√			√
11	The number of Incidents of moderate or severe harm	√		√	√				√		√			√
12	The number of Restrictive Intervention Used	√		√	√		√				√			√
13	The number of Medication Errors with a severity of moderate harm and above	√			√	√			√		√			√
14	The number of unexpected Inpatient unnatural deaths reported on STEIS	√		√	√		√			√	√			√
15	The number of uses of the Mental Health Act	√	√						√	√	√			
16	Percentage of staff recommending the Trust as a place to work	√	√				√		√	√	√			√
17	Percentage of staff feeling they are able to make improvements happen in their area of work	√		√					√	√	√			√
18	Staff Leaver Rate	√							√		√		√	√
19	Percentage Sickness Absence Rate	√	√								√		√	√
20	Percentage compliance with ALL mandatory and statutory training	√			√			√	√	√	√		√	√
21	Percentage of staff in post with a current appraisal	√			√				√		√			√
22	Number of new unique patients referred		√		√				√	√	√		√	√
23	Unique Caseload (snapshot)	√	√		√				√	√	√		√	√
24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit					√		√	√		√	√	√	
25	Financial Plan: Agency expenditure compared to agency target	√	√		√				√		√		√	
26	Agency price cap compliance	√							√		√		√	
27	Use of Resources Rating - overall score	√	√		√				√		√		√	
28	CRES Performance - Recurrent	√	√				√		√		√		√	
29	CRES Performance - Non-Recurrent								√		√		√	
30	Capital Expenditure (CDEL)					√	√		√		√	√	√	
31	Cash balances (actual compared to plan)					√	√				√	√	√	

National Quality Standards and Mental Health Priorities Headlines

Headlines

- **72 hour follow up** failed target in all areas.
- **EIP waiting times** failed target in County Durham and Vale of York.
- **Talking Therapies waiting times (6 and 18 weeks)** achieved target in all areas.
- **Child Eating Disorders waiting times** failed target in all areas except for North Yorkshire (urgent cases).
- **Talking Therapies: 1st to 2nd treatment waits** – failed target in all areas except for North Yorkshire. **Reliable Recovery –** achieved in all areas except for County Durham. **Reliable Improvement –** failed target in County Durham & Tees Valley.
- **Children: 1 contact -** failed target in all areas. **Paired Outcomes -** failed target in all areas.
- **Access to transformed community services** failed target in all areas except Tees Valley where we do not yet have fully Transformed services.
- **Active OAP (inappropriate)** achieved plan in both ICB areas.
- **Specialist Community Perinatal Mental Health (PMH) services** failed target in North Yorkshire and Vale of York

Risks / Issues

Of most concern:

- 72 hour follow up*
- Child Eating Disorders Waiting Times (except North Yorkshire urgent cases)
- Talking Therapies 1st to 2nd treatment (except North Yorkshire)
- CYP 1 contact (except Tees Valley)
- Childrens Paired Outcomes (except North Yorkshire)
- Access to transformed community services (except Tees Valley)

Of concern:

- EIP Waiting Times (County Durham and Vale of York)
- Talking Therapies Reliable Improvement (County Durham and Tees Valley)
- Specialist Community PMH services (North Yorkshire & Vale of York)

This measure has been impacted following the implementation of Cito. A comprehensive validation has been undertaken on data for April and May to ensure that we can accurately demonstrate that our patients are safe and are receiving the quality of care that we would endeavour to deliver; that confirms we achieved target in those months. Work is currently in progress to validate June data.

Positive Assurance

- Talking Therapies waiting times (6 and 18 weeks)
- Active OAPs (inappropriate)

National Quality Standards and Mental Health Priorities Headlines

Mitigations

Child Eating Disorders waiting times
DTVFCG had one outstanding PIP action to ensure the patient tracker is fully utilised and data quality is corrected in a timely manner going forward; this has been completed and no data quality issues have been recorded in June. In relation to NYYSCG the underlying issue was Patient Choice. Non-attendance is managed through engagement with patients/families in line with the DNA policy.

Talking Therapies 1st to 2nd treatment waits
DTVFCG have one outstanding PIP action which is to review the suitability criteria with GPs and secondary care services to ensure patients are referred to the correct service for their needs; it is anticipated that by September 2024 there will be no patients on caseloads that are not appropriate for service (previous timescale of August 2024 was an error). NYYSCG have a PIP with an action to temporarily increase capacity through overtime which will reduce the wait between first and second appointment; the full impact visible by the end of November (December report). Professional development training to prevent patients being mis-diagnosed with social phobia and reduce the step 3 waiting list by 30% by the end of September 2024 (October report) has been delivered.

CYP 1 contact
Following 3 successive months' not achieving target, we are recommending the development of PIPs for County Durham (5% from target), North Yorkshire (11% from target) and Vale of York (6% from target) Sub-ICB Locations. Deep dives are to be completed by the end of July 2024 to inform the development of these.

Childrens Paired Outcomes
Whilst NHS England Policy Team have acknowledged the construction of this measure does not fit all service models (including those within the Trust), following 3 successive months' not achieving target, we are recommending the development of PIPs for County Durham (24% from target) and Tees Valley (15% from target) Sub-ICB Locations. Deep dives are to be completed by the end of July 2024, to inform the development of these.

Access to transformed community services
Following 3 successive months' not achieving target, we are recommending the development of PIPs for County Durham (6% from target), North Yorkshire (8% from target) and Vale of York (5% from target) Sub-ICB Locations. Deep dives are to be completed by the end of July 2024, to inform the development of these.

EIP waiting times
NYYSCG have recruited to all 4 posts, two of which are preceptorship roles, start dates July 2024. The service is continuing to recruit temporary staff in the interim to support improvement in waiting times and have a recovery plan in place. DTVFCG have recruited to 2 posts within the Durham team; one member of staff has commenced their appointment in June, the second member of staff will start in July. However, given the current level of performance we are recommending the development of a PIP for DTVFG.

Talking Therapies Reliable Improvement
Following 3 successive months' not achieving target, we are recommending the development of PIPs for County Durham (3% from target) and Tees Valley (3% from target) Sub-ICB Locations. Deep dives are to be completed by the end of July 2024, to inform the development of these.

Specialist Perinatal Mental Health
NYYSCG have developed a PIP and the actions are to recruit to the vacant posts and to develop standardised triage criteria to ensure all appropriate woman are accepted onto caseload. It is anticipated the impact of these actions will increase the number of women accessing services and achievement of standard by end of January 2025. Pending this, a demand and capacity deep dive has commenced for assurance no further actions are required.

National Quality Standards and Mental Health Priorities Dashboard

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

National Quality Requirements

Measure	Agreed S-ICBL Plan	Trust					County Durham					Tees Valley					North Yorkshire					Vale of York				
		Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD
Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care	80%	63.93%				63.93%	56.78%				56.78%	65.48%				65.48%	67.91%				67.91%	72.97%				72.97%
Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care	60%	54.12%				54.12%	41.38%				41.38%	61.54%				61.54%	72.00%				72.00%	45.45%				45.45%
Percentage of Service Users referred to an NHS Talking Therapies programme who wait six weeks or less from referral to entering a course of NHS Talking Therapies treatment	75%	99.73%				99.73%	99.81%				99.81%	99.66%				99.66%	99.56%				99.56%	99.77%				99.77%
Percentage of Service Users referred to an NHS Talking Therapies programme who wait 18 weeks or less from referral to entering a course of NHS Talking Therapies treatment	95%	99.99%				99.99%	100.00%				100.00%	100.00%				100.00%	100.00%				100.00%	99.94%				99.94%
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks (rolling 12 months)	95%	90.79%				90.79%	86.76%				86.76%	93.67%				93.67%	91.18%				91.18%	92.86%				92.86%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week (rolling 12 months)	95%	75.44%				75.44%	69.44%				69.44%	77.78%				77.78%	100.00%				100.00%	66.67%				66.67%

Local Quality Requirements

Measure	Agreed S-ICBL Plan	Trust					County Durham					Tees Valley					North Yorkshire					Vale of York				
		Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD
Talking Therapies:Percentage of people who have waited more than 90 days between first and second appointments	<10%	28.88%				28.88%	32.96%				32.96%	43.60%				43.60%	3.60%				3.60%	45.44%				45.44%
Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting caseness	48%	48.87%				48.87%	45.47%				45.47%	49.22%				49.22%	51.16%				51.16%	51.70%				51.70%
Talking Therapies: Reliable improvement rate for those completing a course of treatment	67%	67.36%				67.36%	64.25%				64.25%	64.17%				64.17%	69.51%				69.51%	71.22%				71.22%
Number of CYP aged 0-17 supported through NHS funded mental health with at least one contact (rolling 12 months)	*	28525				28525	9487				9487	11198				11198	3610				3610	4230				4230
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40.00%	22.68%				22.68%	16.35%				16.35%	24.94%				24.94%	33.03%				33.03%	23.27%				23.27%
Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses (rolling 12 months)	*	10685				10685	5444				5444	0				0	2322				2322	2919				2919
Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)	*	1				1	0				0	0				0	1				1	0				0
Number of women accessing specialist community PMH services in the reporting period (rolling 12 months)	*	1358				1358	521				521	487				487	185				185	165				165

NOTES ** Denotes individual plans agreed by area.*
Trust position represents total activity for commissioned services only (with the exception of Talking Therapies)

Tees, Esk and Wear Valleys NHS Foundation Trust

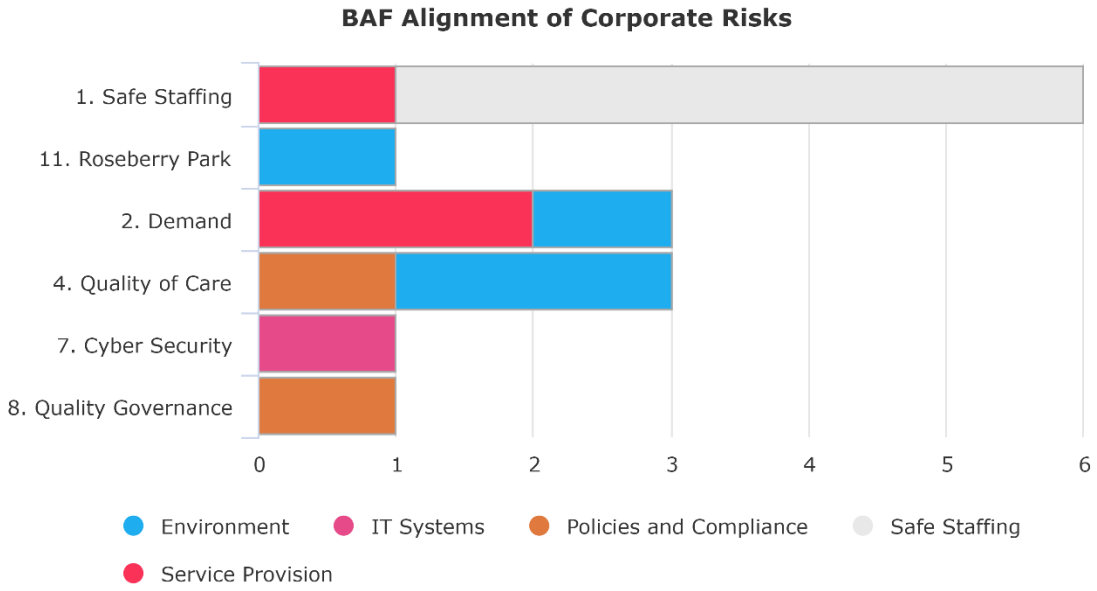
Meeting of:	**Board of Directors**
Date:	**08 August 2024**
Title:	**Corporate Risk Register**
Executive Sponsor(s):	**Beverley Murphy, Chief Nurse**
Author(s):	**Kendra Marley, Head of Risk Management**

Report for:				
	Assurance	✓	Decision	
	Consultation		Information	

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

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

Strategic Risks relating to this report:



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

Executive Summary:

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

Overview: This paper presents to the Exec groups/ Committee the risks that are rated ≥15 on the Corporate Risk Register as of 1st July 2024, reflecting any movement and changes since the last report in April 2024.

There are currently 15 risks on the Corporate Risk Register, this is a reduction of 1 risk.

The following risk was removed:

Aligned to Quality Assurance:

- Risk 1337 – N&G Quality governance – Risk of delays in reviewing serious incidents (reduced from 16 to 12)
    - Rationale for change - Likelihood reduced as the historical backlog is now down to 3 (from 127), and now allocating the review of PSII's (Patient Safety Incident Investigations) in a much more timely way, however there is still a significant number of cases under review and until these are complete and closed, this continues to create a capacity pressure.
    - Executive Risk Group review – The group discussion covered the historic and current position and recognised the improvement in local processes and governance, and the ongoing work to further strengthen these.

2 risks are below the ≥15 threshold for the Corporate Risk Register, the first 1327, Establishment of additional ECAs, and the second, risk 1311, Risk that the NY & Y Crisis team are not always able to cover the rota. The first has been reviewed at the Executive Risk Group, but a further review was requested to demonstrate and assure the group that the mitigation has reduced the risk to this level. The second is a recent reduction. Both will be reviewed in the July meeting of the Group to agree removal if appropriate.

One further risk was reduced, risk 860, risk of a successful cyber attack, but remains above the ≥15 threshold.

This Risk review compliance for corporate risks has dipped to 80% (previously 88%).

A summary breakdown for each committee is included at the end of the report, along with a summary of each risk. This summary outlines the key risks and indicates current assurance based on the risk register entry, completeness, control effectiveness and action progress. As this assessment is based on the risk register entry it is acknowledged that it may not reflect full progress made that has not been added. However, if we needed to provide the risk detail for assurance this is the reflected position. There is work to do to embed our improved processes and as such reasonable assurance is provided as we progress this.

Prior Consideration and Feedback	All risks are considered at service level governance. All risks are considered by the Care Group Risk Group/ Directorate. The Trust Executive Risk Group consider all risks rated as ≥15.

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

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

Further Information

1. Introduction and Purpose

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

2. Background Information and Context

The Trusts Organisational Risk Management Policy was approved by the Board in July 2022 and sets out the responsibilities of the Trust Board, its Committee's and Executive Sub-Groups.

3. Purpose of the Corporate Risk Register

The Corporate Risk Register should be reflective of the highest risks affecting the organisation in the delivery of its objectives. It should also enable the Board, Committee's and Executive Sub-Groups to easily understand the highest risks that they need to be aware of. Corporate risks are aligned to strategic risks reflected on the Board Assurance Framework.

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

4. Current Reporting Period

This paper presents to the Board the ≥15 risks on the Corporate Risk Register as of 1st July 2024, reflecting any movement and changes since April 2024.

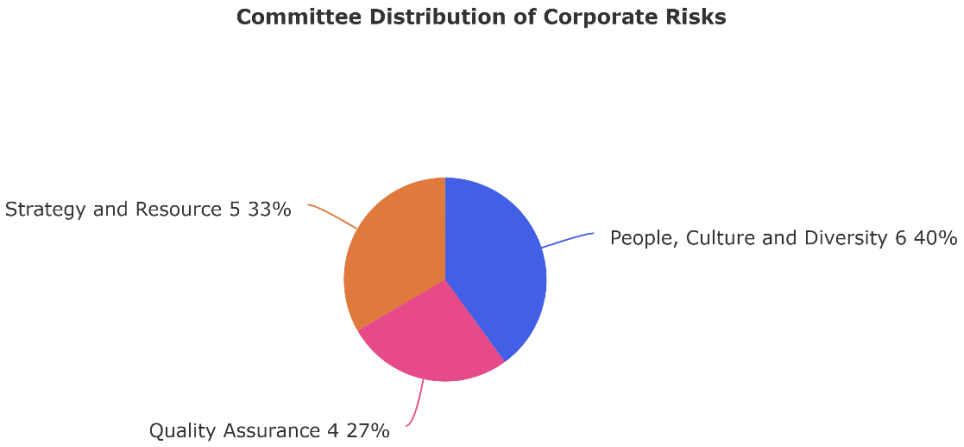
5. Corporate Risk Register

There are currently 15 risks on the Corporate Risk Register, this is a reduction of 1 risk.

There are 2 risks that have been reduced below the ≥15 threshold and await review by the Executive Risk Group this month.

5.1 Committee & Care Group Alignment

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



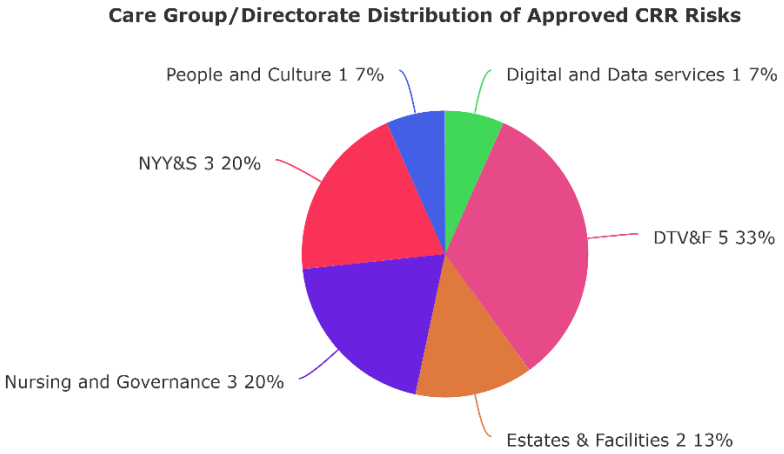
This shows that there are;

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

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

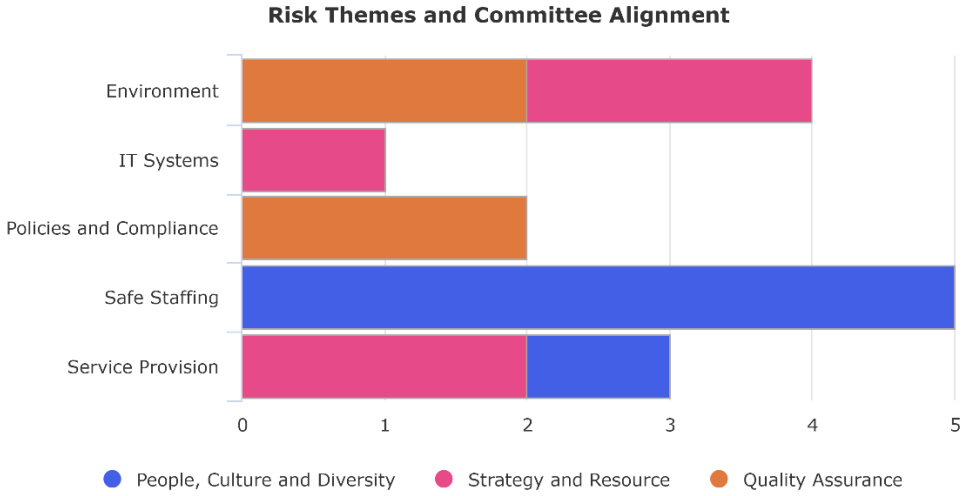
There are currently no risks aligning to the Mental Health Legislation Committee.

Focussing on the Care Group and Directorate breakdown of the Corporate Risk Register shows us that 33% of the current Corporate Risk Register is made up of risks from Durham Tees Valley and Forensics Care Group, with North Yorkshire, York Care Group and Nursing and Governance, 13% Estates and Facilities, with Digital and Data and People and Culture at 7%.



5.2 Risk Themes

The 15 risks fall under the following themes within the Committee Alignment, with higher numbers of risks relating to Safe Staffing and the Environment.



5.3 Risk Movements

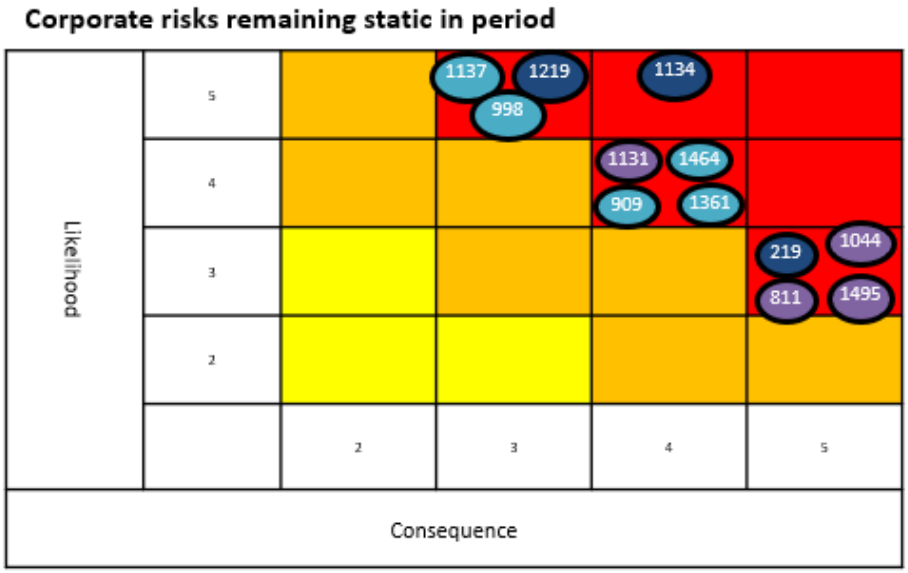
The overall position of risks on the Corporate Risk Register is shown on the following Matricies.

Outline – movement in period
- Black – static
- Green – reduced
- Red – increased

Inner colour Committee alignment
- Turquoise – People , Culture & Diversity
- Blue – Strategy & Resource
- Purple – Quality Assurance

Risks with no movement in the period

The 15 risks on the register remain static and are shown on the matrix below.

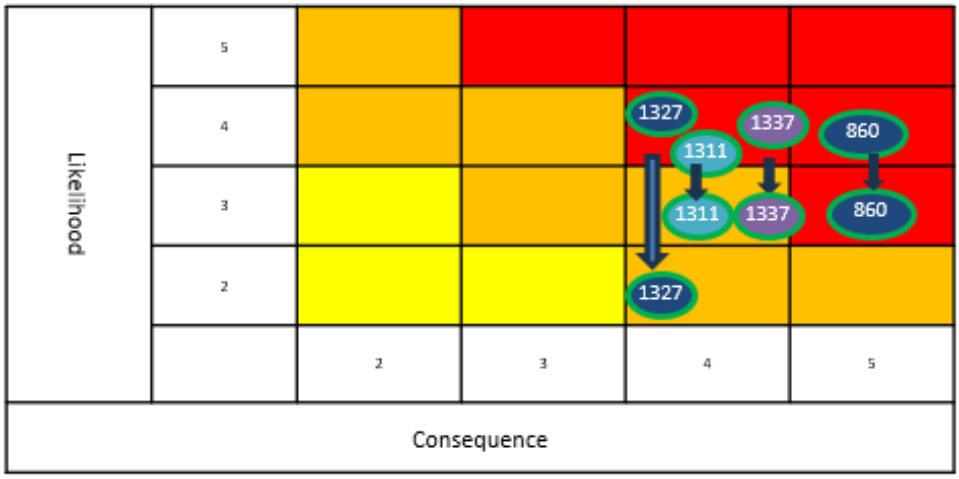


Risks are shown based on current risk rating

Timelines for mitigation to the target levels are shown on the attached risk register.

Risk Reduced and where applicable removed

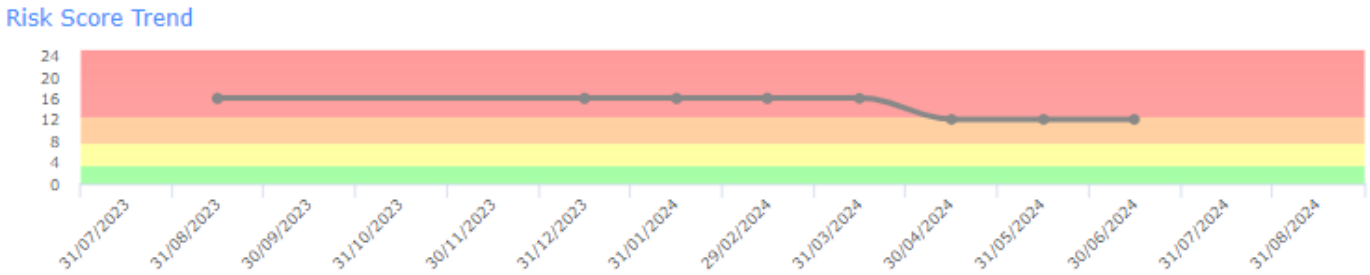
The 4 risks shown below have been reduced, with risk 1327 removed.



The risk that has been reduced below the ≥15 threshold and removed from the Corporate Risk Register is shown below.

Aligned to Quality Assurance:

- Risk 1337 – N&G Quality governance – Risk of delays in reviewing serious incidents (reduced from 16 to 12)

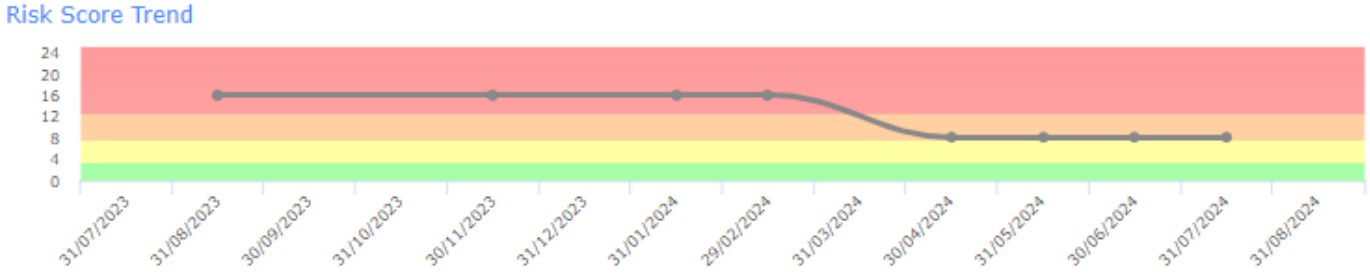


Rationale for change - Likelihood reduced as the historical backlog is now down to 3 (from 127), and now allocating the review of PSII's (Patient Safety Incident Investigations) in a much more timely way, however there is still a significant number of cases under review and until these are complete and closed, this continues to create a capacity pressure.

The 2 risks reduced below the ≥15 threshold but remaining on the register at the present time are shown below.

Aligned to Strategy and Resource:

- Risk 1327 - DTV&F SIS - Establishment of additional ECAs within existing environment and resource (Reduced from 16 to 8).

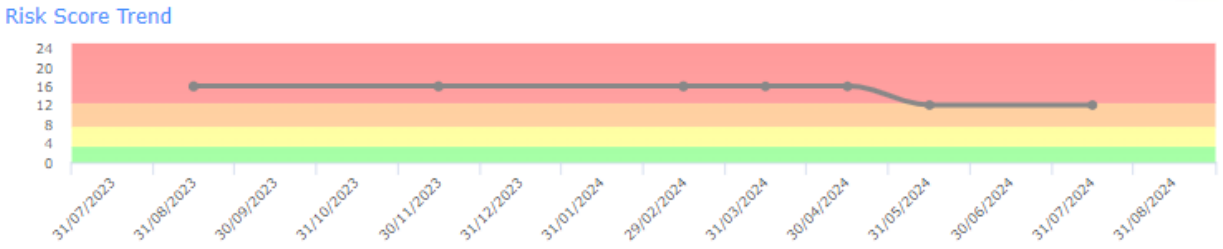


Rationale for change – Likelihood reduced in April 24 as we expect the Provider Collaborative bed model to be finally approved. We have introduced the HOPES model and reduced the number of LTS in Ridgeway. These will all support the reduction of risk shortly.

Executive Risk Group review – The group discussion covered the background to the risk being added and the position at the time in relation to people in enhanced care. The current position of people in enhanced care was also outlined and demonstrated an improvement and the management of additional packages of enhanced care. However, it was considered a large drop in risk and although the Care Group felt there was some strong mitigation in place, it was agreed to have further discussion and consider the risk of more complex care packages within the wider collaborative. There was a recognition of the improvements made and the stabilisation of this position compared to last year. The risk is to be reviewed again in Executive Risk Group in July 2024,

Aligned to Quality Assurance:

- Risk 1311 – NYYS CAMHS - Risk that the NY & Y Crisis team are not always able to cover the rota with enough staff 24/7 (especially at night) to ensure good cover across the whole NYYS geography due to low staffing (as a result of vacancies) (Reduced from 16 to 12).

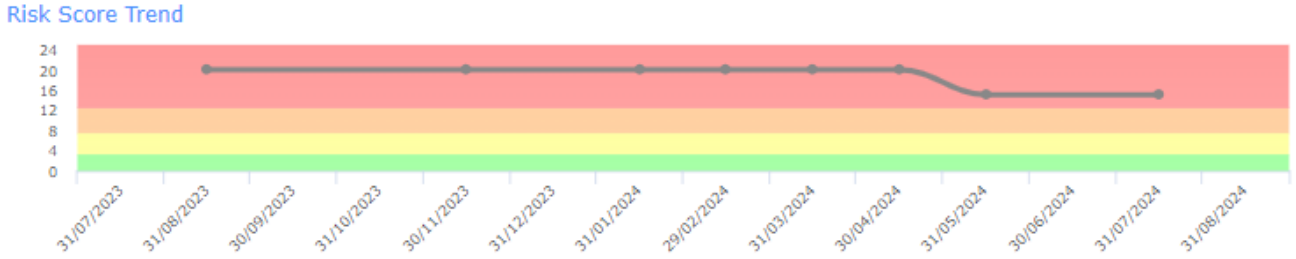


Rationale for change - agreed to reduce as a result of recent improvements in recruitment.

1 risk has also been reduced although remaining within the ≥15 threshold.

Aligned to Strategy & Resource:

- Risk 860 – Digital - There is a risk of a successful cyber attack on the Trust, due to IT Staff having insufficient cyber security resources, and enforced cyber security policies and procedures, along with technical controls, audit and assurance, resulting in the Trust not being able to identify, isolate and rectify the source of attack to prevent loss of data and or access to trust systems. (Reduced from 20 to 15)



Rationale for change – This has been reviewed by the lead and Chief Information Officer. Recent changes to technology and a sustained increased in software patching, NHSmail MFA rollout, the introduction of a strong password policy which has been rolled out Trustwide, immutable backups, routine programme of end user compute device replacements, a network infrastructure and server infrastructure refresh, Microsoft Defender for Endpoint (MDE) being in place and monitored by the National Cyber Security Operations Centre (CSOC), Secure boundary now implemented for guest traffic, IT Health in place for internal risk monitoring, and assurance reported to the Digital Programme Assurance Group. Also reflecting on a reduction within the Trusts average monthly MDE secure score which currently which reflects a sustained improvement year on year.

A summary breakdown for each committee is included at the end of the report, along with a summary of each risk. This summary outlines the key risks and indicates current assurance based on the risk register entry, completeness, control effectiveness and action progress. As this assessment is based on the risk register entry it is acknowledged that it may not reflect full progress made that has not been added. However, if we needed to provide the risk detail for assurance this is the reflected position. There is work to do to embed our improved processes and as such reasonable assurance is provided as we progress this. These demonstrate the increased assurance being sought over risk management from both the assessment of existing control effectiveness and the delivery of actions.

5.4 Risk Review Compliance

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

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

At the time of writing the paper the compliance of timely risk review for the Corporate Risk Register is 80%. Updates and further completion of risk controls and action updates are being sought.

The breakdown by directorate is shown below.

The 3 risks that were overdue at the time of extracting data for the report were 860, 1137 and 1311. Work is currently underway to report on action progress and will be included in future reports.

6. Conclusions

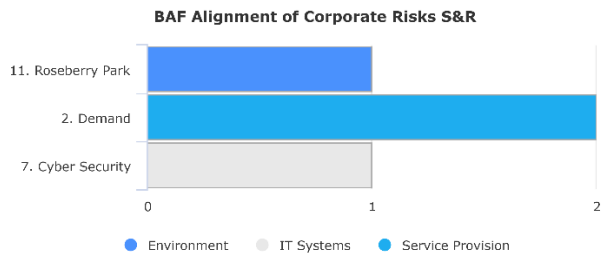
Governance meetings are being undertaken in line with policy and risks reviewed. Those currently on the register at 12 and below will be reviewed in the July meeting of the Executive Risk Group to agree removal from the register. We have some static risks that may take time to mitigate, although timelines for reduction have been identified and are reflected on the risk register provided.

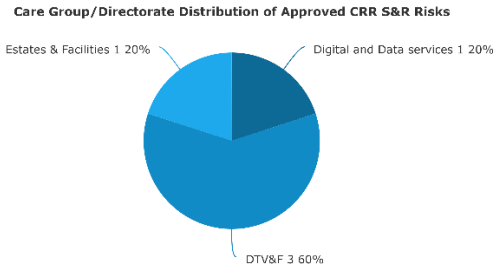
Improving our process to include the assessment of control effectiveness and improved oversight of action delivery will improve our overall management of risk and ability to provide assurance over this. As we are just starting to look to embed this process and starting with higher level risks first, the current initial assurances offered vary, hence providing the Board of Directors with only reasonable assurance at this time.

7. Recommendations

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

Strategy & Resources Aligned Risks





Risk CRR summary

Id	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	31 Jul 2024			
								Control Effectiveness		RM03 Risk Rating	
								Actual	Target	Actual	Target
Risk 00000219	There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.	08 Sep 2016	01/07/2024	Simon Adamson	15		▪ R295 - Achieve contract resolution to the satisfaction of the Trust ▪ Phase 2 rectification works			15	10
Risk 00000860	There is a risk of a successful cyber attack on the Trust, due to IT Staff having insufficient cyber security resources, and enforced cyber security policies and procedures, along with technical controls, audit and assurance, resulting in the Trust not being able to identify, isolate and rectify the source of attack to prevent loss of data and or access to trust systems.	10 Jun 2020	28/05/2024	Nick Black	25		▪ R952 - Hire staff ▪ R952 - Purchase Cyber Software			15	5
Risk 00001134	There is a risk that some patients - particularly those who are CRFD and those who are a Green Light admission - do not have an appropriate placement to move on to. This may result in patients not being placed in the best environment to support their care due to a local and national shortage of LD beds. This results from a national reduction in bed availability post Transforming Care, a high level of inpatient acuity (many of whom currently require single-occupancy care), and a lack of providers to facilitate discharge. resulting in complex patients cared for within temporary ward environments/ inappropriate beds, supported by agency nursing staff and potential adverse patient safety and quality outcomes. This also includes Green Light admissions to AMH and MHSOP beds, including to PICU.	07 Mar 2022	27/06/2024	Patrick Scott	20	Immediate Response Group	▪ Plan to re-open to admissions ▪ Confirm MSU bed for patient at BFC	Amber	Amber	25	9
Risk 00001219	There is a risk that young people being referred for specialist neurodevelopmental assessment face unacceptable waits for commencement and conclusion due to a significant increase in referral demand post-pandemic and exacerbated by the backlogs created during the national lockdowns; resulting in a dissatisfactory experience for families, complaints, knock on effect of long waits for diagnosis-specific support, & reputational damage for TEWV.	01 Apr 2021	27/06/2024	Jamie Todd	20		Revised clinical protocol to improve efficiency.			15	8
Risk 00001327	There is a risk that the service may be required to establish more enhanced care areas (ECAs) within the existing environment and resource, due to increased clinical need, resulting in patients experience and quality of care impacted by the level of restriction, and requirement for additional staff outwith the established budgeted MDT workforce.	02 Feb 2023	12/06/2024	Naomi Lonergan	20		▪ R1419 - Review of discharge/transfer pathways for 2 patients in ECA ▪ R1419 - Through the bed management process, explore access to the medium secure male ECAs at Cedar			8	4

1 risk remains below the ≥15 threshold, and will be reviewed by the Executive Risk Group in July.

Summary of risks

Risk 219– Estates and Facilities - There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.

Owner – Simon Adamson

Initial rating 15 (C5,L3), Current Rating 15 (C5, L3), Target Rating 4 (C5, L2), Date to reduce risk 31 March 2030.

Risk Review – in date, Action Delivery – 2 actions ongoing – one in date and one just overdue, both look to be behind delivery plan.

The new control section has not been started. As such legacy controls and assurances reflected do not include the 3 levels of assurance or enable the capture of the assessment of control effectiveness. Open actions include one in date and one just overdue, but both look to be behind progress and although there is no ongoing progress information to confirm this they have been rated at individual point as amber. 7 actions have been completed including, facilities management special purpose vehicle, agreement of recourse to legal processes if needed, commitment to programme of works, commitment to fire stopping issues work, full condition survey of roseberry park, determine most appropriate route to defect rectification, review of consultancy report. Progress notes reflect the current position and phase 2 works are now out to tender.

Assurance – Limited Assurance – there is work to do on the risk entry to reflect controls and assurance sources, and assess effectiveness of current controls in the new way. The actions also need to be reviewed and updated to reflect any progress.

Risk 860– Digital - There is a risk of a successful cyber attack on the Trust, due to IT Staff having insufficient cyber security resources, and enforced cyber security policies and procedures, along with technical controls, audit and assurance, resulting in the Trust not being able to identify, isolate and rectify the source of attack to prevent loss of data and or access to trust systems.

Owner – Nick Black

Initial rating 25 (C5,L5), Current Rating 15 (C5, L3), Target Rating 4 (C5, L1), Date to reduce risk 31 October 2024.

Risk Review – in date, Action Delivery – 2 actions ongoing – overdue.

The new control section has not been started. As such legacy controls and assurances reflected do not include the 3 levels of assurance or enable the capture of the assessment of control effectiveness. Open actions are both considerably overdue and not been updated. 2 actions were completed in 2023 relating to cyber strategy and funding. The risk was recently reduced from 20 following review by the new CIO.

Assurance – Limited Assurance – there is work to do on the risk entry to reflect controls and assurance sources, and assess effectiveness of current controls in the new way. The actions also need to be reviewed and updated to reflect any progress.

Risk 1134 – DTVF LD - There is a risk that patients who are CRFD and those who are a Green Light admission do not have a community placement to move on to. This may result in these patients not being placed in the best environment to support their care due to a local and national shortage of LD beds. This results from a national reduction in bed availability post Transforming Care, a high level of inpatient acuity (many of whom currently require single-occupancy care), and a lack of community providers to facilitate discharge. resulting in complex patients cared for within temporary ward environments/ inappropriate beds, supported by agency nursing staff and potential adverse patient safety and quality outcomes. This also includes Green Light admissions to AMH and MHSOP beds, including to PICU.

Owner – Patrick Scott

Initial rating 20 (C4,L5), Current Rating 20 (C4, L5), Target Rating 9 (C3, L3), Date to reduce risk 30 April 2025.

Risk Review – in date, Action Delivery – 2 actions ongoing – one on track and the other just overdue.

One key control added and reflects the 'immediate response group' although no assurance sources are reflected. This control was assessed as amber in March and April, although May and June have yet to be updated. This risk has remained static since being added in March 2022 although 8 actions have been completed including, assess and monitor temporary staffing usage, monitor bed management position, weekly system wide meetings with ICB, Fortnightly CE Commissioning meeting, support for discussion with commissioners to identify and fund, architects floor plans agreed for reconfiguration of Ramsey, investigate suitable alternate provisions, and new matron supporting staff training, resilience and formulation. Of the 2 current actions, the plan to re-open to admissions has just gone overdue and confirm MSU bed for patient at BFC is ongoing but on track.

Assurance – Reasonable Assurance – the risk entry is partly populated although the controls section could be strengthened. Actions have progressed, with 8 being completed, half of which were completed in planned timings. While the risk is updated regularly, there is no movement in the risk score to reflect mitigation of the risk, this suggests either the actions have failed to work or the risk has not been reassessed to reflect their impact.

Risk 1219 – DTVF CAMHS - There is a risk that young people being referred for specialist neurodevelopmental assessment face unacceptable waits for commencement and conclusion due to a significant increase in referral demand post-pandemic and exacerbated by the backlogs created during the national lockdowns; resulting in a dissatisfactory experience for families, complaints, knock on effect of long waits for diagnosis-specific support, & reputational damage for TEWV.

Owner – Jamie Todd

Initial rating 20 (C4,L5), Current Rating 15 (C3, L5), Target Rating 8 (C2, L4), Date to reduce risk 30 April 2025.

Risk Review – in date, Action Delivery – 1 action ongoing – just overdue.

The new control section has not been started. As such legacy controls and assurances reflected do not include the 3 levels of assurance or enable the capture of the assessment of control effectiveness. 1 open action to review and update. 3 actions have been completed including, multi-agency improvement plan, options appraisal paper, and SDF investment, however the risk remains static. Regular progress updates are being undertaken and appear to reflect actions that are not included in the risk entry.

Assurance – Limited Assurance – there is work to do on the risk entry to reflect controls and assurance sources and assess effectiveness of current controls in the new way. The action also needs to be reviewed and updated to reflect any progress or new estimated completion dates. There are also potential actions being undertaken and reflected in progress notes that are not reflected in the risk entry, as such a full and comprehensive picture of the work being taken is not captured.

Risk 1327– DTVF SIS - There is a risk that the service may be required to establish more enhanced care areas (ECAs) within the existing environment and resource, due to increased clinical need, resulting in patients experience and quality of care impacted by the level of restriction, and requirement for additional staff outwith the established budgeted MDT workforce.

Owner – Naomi Lonergan

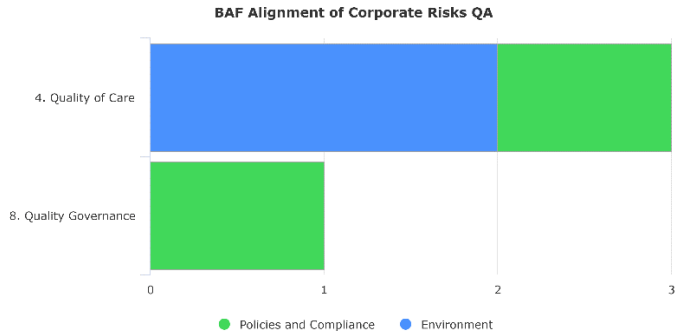
Initial rating 20 (C4,L5), Current Rating 8 (C4, L2), Target Rating 4 (C4, L1), Date to reduce risk 31 May 2024.

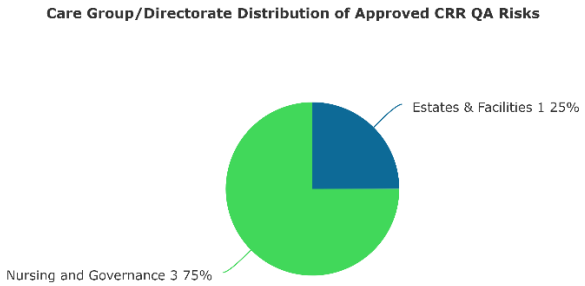
Risk Review – in date, Action Delivery – 1 action ongoing – in date although looks to be behind delivery plan.

The new control section has not been started. As such legacy controls and assurances reflected do not include the 3 levels of assurance or enable the capture of the assessment of control effectiveness. Open action is in date but looks to be behind progress although there is no progress information to confirm this. 3 actions have been completed including , clinical review of patient records, review of discharge/ transfer pathways for 2 patients, review of current ECA's in Ridgeway. Progress notes are added regularly.

Assurance – Reasonable Assurance – there is work to do on the risk entry to reflect controls and assurance sources, and assess effectiveness of current controls in the new way. The action also needs to be reviewed and updated to reflect any progress.

Quality Assurance Aligned Risks





Risk CRR summary

Id	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	31 Jul 2024			
								Control Effectiveness		RM03 Risk Rating	
								Actual	Target	Actual	Target
Risk 00000811	There is a risk that patients may attempt suicide using potential ligature points within clinical areas across the organisation, due to the presence of potential ligature points and access to these, resulting in severe harm/death to patients and significant distress to families and staff, and impact on organisational reputation.	01 Jun 2020	01/07/2024	Simon Adamson	20		▪ R903 - Implement phase 2 of the ligature reduction programme ▪ R903 - Phase 3 delivery			15	10
Risk 00001044	There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the lack of a timely initial review resulting in failure to quickly identify learning, and mitigate patient safety and quality risks, affecting regulator confidence in services and trust reputation.	08 Aug 2022	03/06/2024	Rachel Weddle	20	▪ INC - Patient Safety Huddle Daily - reviews moderate and above incidents ▪ Staff understand the initial review process and timelines	▪ INC - Transition to PSIRF ▪ INC - Local incident review processes ▪ R1044 - QI work on operational management and governance of incidents from ward to board	Green	Green	15	10
Risk 00001131	There is a risk that medical devices may not be available/ or safe to use due to the potential for devices being obsolete, out of date, poor working condition etc. when needed most i.e. emergency situation, resulting in patient harm.	16 Feb 2022	01/05/2024	Carole Rutter	16		▪ Reconciliation of all medical devices onto E-Quip system ▪ R1223 - Undertake a baseline assessment of medical devices stored within operational services to asc			16	3
Risk 00001495	There is a risk of increased public interest, and FOIs, as a result of a new public facing dashboard potentially resulting in adverse publicity and increased FOI's.	12 Feb 2024	03/06/2024	Beverley Murphy	15	▪ Expected deaths recorded as Outcomes ▪ Safeguarding referrals recorded as outcomes	▪ 1495 - Review LFPSE dashboard with a view to identifying any areas we may need to address. ▪ Ongoing process to ensure deaths are recorded correctly as incidents or outcomes. ▪ Ongoing process to ensure safeguarding incidents and referrrals are correctly recorded ▪ R1495 - existing rejected records to be reviewed and identified for notification to NHS E ▪ R1495 - ongoing process for rejected records to be established and monitored	Amber	Green	15	2

Summary of risks

Risk 811 – EFM Estates - There is a risk that patients may attempt suicide using potential ligature points within clinical areas across the organisation, due to the presence of potential ligature points and access

to these, resulting in severe harm/death to patients and significant distress to families and staff, and impact on organisational reputation.

Owner – Simon Adamson

Initial rating 20 (C5,L4), Current Rating 16 (C5, L3), Target Rating 9 (C5, L2), Date to reduce risk 31 May 2024.

Risk Review – in date, Action Delivery – 2 actions ongoing, 1 overdue.

The new control section has not been started. As such legacy controls and assurances reflected do not include the 3 levels of assurance or enable the capture of the assessment of control effectiveness. This risk is a longstanding risk from 2020 and no reduction in risk has been made due to the challenges in assessment of such a complex risk. The risk has been discussed in Environmental Risk Group and it was agreed that the risk is to be separated out to reflect the estate element of potential anchor points and the plan to mitigate these, and the assessment and management of patients who may attempt to ligature whether using anchor points or not. This will enable clearer management as controls and actions will be specific enabling a clearer and more evidence based risk reduction.

Assurance – Limited Assurance - there is work to do on the risk entry to split the risk and then fully reflect controls and assurance sources, and assess effectiveness of current controls in the new way. Actions will also need to be reviewed and updated to reflect any progress or new estimated completion dates.

Risk 1044 – N&G Quality Governance - There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the lack of a timely initial review resulting in failure to quickly identify learning, and mitigate patient safety and quality risks, affecting regulator confidence in services and trust reputation.
Owner – Rachel Weddle

Initial rating 20 (C5,L4), Current Rating 16 (C5, L3), Target Rating 9 (C5, L2), Date to reduce risk 30 September 2024.

Risk Review – in date, Action Delivery – 3 actions ongoing, 2 overdue.

The new control section has been started reflecting key controls in place: patient safety huddle, Staff understanding an application of processes. The huddle control was assessed for effectiveness and this reflected amber in February 24 as changes were embedded, moving to green in March 24 reflecting that they were fully effective. The second control relating to staff application of processes is assessed as amber reflecting the current position of timely review of incidents and the ongoing actions related to quality improvement work to understand local processes to determine a consistent and sustainable review process. 3 actions are underway and reflect some progress, although do need updating to reflect their completion or extension.

Assurance – Good Assurance – while there is work to do on the risk entry to review and update actions, the controls effectiveness assessment and progress comments reflect the progress being made.

Risk 1131 – N&G Nursing & Quality - There is a risk that medical devices may not be available/ or safe to use due to the potential for devices being obsolete, out of date, poor working condition etc. when needed most i.e. emergency situation, resulting in patient harm.

Owner – Carole Rutter

Initial rating 16 (C4,L4), Current Rating 16 (C4, L4), Target Rating 3 (C3, L1), Date to reduce risk 30 September 2025.

Risk Review – in date, Action Delivery – 2 actions ongoing, 2 overdue.

The new control section has not been started. As such legacy controls and assurances reflected do not include the 3 levels of assurance or enable the capture of the assessment of control effectiveness. Actions need reviewing and updating.

Assurance – Limited Assurance – there is work to do on the risk entry to reflect controls and assurance sources, and assess effectiveness of current controls in the new way. Actions also need to be reviewed and updated to reflect any progress or new estimated completion dates.

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

Owner – Beverley Murphy

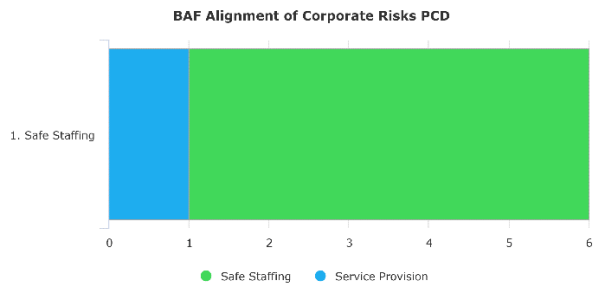
Initial rating 15 (C5,L3), Current Rating 15 (C5, L3), Target Rating 3 (C1, L2), Date to reduce risk 31 December 2024.

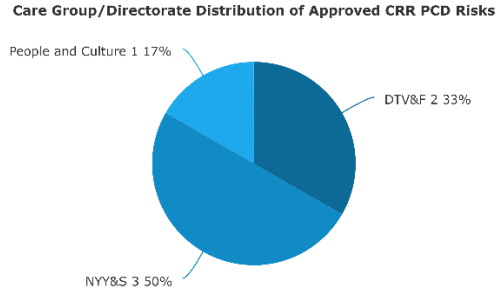
Risk Review – in date, Action Delivery – 3 actions ongoing – within realigned dates.

Key controls reflect key areas identified that may affect the published data and be out of sync with other organisations, including how we record fatalities and safeguarding referrals. Control effectiveness for the new processes to review and monitor all records reflecting safeguarding are now embedded and fully effective (green) following the completion of 2 actions. The change of recording of fatalities, although progressed via actions 3 completed to address those previously reported and those newly reported as well as put in place regular local review, higher numbers still reported resulted in an amber rating while this was embedding. With the release of the new draft ‘public’ dashboard to review, data errors identified and high numbers of fatalities still reflected this has changed to red as urgent work is need to address and maintain this going forward. 3 actions are ongoing having been extended past the original due dates as the delay in the release of the dashboard has delayed assessment and identified further work needed on these.

Assurance – Good Assurance – the risk entry is well populated and updated regularly. Progress comments are reflected on actions, controls and overall risk, providing good assurance over the management of the risk. While action estimated completion dates have been extended past the due date, the reason for this are reflected in the actions and by extending the estimated completion date and not the due date, the original planned and new delivery dates are clear.

People, Culture & Diversity Aligned Risks





Risk CRR summary

Id	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	31 Jul 2024			
								Control Effectiveness		RM03 Risk Rating	
								Actual	Target	Actual	Target
Risk 00000909	There is a risk due to difficulties in recruitment to vacant posts in the consultant workforce across NYYS due to local and national shortages, resulting in the potential impact on; safe care delivery, teaching and training of junior staff and students, OOH on call rota, research, existing staff morale and wellbeing, finances.	20 Oct 2020	05/06/2024	Tolulope Olusoga	20	▪ Mind the Gap arrangement ▪ Retention of Existing Consultant workforce	▪ R1001 - Develop non-medic colleague skills to ensure consistent service delivery ▪ R1001 - Explore and encourage group job planning to increase flexibility of the workforce supporting ▪ R1001 - Putting in place a middle grade oncall rota to support medical staff retention			16	9
Risk 00000998	There is a risk that we may have to run services with less than minimum staffing levels at HMP Northumberland. This is due to reduced staff availability as a result of being unable to recruit to clinical lead vacancies. This results in an increased potential for patient and staff safety issues, reduced quality, poor experience, increase in use of agency/spend and impact on staff wellbeing.	26 Apr 2021	18/06/2024	Janet Telford	20	▪ Business Continuity ▪ Leadership Support ▪ Recruitment Fayre ▪ Recruitment Incentive ▪ Support for Workload	▪ R1090 - Recruit x 3 wte B6 Nurses ▪ Liaison with University			15	9
Risk 00001137	Due to vacancies, staff absence and clinical activity compliance with the clinical supervision of Registered and unregistered nursing staff is below the desired compliance. Current system unable to provide assurance. The lack of opportunity to discuss clinical cases and reflect on the care delivered reduces opportunities for staff development and support of their wellbeing and in turn potentially impacts on the quality and effectiveness of care delivered.	22 Mar 2022	06/03/2024	Elspeth Devanney	15		▪ R1229 - All ward team managers to be using the same clinical supervision recording system ▪ R1229 - Routine performance monitoring of clinical supervision compliance to take place within all s			15	9
Risk 00001311	There is a risk that the NY & Y Crisis team are not always able to cover the rota with enough staff 24/7 (especially at night) to ensure good cover across the whole NYYS geography due to low staffing (as a result of vacancies), especially for night shifts there may only be one qualified and 1 HCA on duty across the whole county. This may result in service users waiting longer to be seen and if presenting at A&E can result in a breech of the 4 hour response time. Due to long waits there is a risk that some young people and families do not wait to be seen. There is also an impact on staff as the pressure in the team is impacting on workload staff morale due to the pressure to cover shifts and staff working overtime to cover these in the absence of vacancies being filled.	19 Dec 2022	27/05/2024	Melanie Woodcock	20		▪ R1403 - Continue to proactively advertise for staff ▪ Band 7 CNS appointed ▪ Review of BCP Plan	Amber	Green	12	6
Risk 00001361	There is a risk of delayed access to telephone crisis triage, very urgent assessments (crisis 4hour response) and limited support through home based treatment across the NYYS AMH crisis response home based treatment teams due to the inability to recruit into vacant posts or secure temp staffing for the teams, resulting in the inability to mitigate against risk presentations and support alternative to admissions that supports treatment and promote patient safety and family/carer wellbeing.	03 Apr 2023	05/06/2024	Billie Cameron	20		▪ R1453 - ability to reatin a night time offer across HHR ▪ R1453 - Offer of overtime to core staff across services ▪ R1453 - to secure locum medics for York, Harrogate and Ham Rich crisis ▪ R1453 - to secure student/newly qualified placements into crisis team capacity			16	4
Risk 00001464	There is a risk that OH / physiotherapy services would be suspended due to current contract disputes, resulting in wider impact on staff, their availability and capability to work, their overall health & wellbeing, timely clearance for new staff to commence work, and impact on small number of staff applying for ill health retirement.	01 Nov 2023	05/06/2024	Helen Cooke	16	Contract in place	1464- Develop BCP	Amber	Green	16	8

1 risk remains that was reduced below the ≥15 threshold last period. This will be reviewed by the Executive Risk Group in the July meeting.

Summary of risks

Risk 909 – NYY Management - There is a risk due to difficulties in recruitment to vacant posts in the consultant workforce across NYYS due to local and national shortages, resulting in the potential impact on; safe care delivery, teaching and training of junior staff and students, OOH on call rota, research, existing staff morale and wellbeing, finances.

Owner – Tolu Olusoga

Initial rating 20 (C4,L5), Current Rating 16 (C4, L4), Target Rating 9 (C3, L3), Date to reduce risk 30 November 2024.

Risk Review – in date, Action Delivery – 3 actions ongoing, in date.

The mind the gap control effectiveness has been assessed as amber, recognising that while agency cover is in place this does not cover the total 12.6 WTE consultant vacancies and actions are underway to support this through developing non-medic skills, group job planning and increased flexibility of workforce. Retention controls have yet to be assessed, however action is underway to put in a middle grade oncall rota to support medical staff retention.

Assurance – Good assurance – while there is some work to do on the risk entry to strengthen and demonstrate the delivery of actions and effectiveness of current controls, clear controls and related assurance sources are reflected, along with actions, all of which are in date.

Risk 998 – DTVF – H&J - There is a risk that we may have to run services with less than minimum staffing levels at HMP Northumberland. This is due to reduced staff availability as a result of being unable to recruit to clinical lead vacancies. This results in an increased potential for patient and staff safety issues, reduced quality, poor experience, increase in use of agency/spend and impact on staff wellbeing.

Owner - Janet Telford

Initial rating 20 (C4,L5), Current Rating 15 (C3, L5), Target Rating 9 (C3, L3), Date to reduce risk 31 December 2024.

Risk Review – in date, Action Delivery – 2 actions ongoing, both overdue.

The new control section has been started, with 5 controls reflecting: business continuity, leadership support, recruitment fayre, recruitment incentive and support for workload. These do not yet all have assurances sources reflected and an assessment of the effectiveness of these has not yet been undertaken. This is a long-standing risk and while a number of actions were implemented the risk rating prior to November 2023 was a 12, it has been a 15 since December 23. Actions completed in that time include recruitment of 2 psychology posts and the inclusion of Northumberland in H&J. Two current actions are ongoing including liaison with the University and recruitment of 3 nurses. Both of these actions are past target dates.

Assurance – Limited Assurance - there is some work to do on the risk entry to reflect assurance sources and assess effectiveness of current controls. Actions are overdue delivery and while reflecting the recruitment one reflects 33% complete the estimated completion has not been updated to give an

indication of when this action is to be completed and there is no commentary to provide an explanation of the delay.

Risk 1137 – DTVF Management - Due to vacancies, staff absence and clinical activity compliance with the clinical supervision of Registered and unregistered nursing staff is below the desired compliance. Current system unable to provide assurance. The lack of opportunity to discuss clinical cases and reflect on the care delivered reduces opportunities for staff development and support of their wellbeing and in turn potentially impacts on the quality and effectiveness of care delivered.

Owner - Elspeth Devanney

Initial rating 15 (C3,L5), Current Rating 15 (C3, L5), Target Rating 9 (C3, L3), Date to reduce risk 30 September 2024.

Risk Review – overdue at point of extract, since updated, Action Delivery – 2 actions ongoing, in date.

The new control section has not been started. As such legacy controls and assurances reflected do not include the 3 levels of assurance or enable the capture of the assessment of control effectiveness. This is a long-standing risk (added March 2022) and while 4 actions were completed in 2023 the risk has remained at 15 which is the same as the initial risk score suggesting that we are not mitigating any risk with existing controls. There are 2 ongoing actions: all ward managers to be using the same clinical recording system, and routine performance monitoring of clinical supervision. Both are indicated as 50% complete, however as the due date is March 2025, this suggests they are not on target, and delivery does not align with the target date to reduce the risk.

Assurance – Limited Assurance - there is some work to do on the risk entry to reflect controls and assurance sources, and assess effectiveness of current controls in the new way. While actions are not overdue delivery, they do not reflect that they are progressing to target and that target is beyond the target date for the risk reduction.

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

Owner - Melanie Woodcock

Initial rating 20 (C4,L5), Current Rating 12 (C3, L4), Target Rating 6 (C2, L3), Date to reduce risk 30 September 2024.

Risk Review – overdue, Action Delivery – 3 actions ongoing, all overdue.

The new control section has not been started. As such legacy controls and assurances reflected do not include the 3 levels of assurance or enable the capture of the assessment of control effectiveness. 3 open actions show overdue, although progress notes indicate improvements in recruitment and support the reduction of the risk.

Assurance – Reasonable Assurance – there is work to do on the risk entry to reflect controls and assurance sources and assess effectiveness of current controls in the new way. The actions also need to be reviewed and updated to reflect any progress or new estimated completion dates. However, progress captured reflects improvements in recruitment and demonstrates regular assessment.

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

Owner - Billie Cameron

Initial rating 20 (C4,L5), Current Rating 16 (C4, L4), Target Rating 4 (C4, L1), Date to reduce risk 30 April 2025.

Risk Review – in date, Action Delivery – 4 actions ongoing, all overdue.

The new control section has not been started. As such legacy controls and assurances reflected do not include the 3 levels of assurance or enable the capture of the assessment of control effectiveness. This risk was identified in April 2023 and no reduction in risk has been made even though an action to secure temporary support workers to screen calls was completed in August 2023. Of the 4 actions identified that are ongoing: ability to retain a night time offer across HHR, offer of overtime to core staff, secure locum medics, and to secure student/ newly qualified placements, all were due to complete last year and none have updates.

Assurance – Limited Assurance - there is work to do on the risk entry to reflect controls and assurance sources, and assess effectiveness of current controls in the new way. Actions also need to be reviewed and updated to reflect any progress or new estimated completion dates.

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

Owner - Helen Cooke

Initial rating 16 (C4,L4), Current Rating 16 (C4, L4), Target Rating 8 (C4, L2), Date to reduce risk 30 March 2025.

Risk Review – in date, Action Delivery – 1 action ongoing, in date.

The contract in place is the main control and while the effectiveness of this control was rated red in March and April as a result of the challenging position, it has subsequently been rated amber as agreements have been reached. 1 ongoing action is in place, to develop a business continuity plan and this is progressing although now expected to complete 1 month later than originally planned.

Assurance – Good Assurance – The risk control and action progress clearly reflect the position and update commentary provides details of progress and future plans. Action in date, and although delivery is now expected later than planned this is documented in the action commentary and visible on the action gannt.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Meeting of:	Board of Directors
Date:	8 August 2024
Title:	Delivery Plan quarter 1 (March-June 2024) update
Executive Sponsor(s):	Mike Brierley, Assistant Chief Executive
Author(s):	Strategy Team

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

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

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

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

Executive Summary:

Purpose: This report monitors the 17 priorities which make up the OJTC delivery plan for 24/25. As part of the delivery plan development process, each of the 17 priority leads was asked to complete a plan on a page (POAP). Each plan on a page details the deliverables which need to be completed to ensure that each plan on a page and the overall **delivery plan** is achieved.

There are a total of 135 deliverables to be achieved by the end of the financial year. For this quarter there are 32 deliverables which were due by the quarter 1 end date (30/6/24). This is an increase on the 61 deliverables (previously called projects) in the 23/24 delivery plan.

Proposal: Board of Director (BoD) members are asked to review the updates on journey, priority and deliverable progress over the first quarter of 24/25. The report also provides a summary delivery position as a percentage at a deliverable and overall journey level.

Board members are asked note the approval of extensions to deliverable timescales as outlined in this report (marked in red font). These extensions were approved at Management Group on 16th July.

Overview: The updates to this report were provided from various sources via verbal & written reports. The legend outlining RAG categories is below:

Complete	
On track	
Delayed – will still meet end date	
Delayed – end date will not be met	
Not started/paused	
Not reported	

This report includes:

- *Deliverable status per journey for Q1* 2024/25
- *Deliverable status overall for Q1* 2024/25
- *Journey updates as at Q1. Approved requests for timescale changes in red*

Prior Consideration and Feedback Where appropriate, progress and issues have been discussed within Care Group or Executive Group meetings. This report has been approved at Management Group meeting on 16th July.

Implications: This is the start of the new financial year, with a new set of priorities and deliverables, and the delivery of this plan is at an early stage.

The tables below outline the percentage of deliverables which have been completed per journey (Table 1) and overall (Table 2).

Table 1: % of Deliverables per Journey for Q1

Deliverable status per Journey for Q1						
	Journey RAG status					
	Complete	On track	Delayed		Paused	Not reported
Clinical	69%	8%	0%	23%	0%	0%
Q&S	76%	0%	33%	0%	0%	0%
Co-Creation	75%	0%	0%	25%	0%	0%
People	0%	0%	0%	100%	0%	0%
Infrastructure	50%	50%	0%	0%	0%	0%

Table 2: **% of deliverables completed overall for Q1**

% of completed deliverables Overall for Q1					
Complete	On track	Delayed		Paused	Not reported
66%	**6%**	**13%**	**16%**	**0%**	**0%**

Recommendations: **BoD members are asked to:**

a) Note the information and analysis provided in this report.

Clinical Journey – Quarter 1 24/25

Transforming Community Services: there are 27 deliverables within this piece of work, with 6 due at the end of Q1. 3 of these deliverables are complete. One deliverable is amber. This relates to AMH/MHSOP in Tees Valley: *Physical healthcare model in place across all 5 Tees Valley localities*. Stockton MH physical hub opened on 3rd June, co-locating some TEWV staff, CAB, Impact psychological therapies, social care, VCSE partners and substance misuse services. Physical healthcare practitioners are all in post except in Middlesbrough (awaiting start date). Due to some contract issues a three month extension is required. ***Management Group agreed at the meeting on 16th July 2024 to extend the milestone to September 2024.*** 2 deliverables due at Q1 are red. The red deliverables relate *to NYY implementation of CYPs all age crisis hub*. The All-age hub is up and running. There is a requirement to have CAMHS workers in the hub to support the calls coming in from YP but due to the ongoing problems around recruitment for the Community Crisis Team this is not yet able to be resourced. Recruitment for the core team is improving as part of the BCP planning and an LCC paper is under development as existing staff are also impacted. ***Management Group agreed at the meeting on 16th July 2024 to extend the milestone to September 2024.***

Transforming Urgent Care: there are 5 deliverables within this piece of work, with 1 due at the end of Q1. This milestone is complete.

NENC Secure Services Provider Collaborative Bed Model - there are 8 deliverables within this piece of work, with 1 due by July 2024. This milestone - to develop an Individualised Care Area Model of Care is delayed however, this is now due by October 2024. ***Management Group agreed at the meeting on 16th July 2024 to extend the milestone to October 2024.***

Expanding our Health & Justice services - there are 3 deliverables within this piece of work, with 1 due at the end of Q1 – to mobilise for contract commencement HMP Full Sutton This deliverable is complete and the service went live in line with contract commencement on 1/6/24.

Autism: all 4 deliverables are on track with one due by the end of this quarter (recruitment of post for the Advocated the autistic Voice).

Young Adult Services: there are 7 deliverables within this piece of work with 2 due at the end of Q1. These are: Agreement from the trust to support this priority and move forward including appropriate resources and the establishment of steering group. These milestones are both complete.

Quality & Safety Journey – Quarter 1 24/25

Personalised Care Planning: there are 7 deliverables within this piece of work with 5 due by the end of Q1. 3 of these are complete and 2 are amber. The *ratification of the trust personalised care policy is delayed*. Further work is required around keyworker and systems working. The policy is to be revised and taken back in September 2024. ***Management Group agreed at the meeting on 16th July 2024 to extend the milestone to September 2024.***
There is an interdependency on the deliverable *to ensure there is a comprehensive communications plan to ensure all stakeholders are aware of developments and the related implications*. This cannot be completed due to this delay, until the PCP policy is ratified. ***Management Group agreed at the meeting on 16th July 2024 to extend the milestone to August 2024.***

Physical Health: there are 4 deliverables within this piece of work which are due by the end of Q1. 2 are complete and 2 are amber. These are: *Communication plan developed by end April 2024 and engagement through to June 2024*. The engagement for the completion of the physical health delivery plan is complete. However the formal communications plan is delayed due to competing priorities for the communications team. The PHDG will oversee the soft launch in July 2024 and work with communications through August 2024 to develop a focussed and sustained comms plan. ***Management Group agreed at the meeting on 16th July 2024 to extend the milestone to September 2024.*** Also, the *final approach to physical health, for people using our services, presented to Executive Directors and Quality Assurance Committee is delayed and will be presented to* Executive Directors Group on 9th July 2024.

Improved patient safety: there are 5 deliverables within this piece of work of which 3 are due by the end of Q1 and these are all complete.

Co-creation Journey – Quarter 1 24/25

Further develop our co-creation infrastructure: there are 5 deliverables within this piece of work of which 2 are due by the end of Q1 of which 1 is complete and 1 is red. This deliverable is: *Co-creation communication and engagement strategy developed.* This deliverable has not been completed due to operational demand but will be complete by end of Q2. ***Management Group agreed at the meeting on 16th July 2024 to extend the milestone to July 2024.***

Lived Experience/ Peer Roles: there are 6 deliverables within this piece of work of which 2 are due by the end of Q1. Both of these deliverables are complete. These were*: Systemwide LE Strategic Leads network/community of Practice (*completed ahead of schedule) *and Supervision Protocol (required by CQC action plan)*

Improve Patient Experience: there are 6 deliverables within this piece of work, none of which are due at Q1, however 1 milestone which is due by the end of July 2024 is already complete. This is: *Ensure Complaint Themes and Trends are shared with the Organisational Learning Group for service improvement.* The complaints data is provided to the organisational learning group in order that this can be further analysed alongside other sources of intelligence e.g., patient safety incidents. As the organisational learning group matures this will become an important aspect of understanding the areas of learning and enabling the 'so what', actions to be taken as a result of these to ensure that these are not areas of learning in the future.

People Journey – Quarter 1 24/25

Deliver our people plan: There are 4 deliverables within this piece of work, 1 of which is due at the end of quarter 1. This Q1 deliverable is to have the newly procured Occupational Health Service in place. This deliverable is red as a new tender process is required which will be in place by the end of December 2024. However we still have an occupational health provision in place.
Management Group agreed at the meeting on 16th July 2024 to extend the milestone to December 2024.

Infrastructure Journey – Quarter 1 24/25

Estates: There are 10 deliverables within this piece of work, 1 of which is due at the end of quarter 1 and is complete. This deliverable is to *complete a detailed Design Sign Off and lease agreement for -Catterick Integrated Care Centre (CICC).*

Digital and Data: There are 12 deliverables within this piece of work, none of which are due at the end of quarter 1. However 3 deliverables are due by July 2024. One is complete ahead of schedule: *Deliver network bandwidth across 20 Trust sites experiencing performance issues and deliver MFA to all NHS Mail users.* One is on track: *Phase 2 & 3 Asset Management* will be fully complete and the end project report is being progressed. The third is red: *Move Business Intelligence system to cloud. deliver network bandwidth across 20 Trust sites experiencing performance issues and deliver MFA.* This project is behind schedule. The build is not yet complete and User acceptance testing cannot proceed. System and integration testing is ongoing with the final network connectivity elements. Revised timescales will be known in August.

The Green Plan: There are 7 deliverables within this piece of work, 1 of which is due at the end of quarter 1 and is complete. This deliverable to submit a bid to *Carbon skills for the Heat Decarbonisation Plan*. This bid was submitted in April 24 and we expect to hear if this has been successful by end July 24.

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**8 August 2024**
Title:	**Quarterly Report of the Guardian of Safe Working Hours for Postgraduate Doctors**
Executive Sponsor(s):	**Dr Kedar Kale**
Author:	**Dr David Burke – Interim Guardian of Safe Working**

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

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

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

Strategic Risks relating to this report:

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

Executive Summary:

Purpose:

This report aims to provide assurance that postgraduate doctors are safely rostered and that their working hours are safe and in compliance with their terms and conditions of service.

The Board receives annual & quarterly reports from the Guardian of Safe Working as a requirement of the 2016 terms and conditions of service for postgraduate doctors. This is the Q1 report for 2024-25. The appendices have been provided to me by Medical Staffing, and they include aggregated data on exception reports, details of fines levied against departments, data on rota gaps/vacancies/locum usage and a qualitative narrative highlighting, when needed, good practice and/or persistent concern. Reports and appendices are shared with the corresponding NHS England body for the different sectors.

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

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

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

Proposal:

- I am satisfied that all exception reports submitted by doctors on the 2016 contract have been actioned by Medical Staffing. Some exception reports may yet be submitted by doctors in relation to the quarter. In terms of timescales, 60% (0% in Q4) of exception reports in the North, and 93% (100% in Q4) in the South, were responded to within 7 days. I have continued to liaise with the Medical Staffing Manager who advises that staffing pressures have caused challenges in the North.

- All fines have been levied due to breach of the 5 hours overnight rest requirement on NROC rotas. There continues to be a risk of breaches in the two non-residential Core Trainee / GP rotas in the NYY&S Care Group. Introduction of more residential rotas where possible will alleviate breaches relating to achievement of 5 hours of continuous overnight rest.

- The internal system for covering out of hours rota gaps appears to continue to function well in that there is no reported use of agency locums on out of hours postgraduate doctors' rotas.

Overview:

- **Appendices 1 and 2** give details relating to DTV&F (North) and NYY&S (South) Care Groups respectively for the quarter April to June 2024.

- In the North there have been 5 exception reports in Q1, which is

a decrease over Q4 (8), Q3 (12), Q2 (9), and Q1 (8). There appears to be no pattern of concern. One exception was in relation to breach of the requirement for 5 hours of overnight rest on an NROC Senior Registrar rota.

- There have been 15 exception reports in the South in Q1, which is comparable to Q4 (14), and a decrease from Q3 (23), Q2 (39), and Q1 (26.) Medical Staffing advise that over time this can fluctuate considerably, but it will be explored further in the next Postgraduate Doctors' Training Forum. The majority of reports were for working additional rostered hours on NROC rotas.

- Additional information about reasons for the exception reports are given within the appendices.

- I continue to emphasise the importance of exception reporting to postgraduate doctors' representatives in the postgraduate doctors' training fora (PDTFs) and at inductions.

- All four fines this quarter have been levied for breach of the requirement for 5 hours of continuous overnight rest on NROC rotas. One was in the North care group, and the other three in the South care group.

- Vacancies for normal working day posts are given within the appendices, along with the number of shifts remaining uncovered after use of the Trust Doctor Scheme or, where necessary, agency locums. The remaining uncovered normal working day shifts, after accounting for annual leave, have been presented. It is important to note that the Trust does not cover higher trainee (ST4-6) vacancies as these posts are considered to be primarily for training. Also, not all posts can be filled at any one time as there are more available training posts than trainees.

Implications:

- **Compliance with the CQC Fundamental Standards:**
  The work of the guardian will help to inform CQC in the areas of Safety, Good Governance, Staffing and Duty of Candour.

- **Financial/Value for Money:**
  The new contract is underpinned by the principle that postgraduate doctors are paid for the work they do. It is necessary that the Board understands that extra costs will be incurred for breaches of hours and rest agreements. It is vital that broader resources are effectively utilised to ensure work passed to postgraduate doctors is necessary and appropriate.

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

needs within a sound learning environment.

- **Equality and Diversity:**
  The Champion of Less Than Full-time (LTFT) Working is a core member of the Postgraduate Doctors' Training Forums.

- **Other Implications:**
  There is ongoing potential for industrial action to impact the number of exception reports.

  Fines are likely to continue to be generated, particularly in the South Care Group, in relation to NROC rotas and as detailed above. Established patterns of breaches such as these should continue to be reviewed by the Trust.

Recommendations:

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

- The Trust should consider the replacement of the two CT/GP NROC rotas in NYY&S with residential ones.

Background Papers: **Appendices 1, 2:** detailed information on numbers, exception reports and locum usage - North and South Care Groups respectively. These appendices have been written and provided by the Medical Staffing Manager.

Appendix 1 DTV&F (North Care Group)

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

High level data

Number of doctors / dentists in training (total): 124
Number of doctors / dentists in training on 2016 TCS (total): 124
Amount of time available in job plan for guardian to do the role: 1 PA.
Admin support provided to the guardian (if any): 4 days per quarter.
Amount of job-planned time for educational supervisors: 0.125 PAs per trainee

Exception reports (regarding working hours) from 1st January 2024 up to 31st March 2024

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Teesside & Forensic Services	0	0	0	0
F1 –North Durham	0	0	0	0
F1 – South Durham	0	0	0	0
F2 - Teesside & Forensic Services	0	1	1	0
F2 –North Durham	0	0	0	0
F2 – South Durham	0	0	0	0
CT1-2/GP - Teesside & Forensic Services	0	0	0	0
CT1-2/GP –North Durham	0	0	0	0
CT1-2/GP – South Durham	0	0	0	0
CT3 – Teesside & Forensic Services	0	0	0	0
CT3 – North Durham	0	0	0	0
CT3 – South Durham	0	0	0	0
ST4-6 – Teesside & Forensic Services Seniors	0	2	2	0
ST4-6 –North & South Durham Seniors	0	0	0	0
Trust Doctors - Teesside	0	2	2	0
Trust Doctors - North Durham	0	0	0	0
Trust Doctors - South Durham	0	0	0	0
Total	**0**	**5**	**5**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services (F2/CT1-3/ GP/ trust doctor)	0	3	3	0
Teesside & Forensic Senior Registrars	0	2	2	0
North Durham (F2/ CT1-3/GP/trust)	0	0	0	0
South Durham (F2/ CT1-3/GP/trust)	0	0	0	0
South Durham Senior Registrars	0	0	0	0
North Durham Senior Registrars	0	0	0	0
Total	**0**	**5**	**5**	**0**

There were two reports from new doctors who had shadowed out of hours shifts prior to starting on the rota and one who had missed their break. There was one report from a senior registrar who had worked more than the time in the work schedule and another senior registrar who had breached the 5 hours continuous rest rule.

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Teesside & Forensic Services Juniors	0	2	1	0
Teesside & Forensic Senior Registrars	0	1	1	0
North Durham Juniors	0	0	0	0
South Durham Juniors	0	0	0	0
South Durham Senior Registrars	0	0	0	0
North Durham Senior Registrars	0	0	0	0
Total	**0**	**3**	**2**	**0**

The two reports that took longer than 7 days to respond to were addressed between 8 and 20 days, which was due to staff sickness.

Work schedule reviews

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

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

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Teesside & Forensics	F2	0	2	0	0	25
	CT1	56	26	0	588	273.5
	CT2			0		
	GP			0		
	CT3	0	8	0	0	74.5
	Trust Doctor	0	20	0	0	215
	Middle Tier (SR/SAS)	20	20	0	368	368
North Durham	F2	0	0	0	0	0
	CT1	29	23	0	254.5	196.5
	CT2			0		
	GP			0		
	CT3	0	1	0	0	12.5
	Trust Doctor	0	5	0	0	45.5
	Middle Tier (SR/SAS)	21	21	0	384	384
South Durham	F2	0	1	0	0	12.5
	CT1	38	28	0	365.5	266
	CT2			0		
	GP			0		
	CT3	0	1	0	0	12.5
	Trust Doctor	0	8	0	0	74.5
	Middle Tier (SR/SAS)	27	26	0	520	504
Total		**191**	**190**	**0**	**2480**	**2464**

There is 1 less shift worked than requested in South Durham; this is because a senior registrar could not be found and the consultant therefore worked alone.

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	1	1	0	24	24
Sickness	53	53	0	608	608
On call cover	127	126	0	1742	1726
Paternity leave	1	1	0	24	24
Special leave	9	9	0	82	82
Total	**191**	**190**	**0**	**2480**	**2464**

Vacancies

Vacancies by month						
Locality	**Grade**	**Month 1**	**Month 2**	**Month 3**	**Total gaps (average)**	**Number of shifts uncovered**
Teesside & Forensics	F1	2	2	2	2	83
	F2	1	1	2	1.3	65
	CT1	2	2	2	2	34
	CT2					
	CT3					
	ST4 -6	1	1	1	1	49
	GP					0
North Durham	F1					0
	F2					0
	CT1					0
	CT2					0
	CT3					0
	ST4 -6					0
	GP					0
South Durham	F1	1	1	1	1	16
	F2	1	1	1	1	16
	CT1					0
	CT2					0
	CT3					0
	ST4 -6					0
	GP					0
Total		**8**	**8**	**9**	**8.3**	**263**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Teesside & Forensic	1	£481.20
North Durham	0	£00.00
South Durham	0	£00.00
Total	**1**	**£481.20**

Appendix 2 NYY&S (South Care Group)

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

High level data

Number of doctors / dentists in training (total): 72
Number of doctors / dentists in training on 2016 TCS (total): 72
Amount of time available in job plan for guardian to do the role: 1 PA
Admin support provided to the guardian (if any): 4 days per quarter
Amount of job-planned time for educational supervisors: 0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st April 2024 up to 30th June 2024

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Northallerton	0	0	0	0
F1 - Harrogate	0	0	0	0
F2 - Scarborough	0	0	0	0
F1 - York	0	0	0	0
CT1-2 / GP - Northallerton	0	0	0	0
CT1-2 / GP – Harrogate	0	0	0	0
CT1-2 / GP - Scarborough	0	12	12	0
CT1-2 / GP - York	0	0	0	0
CT3 – Northallerton	0	0	0	0
CT3 – Harrogate	0	0	0	0
CT3 – Scarborough	0	2	2	0
CT3 – York	0	0	0	0
ST4-6 - Northallerton	0	0	0	0
ST4-6 - Harrogate	0	1	1	0
ST4-6 - York	0	0	0	0
Trust Doctors - Northallerton	0	0	0	0
Trust Doctors - Harrogate	0	0	0	0
Trust Doctors - Scarborough	0	0	0	0

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Trust Doctors - York	0	0	0	0
Total	**0**	**15**	**15**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
NYY PG doctors	0	0	0	0
NYY Middle tier	0	1	1	0
Scarborough PG doctors	0	14	14	0
Scarborough Middle tier	0	0	0	0
Total	**0**	**15**	**15**	**0**

There was only 1 exception report submitted by the NYY PG doctor (Senior Registrar) which was payment for breach of not having 5 continuous hours of rest from 10pm to 7am.

There were 14 exception reports submitted by the Scarborough PG doctors, 3 were in relation to early starts and late finishes, 1 was for shadowing, 8 were claims for additional rostered hours and the remaining 2 were payments for breach of not having 5 continuous hours of rest from 10pm to 7am.

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
NYY PG doctors	0	0	0	0
NYY Middle tier	1	0	0	0
Scarborough PG doctors	13	0	1	0
Scarborough Middle tier	0	0	0	0
Total	**14**	**0**	**1**	**0**

Work Schedule reviews

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

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

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Harrogate, Northallerton, Selby & York	F2	0	4	0	0	4
	CT1/CT2/GP	55	40	0	503	411
	CT3	0	6	0	0	72.5
	Trust Doctor	0	0	0	0	0
	SAS	74	68	0	819.72	699.72
Scarborough	F2	0	6	0	0	104
	CT1/CT2/GP	41	33	0	362.5	292
	CT3	0	4	0	0	88
	Trust Doctor	0	0	0	0	0
	SAS	94	89	0	1568	1448
Total		**264**	**250**	**0**	**3253.22**	**3119.22**

The discrepancies in the figures are due to:

- *Not all middle tier shifts requested were picked on patchwork.*
- *Shifts are covered by different grades because Higher grades could cover lower grades' shifts.*
- *Some middle tier shifts were covered by consultants which are not included in this report*

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
On call cover	30	26	0	444	395.5
Vacancy	196	189	0	2252.22	2184.72
Sickness	29	26	0	444.5	426.5
Increase in workload	3	3	0	12	12
Special leave	5	5	0	84.5	84.5

Extra weekend support	0	0	0	0	0
Annual Leave	1	1	0	16	16
Total	**264**	**250**	**0**	**3253.22**	**3119.22**

* ***The discrepancies in the figures are due to:***

- *Not all middle tier shifts requested were picked on patchwork.*
- *Shifts are covered by different grades because Higher grades could cover lower grades' shifts.*
- *Some middle tier shifts were covered by consultants which are not included in this report*

Vacancies

Locality	Grade	Month 1	Month 2	Month 3	Average no of vacancies	Number of shifts uncovered (days)
Northallerton	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	1	1	1	1	48.5
	ST4 -6	1	1	1	1	48.5
	GP	2	2	2	2	97
	Trust Doctor	0	0	0	0	0
Harrogate	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	1	1	1	1	48.5
	ST4 -6	1	1	1	1	48.5
	GP	1	1	1	1	0
	Trust Doctor	0	0	0	0	0
Scarborough	F1	2	2	2	2	97
	F2	1	1	1	1	48.5
	CT1-3	1	1	1	1	0
	ST4 -6	1	1	1	1	48.5
	GP	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
York	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	0	0	0	0	0
	ST4 -6	2	2	2	2	97
	GP	1	1	1	1	48.5
	Trust Doctor	0	0	0	0	0

Total	**15**	**15**	**15**	**15**	**630.5**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Scarborough	2	447.17
Harrogate, Northallerton & York	1	55.90
Total	**3**	**503.07**

All fines were for 5 hours continuous rest breaches submitted by different doctors and there were no trends identified.

Although these fines occurred in Q1, they will be processed by finance in Q2.

Tees, Esk and Wear Valleys
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Committee Key Issues Report		
Report Date to Board of Directors – 8 August 2024		
Date of last meeting: 4 July 2024		**Report of: The Quality Assurance Committee**
		Quoracy was achieved.
1	**Agenda**	The Committee considered the following matters: • Summary of the Executive Review of Quality Group • Integrated Performance Report (IPR) • CQC Improvement Plan • Impact of Recommendations from the Edenfield Review • Progress with the Crisis Lines • Safe Staffing Breaches • Physical Healthcare Plan • Positive and Safe Annual Report • Deep Dive into Restrictive Practices • DTV CYP – work with Public Health on friendship groups linked to deaths by suspected suicide in Teesside. • Patient and Carer Annual Report • Medical Devices Annual Report • Resuscitation Annual Report • Infection, Prevention and Control Annual Report • Tissue Viability Annual Report • Annual Report of Safeguarding • Internal AuditOne Reports: Record Keeping Quarter 4 2022/23 Mortality Embeddedness of NICHE Recommendations • Corporate Risk Register • Board Assurance Framework • Quality Assurance Committee Terms of Reference • Organisational Learning Group Terms of Reference • Feedback from the Quality Assurance Developmental Session held on 22 May 2024
2a	**Alert**	The Committee alerts the Board on the following matters: **From the DTVF Care Group:** • Mechanical restraints (soft cuffs) were used twice in SIS as a planned intervention. • One incident of mechanical restraint used by the Police following an incident on Farnham ward. • Three people subject to long term segregation, one at Bankfields and two in SIS. • Two incidents of tough clothing used in SIS. • One incident of prone restraint. • Four people transferred across sites to achieve seclusion. • Two people did not receive 72 hours follow up. Both safe. • A gentleman from an LD service is subject to prolonged seclusion whilst awaiting an appropriate bed. Care is being delivered by LD staff who know him well. • Safety briefing issued to working staff in the Prison estate related to the risk of intoxication of the drug Spice. **From NYY Care Group:** • In April and May two people did not receive 72 hours follow up, where DNAs on both occasions were an issue. All patients safe. • Springwood continues to work beyond planned staffing for registered nurses. Springwood, Wold View and Rowan Lea continue to work beyond planned staffing for health care support workers. Staffing model for older people's care to be considered.

		• A young person aged 17 was in the 136 suite at Foss Park while an appropriate bed is found which took ~24 hours. Admitted administratively to Minster ward. **Other business matters:** • Limited assurance linked to the process of our approach to supporting people with section 17 leave and time away from the ward. Improvement action underway. Oversight will be through the Organisational Learning Group. • There is good assurance related to the systems and processes supporting delivery of the CQC Improvement Plan, however reasonable assurance on delivery of the five individual actions which have exceeded the target date for completion.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: **From the Care Groups:** DTVF: • More than 50 peer reviews completed (including culture reviews) to date with agreed oversight/escalation process in place for governance flow to the care groups boards to identify themes and learning with engagement from junior members of staff. • Significant improvement as only one prone restraint in month. • Only one person admitted to an out of area bed. • Recognition that beds availability is slowly improving, too early to offer significant assurance. • The gentleman who historically did not have access to fresh air whilst in LTS now has this available to him twice a week which meets his needs. NYYS: • No prone restraint/segregation. • No breaches reported on any ward for mixed sex accommodation. • The Perinatal Mental Health team plan to move out of BCP process by end of July 2024 (after 5 months) following full recruitment to the team, access times moving closer to targets and increased visibility of team to referrers in the wider system. • Esk ward have made a significant step to reduce restrictive practices. **Other business matters:** • Strong level of oversight on managing and publishing rosters having a positive impact and reduced agency spend continues. • The Reducing Restrictive practice annual report was received which demonstrates an improving trend with reducing restrictive practices, however there is more work to do. • A proactive deep dive into restrictive practices/ care choices potentially caused by lack of bed availability has offered assurance that the number of patients impacted is limited and that there is oversight. Focus will continue to reduce restrictive practice as a strategic priority and the deep dive will be repeated across all inpatient services at least once each year. • Significant improvement seen in children and young people and adults and older persons showing measurable improvement following treatment – clinician reported. • Good assurance can be taken that the learning following the independent review of Greater Manchester Hospital, Edenfield Centre in Prestwich has been widely shared and considered to reflect on what the recommendations mean to TEWV. Operational, clinical, and professional leaders have fully engaged with the learning. • The following 2023/24 annual reports were received with good assurance: Resuscitation Infection, Prevention & Control Safeguarding Tissue Viability Medical Devices Patient and Carer Experience • There is confidence on the positive progress made to deliver the physical healthcare plan.

		• Good assurance related to risk management processes supporting the corporate risk register. Focus will be given at the next QAC meeting to have a conversation about the static risks and those that are longstanding. • There is good assurance linked to the Board Assurance Framework and those risks linked to quality as several reports on the agenda demonstrated assurance and controls in quality, as well as evidence of co creation. The annual reports presented also support progress with quality governance.
2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: **From the Care Groups:** • Due to a combination of vacancies and sickness AMH community team in Ripon requires support and has a recovery plan in place. Slow and consistent progress can be demonstrated but some way to go. • DTVF looking in more granular way at restrictive practice with closer oversight of seclusion used over a longer period of time. • Decision made to hold the feeling safe metric at a 75% target and for it to be supported by a small suite of metrics that help triangulate rather than one blunt measure. • New methods of attracting nurses to work in HMP services are necessary as current methods are not consistently delivery staffing numbers needed. **Other business matters:** • Significant improvements made over the last year on response rates to the crisis lines. Reasonable assurance linked to current progress and the range of issues are understood. • The Organisational Learning Group's terms of reference were presented. Some suggested amendments from the Company Secretary's department will be considered before they are presented to Executive Directors for approval. • The terms of reference for the Quality Assurance Committee were approved and will be presented to the August 2024 Board of Directors meeting for ratification. • Limited assurance following the internal audit on record keeping quarter 4. Seeking further evidence of progress related to the recommendations.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considers that good assurance can be provided that risks to quality are understood and are being managed effectively. High on the radar from the risks considered at the meeting are the need to see progress with section 17 leave, some of the CQC actions and oversight of record keeping through fundamental standards.
3	**Actions to be considered by the Board**	The Board is asked to note the report.
4	**Report compiled by**	Bev Reilly, Chair of the Quality Assurance Committee, Deputy Chair of Trust/Non-Executive Director, Beverley Murphy, Executive Chief Nurse and Donna Keeping, Corporate Governance Manager

NHS
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For General Release

Meeting of:	**Board of Directors**
Date:	**8th August 2024**
Title:	**Learning from Deaths**
Executive Sponsor(s):	**Kedar Kale, Executive Medical Director**
Author(s):	**Rachel Weddle, Associate Director of Patient Safety**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
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.	There is a risk that if we fail to embed key learning from deaths, patient safety and quality will be compromised and the people we serve will lose confidence in the services we provide. This paper sets out key processes for mortality reviews and learning from deaths and serious incidents across the Trust to reduce and mitigate this risk.
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	

Executive Summary:

Purpose:

The national guidance on learning from deaths requires each Trust to collect and publish specific information. This report covers the period from April to June 2024. The Board of Directors is receiving the report for information and assurance of the Trust's approach in line with national guidance.

All NHS Trusts must publish a dashboard (Appendix 1) highlighting the numbers of deaths that occur in the organisation on a quarterly basis. These are deaths which are in-scope of the Learning from Deaths policy and have been subject to any investigation or mortality review. It is important to note that when reviewing the data presented in the dashboard all the deaths categorised as in scope for the Learning from Deaths policy are subject to an initial review before determining if they require further investigation. Further details and the locally agreed criteria for mortality reviews and Structured Judgement Reviews (SJRs) are in Appendix 2.

Proposal:
That the dashboard and the learning points are provided as good assurance of reporting and learning in line with national guidance.

Overview:
In line with National Guidance the Learning from Deaths Dashboard at appendix 1 details Q1 information for the Trust and includes 2023/24 data for comparison.

- During Q1 the Trust received 325 death notifications of patients who had been in contact with our services in the preceding 6 months. The Trust received 10 death notifications of people with a learning disability in the time frame. These figures represent all deaths (including natural expected/unexpected, and unnatural/unexpected) in relation to people who were currently open to the Trust's caseload which is largely community and includes older people and memory services (>70,000).
- 6 inpatient deaths were reported. Two of these deaths occurred within an inpatient setting and were expected deaths, subject to Part 1 reviews. Three other deaths occurred (2 AMH, 1 MHSOP) following transfer to Acute Hospitals from TEWV wards with physical health causes but the deaths were unexpected and are therefore subject to Patient Safety Incident Investigations (PSII's) which are underway. One in MHSOP is the suspected suicide of a patient on home leave and is subject to a PSII. All deaths have either been reported on the national Strategic Executive Information System (StEIS) and are subject to further investigation as PSII's or are being investigated via the mortality review process.
- Immediate Early Learning Reviews were conducted for all the above deaths and where appropriate, rapid improvements have been made to improve patient safety.
- 5 unexpected community deaths were reported on StEIS during the reporting period and will be investigated as serious incidents.
- 7 Part 2 Structured Judgement Reviews (SJRs) were requested.
- 52 Part 1 reviews and 5 SJRs were completed.
- 32 serious incident investigations for unexpected deaths were completed.
- All deaths of people with either a learning disability or a diagnosis of autism require reporting to LeDER in line with national requirements over the reporting period. Deaths are reported to LeDER via the clinical teams and the Patient Safety team have added a prompt to all After Action Review documents. It has also been built into the InPhase reporting system since 30th October 2023. Any discrepancies in reporting are being followed up by the Patient Safety team. Reasons given for not reporting have been identified as deaths occurring in the Acute Trust or a Care home and it was assumed by the TEWV clinical team that the team providing 24-hour care had submitted the referral. Teams are being asked to confirm this with those providers.

Appendix 3 sets out in detail the specific areas of learning, Trust themes, progress within the Quality Assurance programme and structures to support and embed learning from incident investigations.

16 Patient Safety Briefings were circulated Trust wide during this reporting period, examples included:

- 2 in relation to observation and engagement
- 4 in relation to CITO
- 2 in relation to seclusion
- 2 in relation to illicit substance issues
- 3 in relation to environmental risks and issues

To improve learning and measure progress against the Trusts main themes, all learning requires a SMART action plan. To support learning at the earliest opportunity all serious incidents are subject to an After-Action Review overseen by daily patient safety huddles.

The transition, to InPhase incident reporting in 2023/24 supports additional benefits in terms of triangulating learning and monitoring of actions as well as greater monitoring of Duty of Candour as it is further embedded and refined. It has also highlighted anomalies in reporting processes and in addition to incident reporting for unexpected deaths we now report expected natural cause deaths as outcomes following guidance from NHS England. Some unexpected deaths, once fact finding has been completed to establish if an patient safety incident has occurred can also be moved into outcomes and the patient safety team are currently reviewing and updating processes to reflect this.

Prior Consideration and Feedback

Updates and assurance aligned to improvement work relating to learning from deaths is reported to the Executive Review of Quality group. This includes regular updates on the Quality Assurance schedule (providing assurance of compliance against key patient safety policies such as leave, clinical record keeping, risk assessment and management, observation and engagement) as well as updates on key projects that sit within our Advancing Our Quality and Clinical journeys that relate to themes from patient safety incidents such as progress following implementation of the patient safety incident response framework (PSIRF).

Implications:

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

There are financial and reputational implications associated with poor standards of care. A focus on learning helps the Trust to improve the quality and safety of our care services.

Recommendations:

The Board of Directors is requested to note the content of this report, the dashboard and the learning points as good assurance of reporting and learning in line with national guidance and consider any additional actions to be taken.

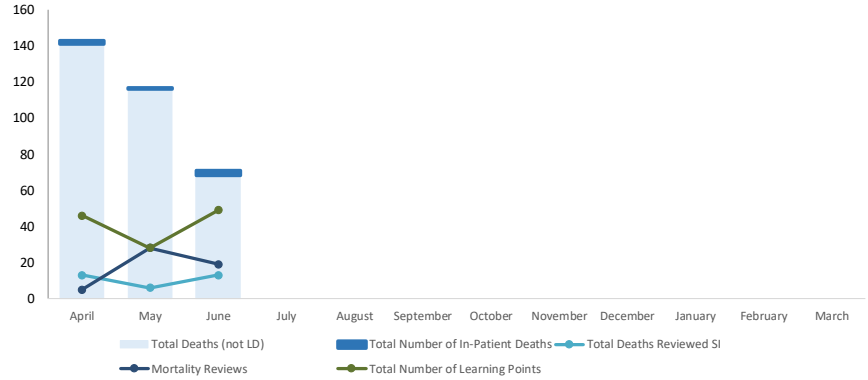
Appendix 1: Learning from Deaths Dashboard Q1 2024/25

Learning from Deaths Dashboard - Data Taken from Paris
Reporting Period - Q1 2024-25

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

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

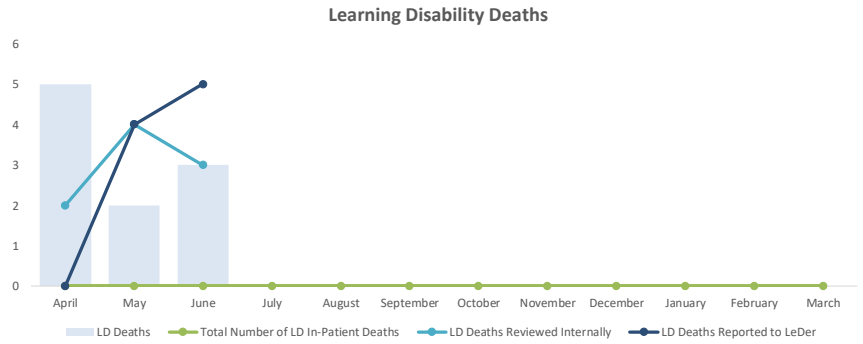
	Total Deaths (not LD)		Total Number of In-Patient Deaths		Total Deaths Reviewed SI		Mortality Reviews		Total Number of Learning Points	
	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24
Q1	325	↘ 509	6	↗ 4	32	↗ 12	52	↘ 66	123	↗ 38
Q2	0	↘ 437	0	↘ 8						
Q3	0	↘ 531	0	↘ 9						
Q4	0	↘ 508	0	↘ 6						
YTD	325	↘ 1985	6	↘ 27	32	↗ 12	52	↘ 66	123	↗ 38



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

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

	LD Deaths		Total Number of LD In-Patient Deaths		LD Deaths Reviewed Internally		LD Deaths Reported to LeDer	
	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24
Q1	10	↘ 26	0	↔ 0	9	↘ 12	9	↔ 9
Q2	0	↘ 18	0	↔ 0				
Q3	0	↘ 38	0	↔ 0				
Q4	0	↘ 24	0	↔ 0				
YTD	10	↘ 106	0	↔ 0	9	↘ 12	9	↔ 9



Appendix 2

Mortality Reviews 2024/2025

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

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

- Family, carers, or staff have raised concerns about the care provided
- Diagnosis of psychosis or eating disorders during the last episode of care
- Psychiatric in-patient at the time of death, or discharged from care within the last month (where the death does not fit into the category of a Serious Incident)
- Under Crisis Resolution and Home Treatment Team at the time of death (where the death does not fit into the category of a Serious Incident)
- Random Selection
- Specific area of interest to the Trust.(e.g.; Clozapine)

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

- All in-patient deaths, not subject to a Patient Safety Incident Investigation (PSII) have either had a Part 1 completed or are in the process of having one completed.
- All LD deaths of those open to TEWV have either been reviewed, or are being reviewed under Part 1 of the mortality review process. Where any concerns are identified, a Structured Judgement Review has been or will be requested. All these cases are to be reported to LeDER for review. The LeDER referral will not necessarily be completed by TEWV if the individual is receiving their main care from another provider.
- All community deaths for patients aged 64 and under have been or are being reviewed under Part 1 of the mortality review process and where any red flags/concerns have been identified a Structured Judgment Review has been requested.
- 20% of community deaths for patients aged between 65 and 74 have been reviewed under Part 1 of the mortality review process and where any red flags/concerns have been identified a Structured Judgment Review has been requested. This 20% is selected from deaths within Trust services as opposed to deaths within care homes where the Trust is not the main care provider.
- 10% of community deaths for patients aged 75 onwards have been reviewed under Part 1 of the mortality review process and where any red flags/concerns are identified a Structured Judgment Review has been requested. This 10% is selected from deaths within Trust services as opposed to deaths within care homes where the Trust is not the main care provider.

Appendix 3

1. Mortality Reviews and Learning

Mortality Review 2024/2025

5 structured judgement reviews were discussed and reviewed by the Mortality Review Panel during Q1. Four of the cases presented were rated as good overall care. The issues from the 5th case identified healthcare record keeping issues and concerns regarding safety summary/plans.

A number of Actionable learning points were identified:

- Lack of documentation/detail not up to date documents in the care record.
- No documented evidence that a prescription was collected.

Learning from actions/assurance

- Findings from SJRs are fed back to the clinical networks, where appropriate, to ensure that learning feeds into existing improvement work. Outcomes are captured in minutes at the following mortality review panel. These will be fed into the re-established Organisational Learning Group for future quarters.
- Where the learning identified is related to the work of a specific professional group, for example Pharmacy, the relevant mortality review panel member ensures this is actioned and shared Trust-wide. Good examples of assurance can be evidenced from the workstreams related to Clozapine, Lithium and Depot Injections.
- Learning for individuals is shared with operational teams where appropriate and addressed via supervision and local governance processes.

Learning from mortality reviews often demonstrate similar themes identified during Serious Incident reviews / Patient Safety Incident Investigations. The themes from mortality reviews are triangulated with learning from serious incidents reviews to establish any new themes occurring.

1.2 Learning from deaths and serious incidents

Within Quarter 1 there were a total of 123 learning points from both Serious Incidents and mortality reviews. The most frequent actionable learning theme identified related to record keeping and documentation. Processes was the second most frequent learning point identified with the top process issue being linked to the Do Not Attend/ Was not brought policy.

1.3 Structures to support and embed learning

1.3.1 Fundamental standards group

Practice Development Practitioners are now integrated into the Care Group Fundamental Standards meetings where wider learning and good practice can be shared to facilitate improvements Trust-wide.

1.3.2 Organisational Learning

The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group (OLG). Any significant issues identified by the OLG are escalated to the Executive Review of Quality Group for further discussion and or actions.

1.3.3 Patient Safety Incident Management/Investigation

The Trust has a continued focus on improving the quality of incident reporting, investigation, and identification of key actionable learning. Key improvements across the incident reporting and investigation pathway have been implemented incrementally and we continue to develop and embed these changes ensuring they are compliant with the requirements of the National NHS Patient Safety Strategy and the Patient Safety Incident Response Framework (PSIRF).

The Patient Safety Incident Management Programme (PSIM) provides oversight on the serious incident backlogs, the Risk management system procurement, and the embedding of the Patient Safety Incident Response Framework (PSIRF) and Learning from Patient Safety Events (LFPSE). The PSIM programme reports into the Advancing our Clinical, Quality and Safety Journeys sub-portfolio Board (AOCQSJ). Identified improvement programmes supported by the project management office include care planning, preventing suicide and self-harm and safeguarding/PAMIC. This improvement work is overseen by the AOCQSJ.

1.3.4 The Environmental Risk Group

This group receives information where environmental factors may have contributed to harm, as well as progression of initiatives to reduce harm. Any urgent learning identified through this group is distributed Trust-wide via Patient Safety Briefings. The annual Environmental survey programme with a multi professional input from estates, health and safety and clinical services continue. The ligature reduction programme is monitored through this group with assurance provided through the Trusts quality governance structures. Significant investment has been dedicated to assistive technology in the form of Oxevision (Oxehealth) and door sensors to make wards safer.

1.3.5 Recruitment and Retention/staffing establishment reviews

When looking at patient safety incidents through a systems and human factors lens, it can be seen that workforce pressures and capacity including community caseloads can impact on the quality of care delivered. Significant work is being undertaken to ensure that we have a suitably skilled and resourced workforce who can carry out their duties in a safe and compassionate way. Further details can be seen within the safe staffing and establishment review papers.

Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**8 August 2024**
Title:	**Feedback from Leadership Walkabouts**
Executive Sponsor(s):	**A Bridges, Director of Corporate Affairs & Involvement**
Author(s):	**A Bridges**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
All		The report highlights summarised feedback from leadership walkabouts in June 2024, which can contribute to the Board's understanding of strategic risks, quality of services and the operation of key controls.

Executive Summary:

Purpose: The purpose of this report is to provide the Board with high-level feedback from leadership walkabouts that took place in June 2024.

Overview:

1 **Background**

1.1 The Trust undertakes a monthly programme of regular leadership walkabouts to services. These visits are not inspections but enable teams to hold conversations directly with Board Members and Governors to raise any matters of importance.

1.2 Walkabouts provide an opportunity for Board to meet with teams to really understand the strengths of the service and consider the more challenging areas, and how we can work together to resolve these and co-create any potential solutions. Full feedback reports and actions are reported and monitored via Management Group.

2 **Speciality areas visited**

2.1 Leadership walkabouts took place on 24 June 2024 primarily

across health and justice services, as well as rescheduled visits to liaison services in Darlington and Mental Health Services for Older People at Westerdale North (both rearranged from previous visits):

- HMP Northumberland, Morpeth
- HMP Old Elvet, Durham
- HMP Holme House, Stockton
- HMP YOI Deerbolt, Barnard Castle, County Durham
- South and Durham Darlington Acute Liaison Psychiatry Service, Darlington Memorial Hospital (previously rescheduled)
- Westerdale North Ward, Mental Health Services for Older People (MHSOP), Roseberry Park Hospital, Middlesbrough (previously rescheduled)

3 Key issues

3.1 Health and Justice Services

- Strengths:
    - Adaptable: flexible and agile approach to barriers in terms of working in a prison environment eg prison regime, lockdowns etc always putting service users first.
    - Collaborative and supportive teams: teams demonstrated strong commitment to each other and were diverse in terms of multi-disciplinary team (MDT) approach, and effective and resilient teams who have historically felt at ‘arms length’ to the Trust, however certainly changing and more positive position now.
    - Innovative: some great examples of working with service users in co-creating new pathways and support for others including ADHD pathway, and learning disability being developed too. Plus, proudly talking about peer mentor programme which has been incredibly successful, and looking at how that might work cross HMP locations.
- Challenges:
    - Staffing: in the main, staffing and recruitment were an issue, with sickness absence also a concern. Some of this related to frustrations around starting therapeutic work only to be paused due to inter-prison transfers, and lack of communication with broader prison regime.
    - Environment: some teams reported issues with the environment they worked in not being suitable, including the absence of therapeutic environments. Some had very poor working conditions eg no heating / hot water, air conditioning etc.
    - IT / equipment / systems: all teams expressed frustration about lack of integration with Trust systems, connectivity

and IT equipment including printers and laptops.

3.2 South and Durham Darlington Acute Liaison Psychiatry Service

- Strengths: good multi-disciplinary team (MDT) approach and good skill mix, which is fully recruited to and supported by compassionate leadership. Any sickness managed well and no work-related stress absence, and team supported to undertake statutory/mandatory training, keep their practice up to date leading to positive morale and feeling valued. Team providing monthly training to acute colleagues and care homes providers etc around mental health diagnoses and established good working relationships across partners.
- Challenges: the team expressed frustration around dedicated space in acute hospital, including appropriate therapeutic and confidential environment for service users and families. Staff were concerned about ongoing inquests and scrutiny from coroner, which felt personal and undermines confidence in clinical decision making, and the impact this has on the team. There was discussion around CITO and some localised issues however, understood that implementing a large-scale data management system can lead to challenges within any organisation. Patient safety as ever was a priority.

3.3 Westerdale North Ward, Mental Health Services for Older People (MHSOP)

- Strengths: The team were very focused on putting patients first and were really proud of the improvements that have made in the service which have had a positive impact, including recent positive peer review. Staff were keen to share their learning with other services. Team meeting their targets in terms of training and appraisals.
- Challenges: working across multiple local authorities and different adult social care regimes was challenging in relation to discharge. Staffing could be an issue at times, particularly HCAs and some concern raised in terms of psychological support for service users.

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

Recommendations: The Board is asked to:

- Receive and note the summary of feedback as outlined.
- Consider any key issues, risks or matters of concern arising from the visits held in June 2024.