Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS
10 April 2025
10.30am

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

AGENDA

NOTE: there will be a confidential session at 10am for the Board of Directors to receive a patient/staff story.

Standard Items

1	Chair's welcome and introduction (verbal)	Chair	10.30am
2	Apologies for absence (verbal)	Chair	
3	Declarations of interest (verbal)	All	
4	Minutes of the board meeting held on 13 February 2025	Chair	
5	Board Action Log	Chair	
6	Chair's report	Chair	
7	Questions raised by Governors in relation to matters on the agenda (verbal) *(to be received by 10.00am on Tuesday 8 April 2025)*	Co Sec	

Strategic Items

8	Board Assurance Framework Summary Report	Co Sec	10.45am
9	Chief Executive's Report	CEO	10.50am
10	Integrated Performance Report	DCEO	11.05am

BREAK 11.30am – 11.40am

11	Corporate Risk Register	CN	11.40am
12	Our Journey to Change Delivery Plan 2024/25 Quarter 3	DCEO	11.50am
13	Our Journey to Change: The Next Chapter	DCEO	12.00pm

BAF Risk 2: Demand
BAF Risk 3: Co-creation
BAF Risk 4: Quality of Care
BAF Risk 8: Quality Governance

14	Report of the Chair of the Quality Assurance Committee	Cmt Chair	12.10pm

BAF Risk 13: Public Confidence

15	Communications update	EDoCA&I	12.20pm
16	Report of the Chair of the Charitable Funds Committee	Cmt Chair	12.30pm

Governance

17	Board Assurance Framework (verbal)	Chair	12.40pm

Matters for Information

18	Feedback from leadership walkabouts	EDCA&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	-

BREAK 12.45pm – 1.35pm

CONFIDENTIAL SESSION

Standard Items

20	Minutes of the last confidential board meetings held on: a. 13 February 2025 b. 20 March 2025	Chair	1.35pm
21	Board Confidential Action Log	Chair	

Strategic Items

22	Chief Executive's Confidential report	CEO	1.40pm
23	Reportable Issues Log	CN	2.00pm
24	Report of the Chair of Audit & Risk Committee Reports recommended for approval: a. Going Concern Report	Cmt Chair EDoFE&F	2.05pm

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

25	Report of the Chair of Resources and Planning Committee Reports recommended for approval: a. Electronic Patient Record b. Yorkshire and Humber Perinatal Provider Collaborative Partnership Agreement	Cmt Chair CIO EMD	2.20pm
26	2024/25 month 11 finance update	EDoFE&F	2.40pm
27	2025/26 Financial Plan (verbal)	EDoFE&F	2.50pm

Governance

28	Deloitte Review	DCEO	3.00pm
29	Report of the Chair of the Board of Director's Nomination and Remuneration Committee (for information)	Chair	-
30	Board Assurance Framework	Co Sec	3.10pm

Matters for information:

31	To receive and note the minutes of the meetings of the following committees: a. Audit and Risk Committee, 28 November 2024 b. Quality Assurance Committee, 6 February 2025 c. Quality Assurance Committee, 6 March 2025	Co Sec	-

Evaluation

32	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	-

David Jennings
Chair
4 April 2025

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

For information: Controls Assurance Definitions	
Substantial Assurance	Compliance with the control framework taking place. The control is being consistently applied. No remedial action required.
Good Assurance	A high level of compliance with the control framework taking place. The control is generally being applied consistently. Limited remedial action is required.
Reasonable Assurance	Compliance with the control framework taking place. The control is not being applied in a consistent manner. Some moderate remedial action is required.
Limited Assurance	Compliance with the control framework not taking place. The control is not being applied. Immediate and fundamental remedial action required.

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Tees, Esk and Wear Valleys
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS HELD ON 13 FEBRUARY 2025 AT ROSEBERRY PARK HOSPITAL AND VIA MSTEAMS

Present
D Jennings, Chair
B Kilmurray, Chief Executive
R Barker, Non-Executive Director
Z Campbell, Executive Managing Director, North Yorkshire, York & Selby Care Group
C Carpenter, Non-Executive Director
K Kale, Executive Medical Director
N Lonergan, Interim Managing Director, Durham Tees Valley and Forensic Care Group
J Maddison, Non-Executive Director
B Murphy, Chief Nurse
K North, Joint Executive Director for People and Culture (non-voting)
J Preston, Non-Executive Director and Senior Independent Director
B Reilly, Non-Executive Director and Deputy Chair
J Robinson, Non-Executive Director
L Romaniak, Executive Director of Finance, Estates and Facilities
C Wood, Non-Executive Director
A Bridges, Executive Director of Corporate Affairs and Involvement (non-voting)
H Crawford, Executive Director of Therapies (non-voting)
S Dexter-Smith, Joint Executive Director for People and Culture (non-voting)
P Scott, Deputy Chief Executive (non-voting)

In attendance
P Bellas, Company Secretary
N Black, Chief Information Officer
K Christon, Deputy Company Secretary (minutes)

Observers
S Adamson, Director of Estates, Facilities and Capital
R Head, Lead Pharmacist (Tees)
E Ross, Trainee Psychologist
S Theobald, Associate Director of Performance
K Castling, Head of Risk and Assurance, South Tyneside and Sunderland NHS FT

24/25-178 CHAIR'S WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

24/25-179 APOLOGIES FOR ABSENCE

None.

24/25-180 DECLARATIONS OF INTEREST

None.

24/25-181 MINUTES OF THE LAST MEETING HELD ON 12 DECEMBER 2024

Agreed: *the minutes of the last meeting are an accurate record.*

24/25-182 BOARD ACTION LOG

Noted.

The Chair proposed that narrative included on the original issue and progress be clear, for the board to be assured on progress.

24/25-183 CHAIRS REPORT

The Chair presented the report, which outlined key areas of focus for the previous two month period.

24/25-184 QUESTIONS RAISED BY GOVERNORS IN RELATION TO MATTERS ON THE AGENDA

The board received a Governor question from M Booth related to safe staffing and it was agreed that a response would be provided by the Executive Director for People and Culture.

Action: S Dexter-Smith/ K North

24/25-185 BOARD ASSURANCE FRAMEWORK

The board received the report, which provided information on risks included in the Board Assurance Framework to support discussion at the meeting.

In discussion the following points were noted:

1. N Lonergan advised that the care group managing directors would review the controls listed for risk 2 [demand] and would provide further details in relation to areas of greater demand.
2. N Black reminded the board that risks 5 [digital – supporting change] and 7 [data security and protection] were relatively new and further work would be undertaken to ensure the controls identified were appropriate.
3. P Scott noted that risk 9 [partnerships and system working] would be reviewed and amendments considered by Resources and Planning Committee.
4. B Reilly advised that Quality Assurance Committee had sought assurance on the Trust's transformation agenda and would consider a report in March.
5. A query was raised about whether it would be appropriate to consider a reduction in risk score and gap to target for risk 1 [safe staffing], where a range of actions had been undertaken.
6. It was proposed that risk owners consider the positive and negative assurances for risk 13 [public confidence] and risk 9 [partnerships and system working].
7. A query was raised about the high score for risk 10 [regulatory compliance], where there was good oversight and scrutiny by Quality Assurance Committee and positive narrative included for risk 8 [quality governance] in relation to regulatory compliance.

   P Bellas advised that risks 10 and 12 [financial sustainability] had been identified as areas of most concern to the board as they could not be mitigated to an acceptable level.
8. It was acknowledged that the score for risk 12 [financial sustainability] reflected the Trust's difficult operating environment and proposed that the board had good assurance from reports provided by the Director of Finance, Estates and Facilities.
9. L Romaniak noted that the report would be updated to reflect further assurance on the Green Plan.
10. Responding to a request, the Chair agreed to return to the Board Assurance Framework on conclusion of the Board's agenda.

24/25-186 CHIEF EXECUTIVE'S REPORT

B Kilmurray presented the report, which provided a briefing on topical issues of concern to the Chief Executive and in discussion, he undertook to circulate a copy of the 2025/26 planning guidance.

In addition to that reported:

- B Murphy drew attention to the board briefing on the CQC inspection of adult mental health crisis, acute liaison and health based places of safety, which had identified: learning in relation to how the Trust articulated processes in services; a reduction in a domain rating related to medicine management, mandatory and statutory training and supervision; and a number of positive improvements, which included the safety of people in the Trust's care, their assessment and how the Trust responded to risk.

  B Kilmurray noted the Trust had maintained its overall rating and placed on record his thanks to all staff involved in the inspection process.
- B Murphy commented on work undertaken to respond to the recommendations of the independent investigation into the care and treatment provided by Nottingham Healthcare NHS FT. She noted that, whilst there was confidence that community teams understood those who did not attend appointments, the Trust would also seek to develop an automated way to report trends and themes via Cito.

  B Kilmurray noted a request from NHS England's National Mental Health Director that the Board of Directors of all Trusts receive an update on this work by June 2025.

In discussion the following points were raised:

1. The Chair welcomed the positive outcome of the independent review of Trust services by the CQC.
2. The Chair noted the focus on accountability in the 2025/26 planning guidance and welcomed further development of the Integrated Performance Report to give greater visibility to key metrics to provide assurance to the Integrated Care Boards on progress.

B Kilmurray thanked the board for their best wishes and messages of support following the announcement of his departure and he confirmed that the board would be briefed on any interim arrangements.

The Chair placed on record the board's thanks for the exceptional work he had undertaken as Chief Executive and proposed that his resilience and leadership had been a significant factor in stabilising the organisation and building a platform for further transformation.

24/25-187 INTEGRATED PERFORMANCE REPORT

P Scott presented the report, which proposed there was good controls assurance on the oversight of the quality of services delivered, good performance assurance on the Integrated Performance Dashboard, reasonable performance assurance on the National and Local Quality Standards and reasonable performance assurance on waiting times.

He noted a correction to the reported metric on out area placements at 31 December 2024, which should be 2 [page 72].

N Lonergan reported from Durham, Tees Valley and Forensic Care Group and drew attention to: the inclusion of additional narrative on bed occupancy; an OPEL event mid-February to strengthen the bed management process; and the establishment of a deep dive into Talking Therapies alongside leadership support to help teams improve processes.

Z Campbell reported from North Yorkshire, York and Selby Care Group and drew attention to: improved compliance with section 17 standards and 24 hour follow-up; an increase in patients clinically ready for discharge, due to a decrease in the availability of care home placements; and the development of the patient tracker list for community services to monitor waiting times.

In discussion the following points were noted:

1. S Dexter-Smith advised of an improvement in mandatory and statutory training, with further details to be reported to Quality Assurance Committee.
2. L Romaniak drew attention to January 2025 data, which indicated that 15.7% of adult beds and 21.9% of older adult beds – a combined figure of 18.8% - were occupied by patients who were clinically ready for discharge. This represented a deterioration in perceived productivity from 2024 and costs in excess of £7m.

   The Chair queried what further action the Trust may take with system partners to improve the position.

   N Lonergan commented on arrangements in place to monitor the position, to discuss delays with local authorities and to escalate concerns to integrated care boards. She noted an increased challenge in achieving complex packages of care to support the discharge of those with the longest stay.

   Commenting further, Z Campbell confirmed that service level conversations took place with partners about every individual whose discharge was delayed. She commented on challenges related to lack of appropriate social care accommodation and provision in the community and also noted a pressure in North Yorkshire, where there was a greater number of private care home providers who would not take patients that required a higher level of care.

   P Scott commented on improved engagement by local authorities and integrated care boards to seek solutions and B Kilmurray also noted the opportunity to use resources creatively to support individuals in their community, to reduce the need for them to enter hospital.
3. It was noted that service users and carers in North Yorkshire had expressed concern about bed availability due to the placement of patients from elsewhere in the Trust's geography.

   B Kilmurray acknowledged the negative impact that a placement outside of a patient's community would have on their experience and that of their family.

   B Reilly advised that Quality Assurance Committee was sighted on the concern and had requested a report to provide clarity on the position and she proposed that the Integrated Performance Report be updated to include related information.
4. It was noted that the Integrated Performance Report had been updated to reflect the discussion at the last board meeting and this was welcomed.
5. Attention was drawn to waiting times for children and young people eating disorder services and talking therapies and a query was raised about the focused work could be undertaken in response and the timescales for improvement, if the Trust had the necessary resources.
6. The Chair reflected on the positive development of the Integrated Performance Report and its continued refinement in the context of an increased focus by the system on the accountability of providers. He proposed there was an opportunity for board members to meet to discuss how the narrative of the report would be developed to provide an overall sense of areas of concern and progress.
7. B Reilly drew attention to the reported overall bed occupancy figure of 99.66% and patients clinically ready for discharge at an average of 30 adults and 32 older adult beds,

which equated to approximately three wards at a cost of £6.3m. She advised that Quality Assurance Committee had sought to understand the impact of transformation proposals and queried progress made towards 85% bed occupancy.

In response, L Romaniak advised that 85% occupancy was the standard at which the Trust was commissioned and she noted the impact that a higher level of occupancy would have on staffing and productivity. She proposed that a reduction to 85% would remain a challenge while the Trust had high numbers of patients who were clinically ready for discharge.

Commenting further, N Lonergan noted the report outlined risks to delivery of transformation activity over the next 12 months and suggested that the Trust's bed occupancy standard may change over time with a stronger focus on community services.

Bringing the discussion to a close, the Chair reflected that the Integrated Performance Report provided an overview of current performance and highlighted areas that required transformation with partners in order to make progress. He proposed that a link be made in other board papers to proposals that would support transformation activity.

Agreed: *There is good controls assurance on the operation of the performance management framework; good performance assurance on the Integrated Dashboard Report; reasonable performance assurance on the National and Local Quality requirements and waiting times; and strategic risks are being managed effectively.*

24/25-188 REPORT OF THE CHAIR OF PEOPLE, CULTURE AND DIVERSITY COMMITTEE

R Barker, Chair of People, Culture and Diversity Committee, presented the report, which outlined matters arising from the committee meetings held on 11 December 2024 and 23 January 2025. She commented on key matters considered at the meetings and advised that committee had noted increased compliance and had good assurance, based on the quality of data and reporting mechanisms.

Responding to an earlier query on the Board Assurance Framework safe staffing risk, S Dexter-Smith proposed that there was increased assurance and an opportunity for the committee to consider a reduction in the risk score towards the end of the financial year. She also commented on a piece of work to review the apprenticeship levy to ensure it was used in a strategic way to support workforce requirements.

24/25-189 REPORT OF THE GUARDIAN OF SAFE WORKING

K Kale presented the independent report on behalf of the Guardian of Safe Working, which outlined compliance levels in relation to terms and conditions of employment for resident doctors, focused on their hours of work and rest periods.

In discussion the following points were raised:

1. Responding to a query on historical fines related to the non-resident on call rota in North Yorkshire and York, K Kale advised that from April 2025 the Trust would adopt a hybrid rota to improve the position.
2. K Kale provided assurance that concerns would continue to be raised, whilst the post of Guardian of Safe Working was vacant, and noted there were also other routes by which concerns could be raised.

24/25-190 PAY GAP REPORTS

K North presented the report, which proposed there was good assurance that the Trust had adhered to the statutory requirements of the gender pay gap reporting legislation, ethnicity and disability pay gap reporting.

In discussion the following points were raised:

1. It was noted that salary sacrifice schemes were a personal choice for staff and their deduction prior to the calculation of gross pay, would impact on figures reported and it was suggested that in future the report provide gross pay information pre and post any salary sacrifice deduction.

   K North confirmed that deduction prior to calculation was a national requirement and advised that the Trust did consider the impact of salary sacrifice in relation to the minimum and living wage.
2. A query was raised about the reported suggestion that the take up of salary sacrifice was higher among women and this had caused the pay gap differential, as the report indicated women were proportionally less likely to access a salary sacrifice scheme.

   Commenting further, L Romaniak noted that, whilst the Trust applied national guidance for salary sacrifice schemes, the report indicated there was a difference in relation to access due to minimum wage requirements, which would impact most on staff who were most disadvantaged, as a group that may already have limited credit options.

   She also proposed analysis be provided on average value or total value of salary sacrifice schemes accessed, to recognise that staff may access a number of schemes provided the minimum wage was not breached.
3. A query was raised about the analysis of the gender pay gap and it was proposed that this be revisited prior to publication.
4. A query was raised about the identification of actions to target the main driver of the gender pay gap, which was due to a proportionately lower representation of women in higher paid roles and a higher representation of women in lower paid roles.

   It was also noted that a significant driver of inequity in the country was economic background and assurance was sought on the Trust's role as an anchor organisation and in the recruitment from disadvantaged groups and groups with a protected characteristics.

   K North acknowledged the points raised and agreed that it was important to be able to demonstrate impact and she proposed to share details of Trust activity in the next report and to discuss specific queries through the People, Culture and Diversity Committee. She went on to comment on the extent of compliance reporting and the impact of this on capacity to undertake proposed actions, which had been raised regionally.
5. K Kale drew attention to the inclusion of clinical excellence and long service awards in the gross pay calculation and the impact of this on the gender pay gap.
6. Responding to a query, K North agreed to review the gender pay gap position without the inclusion of female executive director pay.

Drawing the discussion to a close, the Chair proposed that feedback on the points raised be provided to board via People, Culture and Diversity Committee. **Action: K North**

Agreed:

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

ii. Gender pay gap data can be published on the Trust website and government website by 30 March 2025.

24/25-191 EQUALITY DIVERSITY SYSTEM 2022

K North presented the report, which proposed there was good assurance that the Trust had followed a robust process in completing EDG 2022 and had met its obligations.

In discussion the following points were raised:

1. A query was raised about the impact of actions in relation to the outcome that when at work, staff are free from abuse, harassment, bullying and physical violence from any source.

   In response K North noted the report covered the period 2024/25 and at that point was not able to provide evidence of impact to be scored as 'achieving activity'. She proposed the establishment of a task and finish group would help to support this alongside feedback from staff, reported incidents and work undertaken.
2. K North confirmed that the blank service/ward proforma would be removed from the published report.

Agreed:

i. There is good assurance that a robust process has been undertaken when completing the proposed scoring and evidence for EDG 2022, for 2024.
ii. The scores of EDG 2022 are ratified.
iii. Publication of EDG 2022 on the Trust website.

24/25-192 REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

B Reilly, Chair of Quality Assurance Committee, presented the report, which outlined matters arising from committee meeting held on 6 February 2025. She provided assurance that whilst the agenda was large, committee continued to focus on assurance.

In discussion the following points were raised:

1. B Murphy advised that the Trust would review its policy against principles published by NHS England on use of digital technologies in mental health inpatient treatment and care. She noted that committee had received assurance on this work and that the policy had been developed and reviewed with the lived experience community and the majority of service users and carers were happy to accept use of the technology.

   Responding to a query, she proposed the publication set out good practice principles and if inspected by the regulator the Trust would be expected to have taken account of the best evidence that was available.
2. The Chair queried the board's visibility of progress on proposals to exit teams from business continuity and B Reilly raised a concern that where a team remained in business continuity for some time, its position may become business as usual.

   It was noted that the position was explored at Quality Assurance Committee and B Murphy advised that Executive Review of Quality Group, attended by the executive clinical leads, would review a range of indicators related to the delivery of quality of care, which included teams in business continuity, related exit plans and the impact on care. She noted that this meeting would become part of new Executive Director Group meeting arrangements and as a result would benefit from the contribution of a broader range of executive directors.

   H Crawford also noted that deep dive work had been undertaken by care groups and advised that trends and services of concern would be considered at Executive Review of Quality Group and Executive Risk Group.

Z Campbell proposed that consideration be given to application of the term ‘business continuity’ and she commented on care group governance arrangements to monitor action plans and report into the Executive Review of Quality Group.

Summing up, B Kilmurray proposed that care groups and executive directors had good line of sight on services that required support and services would be reported to Quality Assurance Committee by exception. The Chair welcomed the assurance provided on process and he invited executive directors to reflect on board visibility of services that may have been in business continuity for some time.

24/25-193 NICHE INDEPENDENT ASSURANCE REVIEW

B Murphy presented the report, which outlined the findings from the final Niche Quality Assurance Review undertaken September to November 2024 and which proposed there was good assurance that the Trust had met the recommendations in the Niche independent reviews and that delivery of community child and adolescent services and quality governance was in line with expectations.

In discussion the following points were raised:

1. B Kilmurray noted that assurance against the Niche recommendations was key to the exit criteria for the oversight framework and these would be discussed at the next Quality Board and feedback provided to the next board meeting.
2. K Kale noted the independent review had considered 18 individual cases, complaints and serious incidents and had provided good assurance.

24/25-194 LEARNING FROM DEATHS REPORT QUARTER 3 2024/25

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

In discussion the following points were noted:

1. B Reilly advised that Quality Assurance Committee had received the national annual report on deaths of people with a learning disability and autistic people (LeDER) and assurance that the Trust was compliant with national guidance. She expressed concern about the backlog of reviews by the Integrated Care Board, which they had acknowledged, and noted the Trust had offered to provide support on those outside of the Trust area.
2. Assurance was sought on action the Trust had taken in relation to learning themes and K Kale commented on the process to identify and disseminate learning through a patient safety bulletin and the Organisational learning Group.

   H Crawford also noted that the Organisational Learning Group had been structured in response to a retrospective review of learning, which had identified 12 learning themes. The group – supported by the Directors of Nursing and the Patient Safety Team – reviewed two themes per meeting, to consider learning, areas of good practice, opportunities to integrate learning and how improvement and impact would be monitored.
3. It was noted that assurance on the implementation and consistency of learning would be reported to Quality Assurance Committee and escalated to board where needed.
4. Based on her experience at NHS Improvement, H Crawford advised there were five main themes for avoidable deaths for those with a learning disability and she proposed the Trust was well sighted on these and would focus on their implementation.

24/25-195 PATIENT CARER RACE EQUALITY FRAMEWORK

H Crawford presented the report, which proposed there was good assurance that the Trust had met its obligations under the Patient Carer Race Equality Framework.

In discussion the following points were raised:

1. H Crawford noted that the national framework was in early development and learning would be captured from a number of national pilot sites. She commented on a range of positive work with partners and grass roots community groups and proposed to share information with Quality Assurance Committee.
2. B Murphy drew attention to the raw data, which suggested there was disparity of experience in relation to use of restrictive practice, which reinforced the national position and she commented on the opportunity to work with community leaders to understand how the Trust would flex services to reach people at an earlier point.
3. Caution was expressed about publication of data without narrative and H Crawford agreed to provide further detail in the report. The Chair also proposed that the report indicate where narrative was in development, to show the Trust was not an outlier in respect of its commitment to the framework.
4. It was agreed that data on detentions under the Mental Health Act would be considered by Mental Health Legislation Committee.

Agreed:

i. There is good assurance that the Trust has developed data flows and a governance process, as required by the Integrated Care Boards.

ii. There is good assurance that the Trust has followed a robust process in producing and analysing the data required for the Patient Carer Race Equality Framework and in doing so has met its obligations.

iii. Publication of the Patient Carer Race Equality Framework on the Trust website.

24/25-196 REPORT OF THE CHAIR OF MENTAL HEALTH LEGISLATION COMMITTEE

R Barker, Chair of Mental Health Legislation Committee, presented the report, which outlined matters arising from committee meeting held on 13 January 2025.

In discussion the following points were raised:

1. In respect of section 17 leave and time away from the ward, B Murphy confirmed that the Organisational Learning Group had oversight of learning and the Quality Assurance Schedule would review compliance with standards, which the Trust reported to the Quality Board. She advised there was a consistent level of compliance in North Yorkshire, York and Selby Care Group and a good level of assurance on improvement in Durham, Tees Valley and Forensic Care Group.
2. A query was raised about oversight of section 17 leave by Quality Assurance Committee and Mental Health Legislation Committee and it was agreed that, whilst the committees considered the issue from different perspectives, the approach each would take would be confirmed. **Action: B Murphy, K Kale**
3. In response to a query on use of section 136 suites, B Murphy advised that Quality Assurance Committee had previously received a report on individuals who had waited or who had moved outside of their local community due to capacity and the review would be rerun to provide assurance on the current position. The previous report had highlighted an impact on a small number of people and the Trust had been commended on its work by the Chief Nursing Officer for England.

24/25-197 BOARD ASSURANCE FRAMEWORK

The Chair invited the board to consider if there had been any matters arising from the discussion at the meeting that changed the position outlined in the Board Assurance Framework.

No matters were highlighted.

24/25-198 REGISTER OF SEALINGS (FOR INFORMATION)

Noted.

24/25-199 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 disclosure of confidential information as defined in Annex 9 of the Constitution.*

On conclusion of confidential business, the meeting ended at 5.22pm

Board of Directors
Public Action Log

RAG Ratings:

	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
	Action in progress & date for completion of action not yet reached

Changes since the last board meeting are provided in bold

Date	Minute Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
10/10/24	116	Workforce Race Equality Standard (WRES)	It was noted at the meeting that there had been no identified improvement in WRES data - SDS advised that an objective had been agreed and support would be provided to the Leadership and Management Academy to consider the Trust's response. The Chair invited executive directors provide feedback on progress to a future board meeting.	S Dexter-Smith/ K North	Apr-25	in progress - Proposed that the action transfers to PCDC action log	Dec24 update: EDI discussions to be held at December and February committee meetings and January time out. The April board report will update the board on strategic plans in relation to areas of EDI static progress. Feb25: formal WRES, Workforce Disability Equality Standard (WDES) and Sexual Orientation Workforce Equality Standard (SOWES) reports discussed by committee in January, discussions underway about future leadership of equality, diversity and inclusion work to support accelerated progress (across patient and staff domains) **Apr25 update: Work on cultural competency for board is being scoped. Ulder the strategic refresh, this will be one of the key areas of focus, updating proposed areas of work in May committee. Proposed that the action transfers to the People, Culture and Diversity Committee (PCDC) Action Log.**
10/10/24	118	Transformation Programme	It was requested that a summary be provided to Quality Assurance Committee on each theme of the transformation programme, linked to the Integrated Performance Report/Board Assurance Framework and assurance to be provided to the Board.	P Scott	May-25	in progress	Dec24 update: TSB reported to Resources and Planning Committee in Dec24. Feb25: Report to be provided to Quality Assurance Committee in March 2025 - assurance to be provided to the Board via the committee report.
13/02/24	**184**	**Governor Question**	**Response to be provided to M Booth in relation to the governor question on safe staffing.**	**S Dexter-Smith/ K North**	**Apr-25**	**Complete**	**Response provided**
13/02/24	**190**	**Pay Gap Reports**	**Feedback on points raised during discussion be provided to the board via People, Culture and Diversity Committee. - analysis of gross pay information pre and post any salary sacrifice deduction. - analysis of average value or total value of salary sacrifice schemes accessed. - analysis of the gender pay gap position without the inclusion of female executive director pay.**	**S Dexter-Smith/ K North**		in progress - Proposed that the action transfers to PCDC action log	**Action to be transferred to People, Culture and Diversity Committee (PCDC) action log**
13/02/24	**196**	**Oversight of section 17 leave**	**Agreement on how oversight of section 17 leave between Quality Assurance Committee and Mental Health legislation Committee is managed, to ensure there is no duplication.**	**K Kale, B Murphy**	**Apr-25**	**Complete**	**Apr25 update: We have discussed this and agreed that assurance in relation to implementation of section 17 leave and completion of appropriate documentation will be sought by Quality Assurance Committee (QAC) on a regular basis as decided by the committee. The report and the discussion from QAC will also be presented to MHLC for information.**

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Chair's Report: 14th February – 9th April 2025.

Headlines:

External:

- Chairs / ICB meetings for North East North Cumbria and for Humber & North Yorkshire
- Health Inequalities Leaders Lunch & session
- Partnership session with Teesside University
- Oxyhealth visit to TEWV
- Carer Meeting York
- Carers Working Group
- NHS Providers Board meetings

Council of Governors (CoG)

- TEWV Council of Governors meeting
- 121 meeting Chair & Lead Governor
- Council of Governors
- Locality Governor Meeting North Yorkshire, York & Selby

Internal

- Leadership Walkabout Hartlepool EIP Team
- Extraordinary Board of Directors (2025/6 Financial Plan)
- Board Seminar
- Series of 121 meetings with various executive colleagues
- Series of 121 meetings with potential Chief Executive candidates
- (Interim) Director of Transformation & Strategy Interviews

Key themes for me:

1) Chief Executive recruitment process is progressing well despite NHS 'turbulence'.
2) Service visit was an insight into amazing frontline work and 'empowered' culture in TEWV teams.
3) Real progress in working with partners on key strategic outcomes including health inequalities, anchor institution status with other partners.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**10 April 2025**
Title:	**Board Assurance Framework – Summary Report**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Report Author:	**Phil Bellas, Company Secretary**

Report for:

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

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

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

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
10	Regulatory Compliance	Under its Provider Licence, the Trust must take all reasonable precautions against the risk of failure to comply with: a. The Conditions of the Licence, b. Any requirements imposed on it under the NHS Acts, and c. The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

Executive Summary:

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

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

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

A summary of the BAF is attached. It seeks to provide information on:

(a) The strategic risks together with positive and negative assurances relating to key controls which have been identified since the last board meeting

(b) Any new, emerging or increasing risks identified by the Board's committees

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

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

- Reportable Issues Log (confidential)

In regard to progress on managing the BAF risks (as at Quarter 4, 2024/25):

(1) The three lines of defense are articulated for each control identified in the BAF with the exception of:
   - BAF 2 (Demand) – Establishment Reviews – 3rd line
   - BAF 6 (Estates/Facilities Management) – Green Plan Submission and Monitoring - 3rd line

(2) In regard to changes in "present" risk scores during 2024/25:
   - BAF ref 11 (Roseberry Park) reduced in Q1
   - BAF ref 3 (Co-creation) reduced in Q4 but not to the extent planned due to the need to gain assurance on the embeddedness of the Co-creation Framework
   - BAF ref 8 (Quality Governance) was due to reduce in Q4. A reduction has been supported by the Quality Assurance Committee and confirmation will be provided to the Board in Q1, 25/26
   - BAF ref 10 (Regulatory Compliance) reduced in accordance with its planned trajectory at Q4; however, a new trigger has been identified that (should it materialise) will increase the score in Q1, 2025/26
   - BAF 13 (Public Confidence) was due to reduce in Q3; however, the score is being maintained due to ongoing uncertainties and national announcements.

(3) There have been no changes to the indicative controls assurance ratings of the BAF risks during Q4, 2024/25

(4) Those risks with the greatest variance between their "present" and "target" risk scores are as follows:
BAF 1 (Safe Staffing) – 10 point difference
BAF 5 (Digital - Supporting Change) – 10 point difference
BAF 7 (Digital – Data Security and Protection – 10 point difference
BAF 13 (Public Confidence) – 10 point difference

(5) Those risks with the greatest variance between their present score and tolerance (the acceptable upper threshold for day to day risk fluctuation) are as follows:
   - BAF 1 (Safe Staffing) – 11 point difference
   - BAF 13 (Public Confidence) – 11 point difference
   - BAF 5 (Digital – Supporting Change) – 8 point difference
   - BAF 7 (Digital Security and Protection) – 8 point difference
   - BAF 12 (Financial Sustainability) – 8 point difference*

*(*Note: cannot, at present, be mitigated to tolerance and therefore provides the greatest longer-term risk)*

Prior Consideration and Feedback None relating to this report.

Implications: None relating to this report.

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

BAF Summary

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/ Negative Assurances identified since last ordinary meeting	New, Emerging or Increasing Risks	Material Reports for consideration at the meeting
	1	2	3												
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.	**DoP&C**	**PCDC**	**High 20** (C5 xL4)	**Moderate 10** (C5 x L2) **Q3, 25/26**	**Q1, 25/26** Workforce plans in place for all services (-1L)	**Good**	Knowing which staff we need and where	▪ Daily operational processes in care groups ▪ Monthly e-roster reviews re fill rates etc ▪ Safe staffing reports re shifts over 13 hours, missing RN, missed breaks	**Positive:** **Deloitte Action Plan** Proposed good assurance on the timely implementation of the actions and impact of changes **Negative:** -	-	**Confidential Agenda Item 28** – Deloitte Action Plan
											Ensuring that staff are recruited to and safely deployed to the right places	▪ Rosters for inpatient services ▪ Daily management huddles/ staffing calls ▪ Daily safety huddles on wards			
											Staff are appropriately trained to support people using our services	▪ Daily safety huddles on wards ▪ Increasing number of development JDs in place to ensure people are safely developed into more senior roles ▪ Individual and manager compliance reports available weekly			
											Staff are supported to maintain their wellbeing, feel they belong and choose to stay and work here.	▪ Quarterly reviews and annual appraisals support staff ▪ Supervision – managerial and clinical ▪ OH provision ▪ Multiple H&W interventions including comprehensive support and psychological services – all with outcome measures			
											Ensuring that local leaders and managers are equipped to lead and maintain safe staffing	▪ Recruitment processes inc LE panel members ▪ 3 year leadership programme and quarterly leadership events for service management level and above			
											Early understanding of when things go wrong	▪ Operational escalation processes ▪ Links from services to ePCD increasingly strengthening ▪ Thinking about leaving interviews ▪ 'Working in TEWV' monthly online meetings			
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.	**Mng Dir**	**QuAC**	**High 16** (C4 xL4)	**Moderate 12** (C4 xL3) Q4 25/26	**Q4 25/26** Implement transformational developments (-1L)	**Good**	Partnership Arrangements	▪ Weekly operational interface meetings with Local Authority partners to support flow within inpatient services	**Positive:** **QuAC (3/4/25)** Waiting times: good assurance on the oversight of the quality of services being delivered **Negative:** **QuAC (6/3/25)** Limited assurance on the known impact of those people waiting to access our services in the community. Areas of concern	-	-
											Demand Modelling	▪ Associate Director of Strategic Planning and Programmes – Lead for demand modelling in the Trust			
											Operational Escalation Arrangements	▪ Inpatient wards – Management of admissions through PIPA process and the operational daily escalation calls ▪ Bed Management Team – Responsible for the oversight and management of the use of beds ▪ On-call arrangements – Agreement of actions in response escalation ▪ Freedom to Speak Up Guardian – Point of contact for staff with concerns about quality e.g. the impact of demand ▪ Daily Lean Management			

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	1	2	3									Processes – to understand and escalate risks associated with operational delivery are in place across inpatient and community services	are waiting for neurodevelopmental assessments and adults waiting for their second contact with Talking Therapies **QuAC (3/4/25)** Waiting times: reasonable assurance as the impact on quality for those patients waiting to access our services is not fully understood		
											Integrated Performance Reporting	▪ Operational delivery of performance standards by wards and teams ▪ Performance Department – Management of the IPR including validation of data, oversight of data quality and reporting to the various tiers of the governance structure				
											Establishment Reviews	▪ Safe Nursing Workforce Staffing Standards Team – Responsible for managing and delivering the establishment review process. This is based on: ▪ Acuity dependency assessments for each ward using the MHOST tool and professional judgements ▪ General Management reviews, including discussions with Matrons, on the ward assessments ▪ Assessments of a range of data including benchmarking, patient outcomes, staffing information e.g. use of temp staff and overtime ▪ Care Group Boards – Review the outcomes of the establishment reviews and development of proposals (included in the Establishment Review reports to the BoD) ▪ Finance Department – Reviews of affordability of the outcome of establishment reviews *(Reports to the FSB/EDG)*				
											Strengthen voice of Lived Experience	▪ Role of peer workers. ▪ Expanding opportunities of lived experience roles, including lived experience facilitators and senior lived experience roles/peers ▪ Service level service user and carer user groups ▪ Triangle of care ▪ Patient Experience reporting ▪ Understanding our complaints themes and impact on services ▪ Patient Safety Partners - PSIRF ▪ Partnership with clinicals networks – cocreation of clinical care initiatives and models ▪ Commissioning VCS lived in core services to meet identified needs			
3	✓	✓	✓	**Co-creation** **There is a risk** that if we do not fully embed co-creation **caused by** issues related to structure, time, approaches to co-creation and power **resulting in** fragmented approaches to involvement and a missed opportunity to fully achieve OJTC	DoCAI	QuAC	**Moderate 8** **(C4xL2)** ↓	**Low 4** **(C4 x L1)** **Q2/Q3 2024/25**	**Q2/Q3 2024/25** ▪ Co-creation Framework: final chapters to completed and rolled out trust-wide (-1L) ▪ Review to provide assurance on patient experience data (-1L)	**Good**	Further develop the co-creation infrastructure	▪ Director of Corporate Affairs and Involvement – Responsible for the delivery of the Cocreation priorities set out in Our Journey to Change (OTJC), and associated Delivery Plan ▪ Head of Co-creation ▪ Lived Experience Directors ▪ Involvement & Engagement (I&E) team ▪ Patient Experience team ▪ Peer Support team ▪ Clinical Leaders ▪ Service Managers	**Positive:** **Deloitte Action Plan** Proposed good assurance on the timely implementation of the actions and impact of changes	-	**Confidential Agenda Item 28** – Deloitte Action Plan

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	1	2	3								Friends and Family / Patient Experience Survey	▪ Director of Corporate Affairs and Involvement – Overall accountability for ensuring that the patient experience data and reporting of such, meets the statutory requirements ▪ Head of Patient Experience ▪ Patient and Carer Experience Team – Responsible for the organisation of patient experience activities including the Patient Experience Survey ▪ Performance Team – Responsible for the delivery of the Integrated Performance Approach including the patient experience metric (based on FFT data)	**Negative:** -		
											Complaints Policy	▪ Chief Executive – Overall accountability for ensuring that the Complaints Policy meets the statutory requirements ▪ Director of Corporate Affairs and Involvement – Responsible for the development, implementation and monitoring of the complaints policy ▪ Head of Patient Experience - Responsible for facilitating the effective reporting, investigation, and communication of all complaint activity ▪ Complaints Team Manager – Responsible for managing the complaints' function including the central database for complaints and producing statistical data ▪ Trust Organisational Learning Group – triangulation between all sources of intelligence to identify and act on service improvements. ▪ General Managers/Service Managers ▪ Ward/Team Managers/Modern Matrons ▪ Complaints Team			
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.	CN	QuAC	**High 16** (C4 x L4)	**Moderate 9** (C3 x L3) **1/4/25**	A number of actions will cumulatively achieve target score: ▪ Achieve safer staffing across all services – to within tolerable levels (1/4/25) ▪ Reduce occupancy on inpatient wards to 85% (TBC) ▪ Complete inpatient safety estates works (1/4/25) ▪ Transform community services and reduce waits for services (TBC) ▪ Achieve a	**Good**	Further develop the co-creation infrastructure	▪ Director of Corporate Affairs and Involvement – Responsible for the delivery of the Cocreation priorities set out in Our Journey to Change (OTJC), and associated Delivery Plan ▪ Head of Co-creation ▪ Lived Experience Directors ▪ Involvement & Engagement (I&E) team ▪ Patient Experience team ▪ Peer Support team ▪ Clinical Leaders Service Managers	**Positive:** **QuAC (6/3/25)** Good assurance on the six-monthly overview of progress with agreed priorities from the medicines optimisation and pharmacy framework (MO&PF), including the ongoing electronic prescribing and medicines administration (EPMA) project **QuAC (3/4/25)** ▪ NYYS Care Group - good assurance in	-	**Confidential Agenda Item 28** – Deloitte Action Plan
											Friends and Family/Patient Experience Survey	▪ Director of Corporate Affairs and Involvement – Overall accountability for ensuring that the patient experience data and reporting of such, meets the statutory requirements ▪ Head of Patient Experience ▪ Patient and Carer Experience Team – Responsible for the orgGooanisation of patient experience activities including the Patient Experience Survey ▪ Performance Team – Responsible for the delivery of the Integrated Performance Approach including the patient experience metric (based on FFT data)			

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	1	2	3						minimum of 85% compliance across all services with mandatory training, supervision and appraisal (TBC) ▪ Demonstrate robust floor to board quality governance (1/9/25)				terms of governance and robust oversight of perinatal services ▪ DTVF Care Group - good assurance following a second review which has revealed that whilst some patients are being admitted to Crisis Assessment /Health Based Places of Safety when waiting for an inpatient bed, they are safe and cared for ▪ Waiting times: good assurance on the oversight of the quality of services being delivered ▪ Good assurance relating to the Trust position for Mixed Sex Accommodation **IPR** Restrictive Intervention Incidents Used (metric 12) - *improved performance and controls assurance* **Deloitte Action Plan** Proposed good assurance on the timely implementation of the actions and impact of changes		
											Our Quality and Safety Strategic Journey	▪ Chief Nurse – Responsible for the development of Our Quality and Safety Journey ▪ Workstreams and key performance indicators have been developed for each of the Journey's four priorities ▪ The professional structure with the care groups have day to day oversight of the quality and safety of care ▪ Integrated Performance Dashboard is utilised to identify variance in care delivery ▪ Learning from serious incidents and near misses			
											Incident management policies and procedures	▪ Chief Nurse ▪ Responsible for ensuring the systems for incident reporting, identification of patient safety issues and reporting appropriate incidents through correct procedures is in place ▪ Clinical and operational Managers medical Staff, modern matrons responsible for the operational implementation of the policy and associated guidelines. ▪ MDT in teams ensure effective after action reviews.			
											Governance arrangements at corporate, directorate and specialty levels	▪ Individual Executive Directors – Responsible for the implementation and delivery of governance arrangements relating to their portfolios including: ▪ ERQ (CN) – Responsibilities include oversight of Serious Untoward Incident/Never Event management processes and receive lessons learnt for sharing across the Trust as appropriate ▪ CGBs (Mgt Dirs) – Responsibilities include Oversight of the day to day management of an effective system of integrated governance, risk management and internal control across the whole Care Group's activities			

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	1	2	3								Performance Management of Serious Incident Review	▪ Patient Safety Team - ▪ Responsible for ensuring all reportable serious incidents are reviewed within the agreed timescales following an internal governance process ▪ Daily patient safety huddles to review incidents of moderate harm and above to identify areas of immediate action and learning and support timely dissemination of information to mitigate risks ▪ Implementation of PSIRF Jan 24	**Negative:** **QuAC (6/3/25)** Limited assurance on the known impact of those people waiting to access our services in the community. Areas of concern are waiting for neurodevelopmental assessments and adults waiting for their second contact with Talking Therapies **QuAC (3/4/25)** ▪ NYYS Perinatal Services: limited assurance for the overall quality of care and patient experience ▪ Waiting times: reasonable assurance as the impact on quality for those patients waiting to access our services is not fully understood ▪ Reasonable assurance linked to the position for sexual safety within the Trust **IPR** ▪ Improvement following treatment - patient reported CYP showing measurable improvement following treatment patient reported (metric 4) - *reduced controls assurance* ▪ Incidents of moderate or severe harm (metric 11) - *reduced*		
											Organisational Learning Group	▪ PSIRF Policy ▪ PSIRF Implementation plan			

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	1	2	3										*performance assurance* ▪ Uses of the Mental Health Act (metric 15) - *reduced performance assurance*		
5	✓	✓	✓	**Digital – Supporting Change** There is a risk of failure to deliver OJTC goals, organisational and clinical safety improvements, caused by the inability to fully deploy, utilise, and adopt digital and data systems	**CEO (CIO)**	**RPC**	**High 20** (C5xL4)	**Moderate 10** (C5 x L2) **2025/26 Q4**	**30/6/2025** EPR deployment and optimisation programme control moves to substantial assurance (-1L)	**Good**	Embedded Digital Strategy and Delivery Plan	▪ Digital Management Meeting ▪ Digital Programme Board (DPB) ▪ Digital Programme Assurance Group (DPAG)	**Positive:** **RPC (27/3/25)** Good assurance in respect of work on digital improvement **Negative:** **QuAC (3/4/25)** Limited assurance on CiTo related actions due the change freeze	-	**Confidential Agenda Item** 25a – Electronic Patient Record
											EPR deployment and optimisation programme:	▪ Executive Strategy & Resources Group (ESRG) ▪ Cito Improvement Group (CIG) ▪ Clinical Advisory Group (CAG) ▪ Transformation & Strategy Board			
											Integrated Information Centre optimisation programme:	▪ Digital Programme Board (DPB) ▪ Digital Programme Assurance Group (DPAG)			
6	✓	✓	✓	**Estate / Physical Infrastructure** **There is a risk** of delayed or reduced essential investment **caused by** constrained capital resources **resulting in** an inability to adequately maintain, enhance or transform our inpatient and community estate, adversely impacting patient and colleague outcomes/experience.	**DoFE**	**RPC**	**Moderate 12** (C4 x L3)	**Moderate 12** (C4 x L3) **2028/29**	**2028/29** Estates Master Plan delivery achieves proposed rationalisation of estate to reduce call for capital and revenue funding on non-core assets (-1C & -1L) *(Note:* *Two other actions have been identified which may reduce or increase likelihood score but this will not be clear until the outcomes are known:* ▪ *NENC ICB CDEL funding methodology – March 2025* ▪ *Confirmation of national capital allocations - 2025/26 to 2027/28) - Summer/Autumn 2025* *One further action has been identified which expected to increase the risk score - Trust Refresh of 3-5 year*	**Good**	NENC Infrastructure board	▪ Executive Director of Finance and Estates/Facilities and Director of Estates, Facilities & Capital (or their deputies) represent the Trust at NENC meetings	**Positive:** - **Negative:** -	-	-
											Estates Master Plan	▪ EFM Directorate – Responsible for the preparation / delivery of the EMP in conjunction with the Care Groups based on an established prioritisation framework ▪ Finance Department – Responsible for the preparation of the annual capital and revenue financial plans for Board approval			
											CIG & CPSG	▪ Estates, Facilities, Capital and Finance teams work closely to ensure engagement across the Trust to collate capital investment priorities, risk / impact assess these and support agreement of final annual capital plan and medium term capital requirements			
											Estates, Facilities & Capital Directorate Management Team Meeting	▪ All of the directorate's functions provide monthly assurance reports to this meeting which is chaired by the Director of Estates, Facilities and Capital			
											ERIC, PLACE and PAM national annual reporting / benchmarks submission and monitoring	▪ EFM Directorate responsible for: ▪ **PLACE** ▪ Organising (with CA&I) the PLACE assessment visits ▪ Compiling the information ▪ Submission of the			

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	1	2	3												
									capital plan to inform Estate and Digital capital Requirement - March 2025 (will require refresh post-CSR)			information to NHSE ▪ Preparation of the Action Plan ▪ **ERIC** Compiling and submitting ERIC submission to NHSE ▪ **PAM** Self-assessment against the questions included in the PAM and on the delivery of resultant action plans, processes in train to ensure timely submission			
											Green Plan submission and monitoring	▪ EFM Directorate responsible for compiling and submitting Green Plan submission to NHSE / ensuring progress to deliver milestones			
											Environmental Risk Group	▪ Director of Estates, Facilities and Capital ensures aligned CPSG and ERG agendas, including close collaboration with Chief Nurse / MD DTVF joint chairs ▪ Directors of Operations / Operational teams support identification of environmental issues ▪ Service desk tracks levels of maintenance issues			
7	✓	✓	✓	**Data Security and Protection** There is a risk of data breach or loss of access to systems, caused by successful cyber-attack, inadequate data management, specialist resource gaps, and low levels of digital literacy resulting in compromised patient safety, impacts on business continuity, systems and information integrity, reputational damage and loss of confidence in the organisation.	**CEO (CIO)**	**RPC**	**High 20** (C5 x L4)	**Moderate 10** (C5xL2) **2025/26 Q3**	**30/6/2025** Internal Audit assurance on 2024/25 DSPT with submission of Meets Standards; and control moves to substantial assurance (-1 L)	**Good**	Digital, Data & Technology (DDAT) Skills and Knowledge	▪ Digital and Data Management Meeting (DDMM) ▪ Digital Programme Assurance Group (DPAG) ▪ Digital Programme Board (DPB)	**Positive:** **RPC (27/3/25)** Good assurance of progress on the implementation of actions in response to Internal Audit reports **Negative:** -	-	-
											Secure IT infrastructure and asset management.	▪ DPAG			
											Cyber Security and Incident Management	▪ DPAG			
											Data Security and Protection Toolkit (DSPT) and Information Risk Management fully operational	▪ DPAG			
											Robust Clinical Safety and Change Control	▪ DPAG ▪ DPB ▪ Digital Change Assurance Board			
											Digital service delivery monitoring	▪ Digital Programme Assurance Group (DPAG)			
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	**CN**	**QuAC**	**Moderate12** (C4 x L3)	**Moderate 9** (C3 x L3) **01/01/25**	A number of actions will cumulatively achieve target score: ▪ Implement the	**Good**	Open and transparent culture working to organisational values steered by Our Journey to Change	▪ Cohesive Board ▪ Engaged and visible Executive ▪ High Quality Care Group Directors ▪ Substantive recruitment of service leadership and clinical teams	**Positive:** **QuAC (6/3/25)** ▪ Good assurance in relation to the	-	**Confidential Agenda Item 28** – Deloitte Action Plan

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	1	2	3	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.					Quality Dashboard ▪ Embed the Executive Review of Quality and supporting forums as an enabler to identifying and managing risks to quality of care ▪ Develop the role of the Associate Director of Nursing and Quality to increase curiosity into the Fundamental Standards of Care ▪ Review and relaunch the Quality and Safety priorities within Our Journey to Change ▪ TEWV Leadership Academy will help all leaders enact their role to safeguard and improve quality		Executive and Operational Organisational Leadership and Governance Structure Quality Management System Oversight / Insight / Foresight	▪ Chief Executive – Responsible for the Operational Leadership and Governance Structure ▪ Executive Directors – Responsible for the delivery of key elements of the Leadership and Governance Structure within their portfolios ▪ Co Sec – Responsible for the provision of secretariat services within the governance structure ▪ Care group clinical leaders responsible for the oversight of care delivery ▪ The QI team is well established and embedded into services. ▪ There is an operational, clinical and professional leadership structure. ▪ There are Improvement plans for incidents, complaints and inspections. ▪ The IPD tracks performance monthly. ▪ The Care Group Board oversees delivery of services. ▪ Performance team are responsible for measuring and reporting performance ▪ Chief Nurse leads the nursing and quality directorate who have responsibility to measure and report out on - patient safety - quality governance -audit - infection, prevention and control - safeguarding - risk -Use of Force ▪ Chief Nurse lead the executive review of quality reporting to QuAC ▪ Medical Director leads on a number of patient safety priorities including Mortality review and Sexual Safety ▪ Care groups have dedicated clinical leaders at director delivery levels with a role to assess delivery of care standards	proposed delivery and monitoring of the clinical effectiveness and quality assurance activities for 2025/26 and the annual Programme. ▪ Good assurance relating to the operational and strategic oversight of clinical effectiveness activities **QuAC (3/4/25)** Good assurance relating to the visibility of all Quality and Equality Impact Assessment across the Trust **ARC (17/3/25)** Good assurance in relation to the proposed delivery and monitoring of clinical effectiveness and quality assurance activities for 2025/26 **Deloitte Action Plan** Proposed good assurance on the timely implementation of the actions and impact of changes **Negative:** **QuAC (3/4/25)** Reasonable assurance relating to the operational and strategic oversight of the key quality and safety measures within the Quality Dashboard Reasonable assurance relating to the actions		

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	1	2	3										underway to improve the use of clinical outcome measures, reporting and monitoring		
9			✓	**Partnerships and System Working** ***There is a risk that*** *failure to effectively align our strategic priorities to the priorities of the Integrated Care Boards, Provider Collaboratives and 'places' within which we operate* ***due to*** *our leadership capacity to the system governance arrangements* ***resulting in*** *our ability to influence service transformation and improve the health of the communities we serve being limited* (Draft revised – to be confirmed)	**DCEO**	**RPC**	**-**	**-**	-	**-**	Alignment to system Governance at ICB and place level to help shape system strategic planning and delivery	▪ Engagement in a wide range of partnership functions and committees/ groups across each place, in line with individual place governance structures ▪ Joint work / operational processes with local authorities and other partners including PCNs ▪ Development of alliances and partnerships with other organisations, including the voluntary sector, to deliver services into the future ▪ Attendance at specialist provider collaborative governance groups ▪ ICB lead on Inpatient Quality Transformation (including bed census) ▪ AD Strategic Planning and Programs placed into NENC ICB MHLDA Transformation Team for one day per week and HNY steering group for 12 months. ▪ AD Strategic Planning and Programs and Finance Business Partner attendance at HNY Operations Group	**Positive:** **Deloitte Action Plan** Proposed good assurance on the timely implementation of the actions and impact of changes **Negative:** -	-	**Public Agenda Item 13** – Our Journey to Change – Next Steps **Confidential Agenda Item 25b** - Yorkshire and Humber Perinatal Provider Collaborative Partnership Agreement **Confidential Agenda Item 28** – Deloitte Action Plan
											Strategic Framework	▪ Visibility of Strategic Framework through internal / external comms (so that it is widely known what our strategic Goals and Objectives are)			
10			✓	**Regulatory compliance** **There is a risk** that failure to comply with our regulatory duties and obligations, at all times, could **result**	**CEO**	**Board**	**Moderate 8** (C4 x L3) ↓	**Moderate 8** (C4 x L2) **31/03/25**	31/3/25 Delivery of CQC Improvement Plan (-1L)	**Good**	Statutory Reporting	▪ Reporting requirements and timetables developed by the Company Secretary ▪ Information provided by designated leads ▪ Reports produced by Corporate	**Positive:** **ARC (17/3/25) -** ▪ Good	-	**Confidential Agenda Item 28** – Deloitte Action Plan

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/ Negative Assurances identified since last ordinary meeting	New, Emerging or Increasing Risks	Material Reports for consideration at the meeting
	1	2	3												
				in enforcement action and financial penalties and damage our reputation								Affairs and Communications based on submissions received. ▪ Annual Accounts timetable drafted by Head of Accounting and Governance ▪ Annual Accounts (and related TAC submissions) undertaken by the Finance Staff ▪ Head of Financial Accounting and Governance considers and coordinates annual training needs for annual accounts team ▪ Accounting ledger and accounts payable entries reviewed including to ensure accurate coding to support reporting as well as VAT recovery	assurance on progress to deliver agreed audit plans, with 2023/24 audits having completed and eleven final 2024/25 reports issued ▪ Modern Equivalent Asset Valuation – Committee assured that the Trust was financially well governed and reporting in line with national requirements. The Trust remained compliant with current requirements of the Group Accounting Manual (GAM) and accounting standards and had contributed to national policy conversations and proposals on policy change ▪ Core Standards for Emergency Preparedness, Resilience and Response - Good assurance from the Trust's final assurance rating for 2024 against NHSE standards **RPC (27/3/25)** Good assurance on the management of the relevant strategic risks included in the BAF		
											Provider Licence	▪ Board certification processes undertaken by the Company Secretary ▪ Delivery of related by policies by operational and corporate departments ▪ Commissioning of external governance reviews, preparation of evidence for and support by the ACE and Co Sec ▪ Delivery of improvement plans by designated leads			
											Environmental Sustainability	▪ The Estates, Facilities and Capital Team are maintaining day to day BAU ▪ Estates & Facilities DMT maintain routine operational oversight			
											Statutory Financial Duties	▪ Processes overseen by the Head of Financial Management including annual budget holder sign off of budgets / establishments following agreement of annual budget setting processes ▪ Annual budget prepared by DoFEF ▪ Monthly financial reports and refreshed forecast outturn positions prepared by Finance Department to support agreement with Care Groups / Directorates and returns for submission to NHSE ▪ Budget holder management of individual budgets ▪ Accountability Framework sets out responsibilities for financial management			
											Compliance with the CQCs Fundamental Standards of Quality and Safety	▪ Day to day delivery of the fundamental standards by ward and team staff ▪ Responsibility for delivery of each element of the CQC Action Plan designated to lead Directors ▪ Chief Nurse is the lead Executive for relationship management with the CQC			
											Compliance with Mental Health Legislation (MHL)	▪ Delivery of the requirements of MHL by ward and team staff			

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/ Negative Assurances identified since last ordinary meeting	New, Emerging or Increasing Risks	Material Reports for consideration at the meeting
	1	2	3								Equality, Diversity, Inclusion and Human Rights	▪ The Director of People and Culture has operational responsibility for Equality, Diversity, Inclusion and Human Rights throughout the Trust in both Employment and Service Delivery ▪ EDIHR Lead and officers: ▪ Provision of support for inclusion networks ▪ Compilation of Equality Act 2010 data ▪ Compilation of evidence and consultation on the EDS ▪ Support for the development of the Trust's equality objectives ▪ Designated managers/leads: ▪ Completion of equality analyses ▪ Delivery of actions under the EDS ▪ All staff are responsible for co-operating with measures introduced by management to ensure equality of opportunity and non-discriminatory practices, including making sure that people have equality of access to service provision ▪ Public Health Consultant engaged to develop the Trust's approach to tackling health inequalities	**Deloitte Action Plan** Proposed good assurance on the timely implementation of the actions and impact of changes **Negative:** **ARC (25/3/25)** ▪ Reasonable assurance from the management and oversight of risks at the last two meetings of the Executive Risk Group ▪ Risk Management Strategy and Policy: reasonable assurance from the progress on managing risks, with oversight by the relevant Committees. It was noted that the next report was likely to see assurance moving from reasonable to good **RPC (27/3/25)** Reasonable assurance related to the risk management processes in place **IPR** Uses of the Mental Health Act (metric 15) - *reduced performance assurance*		
											Risk Management Arrangements	▪ Care Group Managing Directors, General Management Tier and Service Management Tier – ▪ Consider capture and maintain risks raised by staff in local risk registers ▪ Develop and implement action plans to ensure risks identified are appropriately treated ▪ Ensure that appropriate and effective risk management processes are in place and that all staff are made aware of the risks within their work environment ▪ Other Executive Directors - Responsible for ensuring effective systems for risk management, are in place within their directorate ▪ Head of Risk Management – Day to day management of the Trust Risk Register			
											Health Safety and Security (HSS)	▪ The Trust has a Health, Safety and Security Team who manage the day-to-day Health and Safety requirements in line with all relevant parliamentary acts ▪ Reporting system is in place for the reporting of incidents which fall under the requirements of Reporting of Incidents of Disease and Dangerous Occurrences regulation (RIDDOR) ▪ Provision of HSS information for new employees at Trust induction. ▪ HSS awareness training forming part of all staff mandatory package.			

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/ Negative Assurances identified since last ordinary meeting	New, Emerging or Increasing Risks	Material Reports for consideration at the meeting
	1	2	3												
												▪ HSS online tool kit available for all services, wards and departments across the trust. ▪ Regular workplace audits undertaken by the HSS team. ▪ Incidents recorded on 'InPhase' are shared with relevant service leads, including HSS. This enables investigation of incidents to identify trends and flag any remedial actions			
											Executive and Care Group Leadership, management and governance arrangements	▪ Individual Executive Directors – Responsible for the implementation and delivery of governance arrangements relating to their portfolio ▪ Individual staff compliance with the range of policies relating to regulatory compliance e.g. health and safety			
											Inquests and Coroners	▪ Inquest Team - Management of the Inquest process from a Trust perspective including: ▪ Arranging and compiling witness statements and submission to Coroner ▪ Instruction of Solicitors ▪ Co-ordination and compilation of information ▪ Provision of support for staff ▪ Preparation of responses to Regulation 28 Reports by staff nominated by the CEO			
11	✓	✓	✓	**Roseberry Park** **There is a risk that** the necessary Programme of rectification works at Roseberry Park and impacted by limited access to capital funding **could adversely affect** our service quality, safety, financial, and regulatory standing.	**DoFE**	**Board**	**High 16 (C4xL4)**	**Moderate (12) (-1L)**	**Risk score not to be reduced by 2028/29 – uncertain capital outlook / cashflow risks** Two actions have been identified to support achievement of the risk score; however, delivery dates are uncertain: ▪ Roseberry Park Rectification Works complete ▪ Medium Term NHS and ICB Capital allocations confirmed nationally	**Good**	Roseberry Park Rectification Programme	▪ Programme Director and Programme Manager – Responsible for managing the RPRP including key risks and issues log (Assurance to weekly huddle)	**Positive:** - **Negative:** -	-	-
											Capital Programme	▪ Trust CPSG overseeing agreement of priorities for capital investment / impact assessment ▪ DMT overseeing detailed milestone capital project planning ▪ NENC Infrastructure Board (ICS Estates & Finance Directors)			
											External Audit				
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	**DoFE**	**RPC**	**High 20** (C5 x L4)	**High 20** (C5 x L4) **2028/29**	**2028/29** A number of actions have been identified which might cumulatively reduce the risk score; however, the target score is being maintained at the present level given national and regional	**Good**	ICB Financial Governance including Mental Health LDA Sub Committee and CEO and DoF financial planning groups and sub groups	▪ DoFE member of ICS DoF/CFO group ▪ DoFE member of ICS Resource Allocation Steering Group ▪ CEO member of NENC CEO provider collaborative group ▪ CEO led HNY provider collaborative work for MHLDA to date. ▪ DCEO / CNTW COO leading Provider collaborative work to assess implications for beds / pathways and clinical models	**Positive:** **ARC (17/3/25)** Good assurance of strong financial governance, robust processes and that public money was not being expended on disproportionate levels of losses or special payments during 2024/25	▪ Nationally negotiated pay awards ▪ Asset valuation ▪ Employer 3-yearly auto enrolment for pension (See RPC report)	**Confidential Agenda Item 24** – Going Concern Report **Confidential Agenda Item 27** – 25/26 Financial Plan
											Financial Sustainability Board	▪ Financial reporting using intelligence from Care Groups, Directorates and costing transformation programme to inform management of			

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/ Negative Assurances identified since last ordinary meeting	New, Emerging or Increasing Risks	Material Reports for consideration at the meeting
	1	2	3												
									uncertainty			underlying financial position	**IPR** Financial Plan: Agency expenditure compared to agency (metric 25a) - *improved controls assurance* **Negative:** -		
											Business Planning and Budget Setting Framework and in Year Financial Forecasting & Recovery Arrangements	▪ DCEO -Responsible for the delivery of the Business Planning Framework ▪ DoFEF and EDG – Responsible for arrangements to develop the Financial Plan including tracking the recurrent and non-recurrent implications and underlying financial position and cost drivers ▪ Managing Directors (for Care Groups) and other Execs (for their Directorates) responsible for management of costs with budgets and/or agreed forecasts and informing assumptions to underpin financial planning using business planning processes. (Reporting into FSB and EDG with assurances into P&PC and Board)			
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	**DoCAI**	**Board**	**High 20** (C5 x L4)	**Moderate 10** (C5 x L2) **Dec 24**	**Q3 2024/25** (-2L) Refreshed trust-wide communications strategy	Reasonable	Communications Strategy	▪ Director of Corporate Affairs and Involvement ▪ Head of Communications ▪ Communications team	**Positive:** - **Negative:** -	-	-
											Stakeholder Communications and Engagement Strategy	▪ Trust Board ▪ Director of Corporate Affairs and Involvement ▪ Care Group Board Directors ▪ Head of communications ▪ Corporate Affairs and Stakeholder Engagement Lead ▪ Communications team			
											Social Media Policy	▪ Director of Corporate Affairs and Involvement – responsible for the development, implementation and monitoring of the social media policy ▪ Head of communications ▪ Comms team – responsible for ongoing monitoring of social media ▪ General Managers/Service Managers – ▪ Ward/Team Managers/Modern Matrons – as above ▪ Complaints team ▪ Patient experience team ▪ Clinical leaders ▪ Service managers ▪ People and Culture			

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**10 April 2025**
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***
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.*
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*

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.

National Announcements

There are significant changes to the executive leadership of NHS England. This began with the resignation of Amanda Pritchard in February and was followed by announcements that other executives would be leaving by the end of March 2025. Sir Jim Mackey has since been appointed as transitional CEO of NHS England and has appointed a new executive team.

On 13th March 2025, the Prime Minister announced that NHS England would be abolished and its core statutory functions would be subsumed into the Department of Health and Social Care. At exactly the same time leaders from across the NHS were called to a meeting in London to coincide with this announcement.

In addition to a call to action for Trusts and systems to make their very best endeavours on bringing together our strongest planning submissions for 2025/26, working towards financial balance and the strongest plans to deliver key targets, there were a set of specific issues raised regarding the changes to NHS England, also to Integrated Care Boards, provider collaboratives and clinical networks. The requirement is that for each of these that there be a 50% reduction to running costs.

There was also a requirement for provider organisations to reduce growth in corporate costs by 50%.

Since the meeting there has been no detail provided. We understand that there is to be a letter to the service at the beginning of April setting out further information. There will be national model severance and redundancy schemes published in due course. Only national and ICB schemes are likely to be backed by central funding. Any schemes applied in Trust's will need to be funded locally and based on a business case.

These changes sit in the context of significant financial pressures and a requirement for an operational activity stretch. There is much discussion about productivity improvement and transformation. Clearly, this all comes during a time, when the government is currently writing the 10 Year Health Plan. The transitional model that will allow us to deliver the scale of efficiencies set out will require significant organisational focus and careful change management, at a time when an emphasis on transformation, careful financial management and meeting todays demand will mean this is one of our most challenging years.

NHS Performance Framework

NHS England's Board considered a paper on 27th March on the NHS Performance Assessment for 2025/26. There had been significant engagement with the service prior to this.

This work had been started well before the latest announcements were made regarding the running cost reductions in ICBs and the changing structure for NHS England. It is anticipated that, whilst this framework will stand for this financial year, there are likely to be considerable more changes to the overall NHS operating model and significant changes to

the approach to oversight. Some of the most significant aspects of this will be covered in legislative changes and may take longer.

This new framework will be applied to Trust and ICB plans in Q1. This will form part of a testing of this framework and feedback will be sought.

It is intended that the performance framework will form a key part of the NHS operating model, be supported by transparent comparative data and be linked to the Very Senior Managers pay framework.

Each ICB and Provider will be allocated a segment. This indicates its level of performance from 1 (highly performing) to 4 (poorly performing) with an additional segment 5 to indicate intensive support required. Individual organisations with be measured against their own responsibilities, breaking the previous linkage to system overall performance that was previously mentioned in the engagement phase.

There will also be a Leadership Capability Assessment to inform segmentation. This will be based on the six domains of the Insightful Board documentation using a self assessment, third party information and measures of track record.

The Board paper appended a list of metrics linked to the operating priorities for 2025/26 on the basis that these are likely to be those used to assess our performance. I have attached this list to this paper. Executive will be undertaking some review of these and self assessing against them. The Insightful Board guides were circulated to Board members in late 2024.

Link to paper - https://www.england.nhs.uk/long-read/the-nhs-performance-assessment-framework-for-2025-26/

TEWV Operating Framework

An operational framework is a tool that can be used to help plan, implement, and monitor an organisation's activities. It can provide a common language and understanding for all members of the organisation and can be used to communicate the organisation's goals, objectives, strategies and help ensure alignment of effort across corporate and clinical teams and ensure we have the capabilities and tools and methodologies to maximise the potential of our workforce.

We are operating in an increasingly challenging environment including:

- The recently announced changes to NHSE and the ICB'S
- The soon to be published 10 year plan and 3 big shifts
- Intensely challenging financial position
- Consideration of corporate benchmarking and challenge to reduce by 50% growth in corporate services

Therefore it is important that we align as effectively as possible our efforts to provide ongoing assurance around quality and safety issues, operational delivery and financial sustainability.

The operating framework will provide an opportunity to bridge the Gap between BAU, Delivery plan and Transformation agenda.

These cover two related areas:

World Class Planning, Delivery, Management and Leadership

This element of the operating framework covers the corporate support needed to help us deliver world class management. This support could be in such areas as:

- Data availability, analysis and intelligence
- Digital solutions
- Developing managers / leaders
- Removing waste and enhancing productivity
- QI coaching
- Planning and investment tools such as business cases, business plans, options appraisal, capacity & demand
- Project and programme management approaches and tools
- Outcome data collection / analysis
- Supply chain management (i.e. contracting / contract management tools)
- Quality Management System

These could potentially be grouped under the headings

1) Cohesive centre of corporate expertise
2) Digital and data
3) Governance
4) Leadership

Executive's view was that if the support for world class management is right the benefits would be:

- Ground up assurance
- Consistency
- Agility in developing / delivering transformation
- Understanding our changing communities better
- Better prioritisation of where and how we use our resource
- Constant improvement
- Positive changes in how we live the values, i.e. fewer pockets of "bad" culture and behaviours
- A separate accountability framework will not be required

A principle underlying the new Operational Framework would be that corporate teams will develop tools and methodologies that operational managers can use. The Leadership and Management Academy (LAMA) would help to spread the required competencies. Corporate teams can then be brought into do specialist / complex work without this causing bottlenecks elsewhere.

Connecting and Aligning Work to deliver Our Journey to Change

Executive and the Transformation and Strategy Board have been considering how we govern transformation in a way that recognises the role that Care Groups and Corporate Services have in delivering the "totality of change"

The diagrams in appendix 1 have been discussed by Transformation and Strategy Board and will guide this board's metamorphosis to become the Transformation Delivery Board.

Proposed next steps

There will be further development work required to bring the framework to life. The Leadership and Management Academy (LaMA) Board will be tasked with developing and delivering a development programme for team and service management leaders within clinical and corporate services. We will establish a programme for corporate and care group directors, deputy directors and senior leads to develop tools and ways of working to transform our approach to delivering the annual plan. We will align the work to develop a quality management system.

EM Inquest

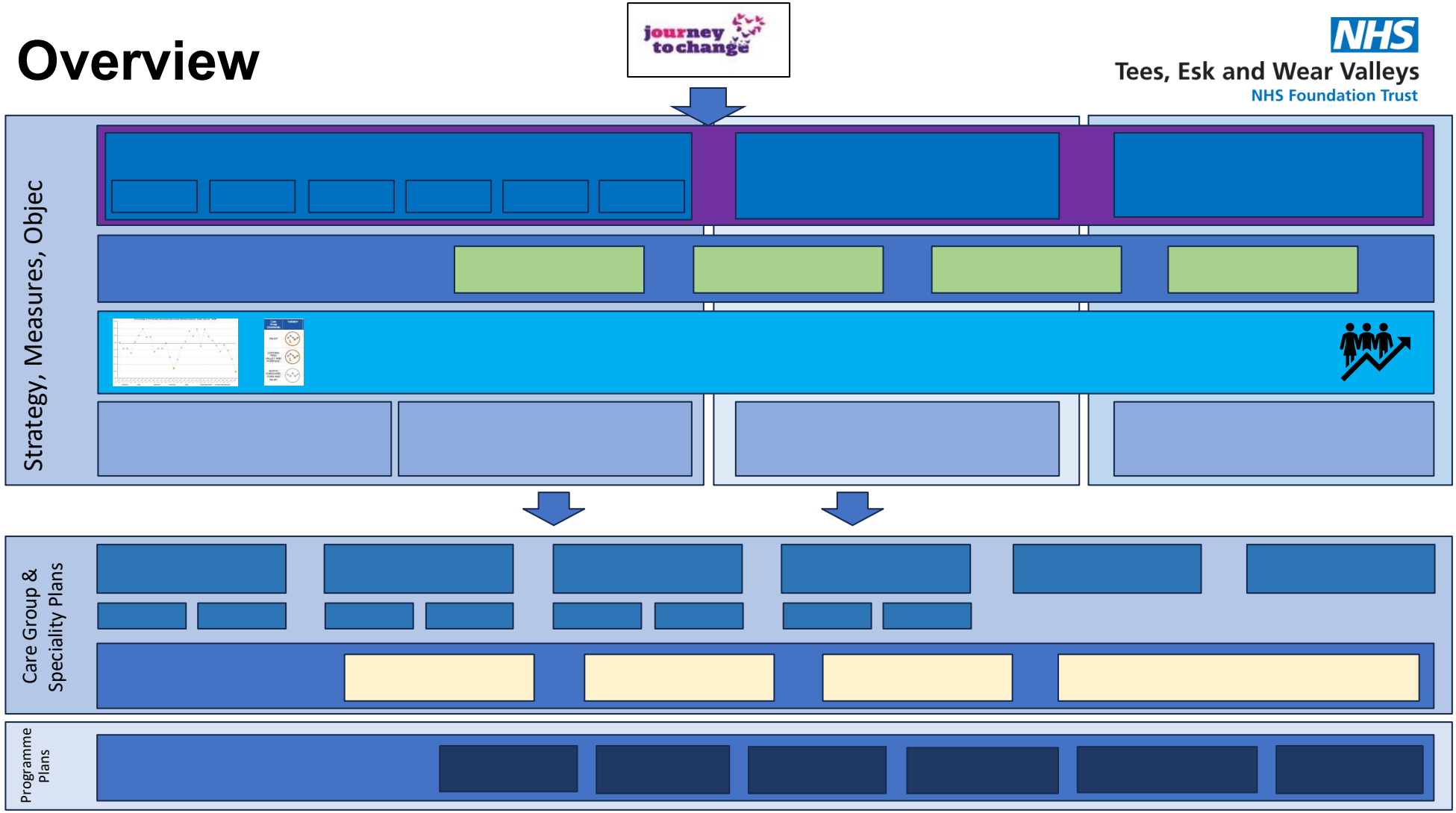
The Durham Coroner held a Pre-Inquest Review hearing on Friday 13th March regarding Emily Moore. The coroner issued directions with regard to the scope of the hearing, a potential timeframe, requests for further information from interested parties, requirements on experts and other potential witnesses. The next deadline is 11th April 2025 for submissions. The deadline for all witness statements is early May 2025.
There will be a further review meeting in June and the hearing itself is being listed to be heard in front of a jury between 2nd March and 2nd April 2026. The coroner has advised all parties that this date may be subject to change.

Calls for a Public Inquiry

The Board is aware that a number of families have made representations to the Secretary of State requesting his support for a public inquiry into TEWV. We understand that a further meeting was held in Middlesbrough on Saturday 29th March between the Secretary of State, families and legal representatives. We were not involved in the meeting. Decisions regarding public inquiries are a matter for the Government to decide. The Secretary of State has agreed to let the families have a decision in the near future.

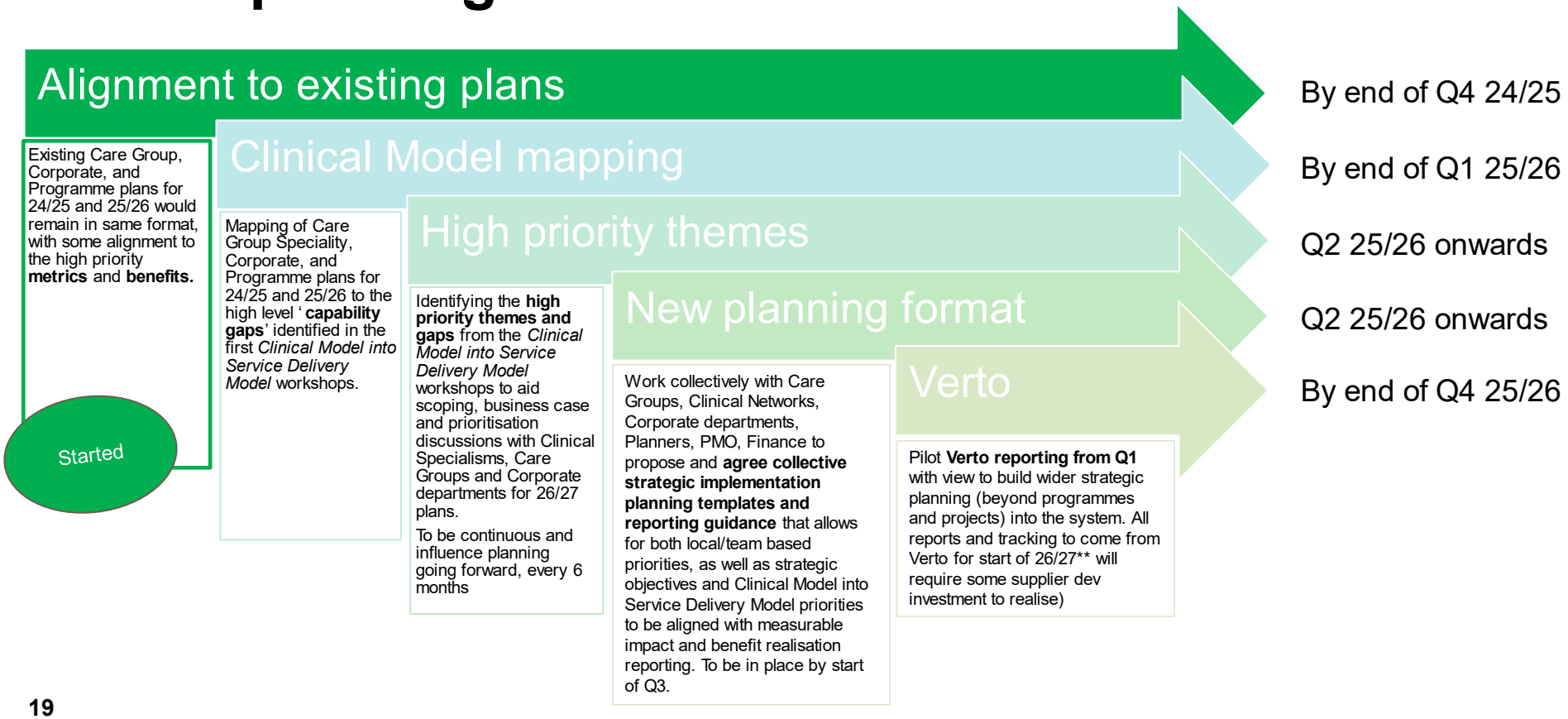
APPENDIX 1 – KEY TSB SLIDES

Overview



Transformation Delivery Board Roadmap through 2025

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



19

Transformation Delivery Board
What would the TDB agenda look like?

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Three areas of focus:

Benefit realisation progress Deep Dives and 'Curiosity Conversations' on Benefits	Plans aligned to impact progress Deep Dives and 'Curiosity Conversations' on schemes aligned to impact measures	Target Operating Model progress – by Specialism and Care Group Deep Dives and 'Curiosity Conversations' on Clinical Model into Service Delivery Model priority themes

Prioritisation
Escalation
Check and Challenge
Dashboard
Actions and Impact

21

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**10th April 2025**
Title:	**Board Integrated Performance Report as 28th February 2025**
Executive Sponsor(s):	**Patrick Scott, Deputy Chief Executive** **Naomi Lonergan, Interim Managing Director, Durham, Tees Valley & Forensic Care Group** **Zoe Campbell, Managing Director, North Yorkshire, York & Selby Care Group**
Author(s):	**Sarah Theobald, Associate Director of Performance** **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.
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 – supporting change	There is a risk of failure to delivery Our Journey To Change goals, organisational and clinical safety improvements, caused by the inability to fully deploy, utilise, and adopt digital and data systems.
6	Estates/Physical Infrastructure	There is a risk of delayed or reduced essential investment caused by constrained capital resources resulting in an inability to adequately maintain, enhance or transform our inpatient and community estate, adversely impacting patient and colleague outcomes/experience.

7	Data Security and Protection	There is a risk of data breach or loss of access to systems, caused by successful cyber-attack, inadequate data management, specialist resource gaps, and low levels of digital literacy resulting in compromised patient safety, impacts on business continuity, systems and information integrity, reputational damage 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 ICSs 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.
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 are proposing that Board of Directors receives this report with:

- **Good controls assurance** regarding the oversight of the quality of services being delivered
- **Good performance assurance** regarding the Integrated Performance Dashboard (IPD)
- **Reasonable performance assurance** regarding the National and Local Quality Requirements
- **Reasonable performance assurance** regarding Waiting Times

Overview:

Controls Assurance

The overall **good** level of **controls assurance** has been determined based on the Performance Management Framework we have in place and the internal audit report by AuditOne, which provided substantial assurance on the integrated approach to performance. Whilst we have robust controls in place, there is some slippage in timescales for a small number of measures.

Performance Assurance

The overall **good** level of **performance assurance** for the IPD has been underpinned by the Performance and Controls Assurance Framework, which demonstrates 20 measures (65%) with good or substantial assurance. Whilst we recognise that 6 measures (4 outcome and 2 staff survey) are known to have some inconsistencies in completeness, the overall data quality scores still provide good assurance.

We have then analysed each measure in more detail to determine the areas of positive assurance and actual areas of concern.

We have positive assurance in relation to **Inappropriate Out of Area Placements (OAPs), Restrictive Interventions, Staff Leaver Rate and Staff in post with a current appraisal**. There is special cause improvement, and we are achieving standard in all measures. We also have positive assurance in relation to Cash Releasing Efficiency Savings (CRES) Performance – Non-Recurrent as we are ahead of plan by £1.1m.

In addition, we now have some positive assurance in relation to the collection of Outcomes. Analysis shows that collection rates for current caseloads are increasing; however, as some patients have very long journeys, improvements in paired rates will not be visible until the point of discharge (approximately 70% of patients will be discharged within 2 years).

The actual areas of concern are as follows:

1. **Outcomes: CYP and Adults & Older Persons PROMs** – The CYP is now indicating special cause concern in relation to measurable improvement and for Adults and Older Persons there is a decreasing trend visible in the SPC chart. The Trust wide Clinical Outcomes Improvement Plan is progressing with 2 key actions completed this month:
    - Embed the use of ROMs in neuro assessment pathways – new process in place for use of GBO's at commencement of

assessment process
- Assess the use of GBOs (as an interim solution in the absence of having accurate psychometric outcome tools for all outcomes measures) - principles agreed and communication planned to coincide with CAMHS clinical standards

Eight actions are on hold due to the CITO change freeze; of these 4 are due to complete at the end of April 2025 and will, therefore, be overdue at that point. The remaining actions are on track. A new action has been added for Executive Directors to promote the importance of clinical outcomes during walkabouts to support culture change.

2. **Bed Occupancy** –special cause concern continues for this measure. There are several mitigating actions in place to support the increased need for inpatient beds, in addition to the work of the Urgent Care Programme Board, including:
   - Daily lean management, bed management and the OPEL framework, including subsequent actions, are now embedded and are business as usual
   - The DTVFCG Managing Director will be presenting the business case for the full roll out of Optica (a digital tool to support flow for inpatient wards) to the April 2025 Executive Directors Group.
   - We have agreed investment for Safe Havens in Durham & Tees Valley Care Group as part of our admission avoidance work. The Business Case and Specification for this new service will be developed in Q1 2025/26. In York there is a 24/7 Alternative to crisis pilot scheduled for implementation in June 2025.
   - Agreed joint work with the NENC ICB, HNY ICB and local authority partners to have oversight of patients clinically ready for discharged who are delayed and improve processes aiming to have a positive impact on patient care through the provision of appropriate support.
   - North Yorkshire Council have approached MHSOP to be involved in a key piece of partnership work around shaping future delivery including appropriate placements/dementia hubs.

   At Trust level (both Care Groups) patients classified as clinically ready for discharge equated to an average of 34.4 Adult and 35.7 Older Adult beds, representing 16.5% and 21.2% of the Trust's beds for each specialty respectively in February 2025, with an associated direct cost YTD of c.£8.72m (including £1.17m independent sector bed costs). Of the cost, c.£3.48m relates to Adult and c.£4.07m relates to Older Adult. This is the highest combined level recorded and of significant concern.

3. **Mandatory & Statutory Training –** Whilst we are achieving the standard, we remain concerned and continue to focus on the face-to-face training compliance of individual courses below the 85% standard. There was a focused discussion at the March Executive Directors Group led by the Associate Director of Improvement and Redesign and Workforce Development Lead. Whilst the number of courses has reduced from 17 to 15 and there has been some improvement in DNA rates, the percentage of wasted training spaces remains a concern, and focus is to be maintained at the Executive Directors Group – Resources and People & Culture Meeting. A systematic review of the various training courses has started with Immediate Life support (ILS). Areas for improvement have now been identified, and scoping work is underway to take these forwards. An action plan has been developed to rationalise the training portfolio, which includes reducing the duration and frequency of some competencies and the removal of others. This is being led by the

Education Governance Group and will be completed by the end of February 2025. (Partially Completed) The required actions regarding Rapid Tranquilisation will be confirmed by the end of March 2025. Daily reviews of staffing continue to ensure that the right staff with the right training are in place to respond to any issues that arise, and staff will be moved to ensure we have the right skill mix available on our wards.

4. **Agency Price Cap Compliance** – Most price cap breaches during 2024/25 have related to medical locum or prison mental health nursing cover for hard to fill vacancies. Actions to focus on medic recruitment and retention, including through international recruitment, have helped to reduce the number and value of breaches and related annualised premia costs. Actions to raise the profile of recruitment into vacancies in prisons have similarly helped to reduce the number of breaches from shifts covered by agency. The annualised premia, based on in-month breaches, has reduced from £3.59m in March 2024 to £1.78m in February 2025. Restrictions on who can fill the post means we will continue to see some breaches until we have completed recruitment.

5. **CRES Recurrent** - Work is ongoing via the efficiency hub to confirm delivery of schemes for 2024/25, and plan for 2025/26. The proportion of schemes that are recurrent is dropping, and work is required to maximise recurrent delivery this year, and improve recurrent delivery next year. Final QA's for 2024/25 are going for organisational approval.

The overall **reasonable** level of **performance assurance** for the National Quality Requirements and Mental Health Priorities has been underpinned by Statistical Process Control Charts, which demonstrates 54% of measures are achieving standard. We have then analysed each measure in more detail to determine the areas of positive assurance and actual areas of concern.

We have positive assurance for **72-hour follow up and Talking Therapies waiting times (6 and 18 weeks)**, where we are achieving targets in all areas.

The actual areas of concern are as follows:

1. **EIP Waiting Times** (Vale of York) – It was expected that the backlog of patients waiting would be addressed by the end of January (originally end of December 2024) and that new patients would start treatment within 2 weeks; however, performance remains below target. All patients that were waiting on the backlog have now been seen and all new patients will start receiving treatment within 2 weeks of referral.

2. **Talking Therapies 1st to 2nd treatment** (County Durham, Tees Valley and Vale of York)**, Reliable Recovery (**County Durham**) and Reliable Improvement** (County Durham and Tees Valley) – A Task & Finish Group was established to oversee a Trust-wide deep dive in relation to these areas of concern. Data has been sourced from a staffing, finance, activity and clinical outcomes perspective, however this needs to be triangulated to understand the different services. This is intended to inform the development of a Trust-wide action plan by the end of March 2025. In addition, DTVFCG are finalising their service recovery plan, which will be taken to the March Care Group Combined Governance Meeting for approval. In NYYSCG, Care Group Directors requested additional information regarding the impact on quality and waiting times to inform further improvement actions; originally due for

completion by the end of January 2025, a meeting has been arranged during March to progress the original options papers and agree next steps.

3. **CYP 1 contact** (North Yorkshire & Vale of York) – Business Intelligence to lead in-depth analysis to support the service in identifying any underlying reasons for a reduction in access. This work will be completed by the end of March 2025.

4. **Children's Paired Outcomes** (all sub-ICB areas) – *please see Outcomes narrative in the Integrated Performance Dashboard section on pages 3-4.*

5. **Access to transformed community services** (County Durham, North Yorkshire & Vale of York) - In County Durham the remaining three PCNs will be transformed by the end of March 2025; however, the chart shows that when all PCNs are transformed, the target would still not be achieved. It should be noted that whilst below the target, there is special cause improvement indicated in the SPC chart. In North Yorkshire & York, the Ripon and Scarborough Community team are in business continuity with recovery plans in place which include recruitment to vacancies. Data has been sourced to provide a triangulated understanding of access to our adult and older adult services and inform the identification of any improvement actions; however, the review of this by the Performance Senior Leadership Team has been delayed and will now be completed by the end of March 2025.

6. **Specialist Community Perinatal Mental Health Services** (North Yorkshire & Vale of York) – The Perinatal teams are continuing to be supported with a service recovery plan in line with business continuity processes. There are several key mitigating actions in place to support improvement which include the completion of a capacity and demand exercise; the first draft has been further delayed and will now be completed by the end of April 2025. It should be noted that whilst below the target, there is special cause improvement indicated in the SPC charts.

The overall **reasonable** level of **performance assurance** for Waiting Times has been underpinned by Statistical Process Control Charts; however, we recognise we have limited assurance about the impact on quality for those patients waiting to access our services. We have then analysed each measure in more detail to determine the areas of positive assurance and actual areas of concern.

Whilst we have several waiting time measures indicating special cause improvement (i.e. a reduction in the number waiting), we still have more patients waiting, some with a much longer wait, than we would like.

We have weekly waiting time reports for EIP and Child Eating Disorder services and monthly waiting time reports for all remaining services. These are overseen by each speciality and include the numbers of people waiting, the time bandings for the waits, the reasons for the longest waits including any planned next appointments. Waiting Times are reviewed weekly within the Care Groups and monthly by both Care Group Boards

Within CYP, AMH and MHSOP services we have a Keeping In Touch (KIT) process for all patients that are waiting that keeps contact with the patient and/or their family and supports them with initiating escalation based on need. Within Durham and Tees Valley CYP services, we are also working with system partners to develop a waiting well offer

The actual areas of concern are:

1. **Waiting for neurodevelopmental assessments (Children & Young People and Adults)**

Durham and Tees Valley

The all-age neurodiversity group across the NENC ICB have both providers reviewing their current processes, levels of demand and activity, financial positions and clinical thresholds. The specification to facilitate partnership-working for children and young people's neurodevelopmental services with alternative, accredited private providers, has been approved. There is anticipation that the first group of young people will be transitioned in April 2025.

CYPS – have a recovery plan in place with Phase 2 testing on dual assessments now underway in Darlington with the full evaluation of the clinical protocol due to be completed by the end of April 25. All actions within the recovery plan are progressing however demand currently continues to outweigh capacity. In addition, a trajectory has been submitted to NENC ICB which tracks performance against plan, factoring in the additional assessments that have been funded. We are currently waiting approval of this trajectory.

Adults – The current KIT process is being redesigned as part of restructure of community services and will align to the process in CYP and CNTW with implementation planned for 1st April 2025. A trajectory has been submitted to NENC ICB which tracks performance against plan for the number of adults waiting for an ADHD assessment, factoring in the additional assessments that have been funded. This trajectory has been approved and we are currently on plan.

In March, Management Group supported the proposal to establish an all-age neurodevelopmental steering group to lead and oversee work internally and align with the work externally, across our respective ICB areas and for this group to align to the Community Transformation Programme Board.

North Yorkshire & York

The service continues to engage with commissioners, Humber & North Yorkshire ICB and the Provider Collaborative regarding capacity within our CYP services versus demand and the subsequent impact on waiting times. The ICB has set up a working group in relation to 'Right to Choose' which is looking at aligning assessment pathways across providers.

A Task and Finish group are reviewing the existing model for the assessment and treatment of neurodevelopmental conditions to see if there are more efficient ways to deliver services which improve the patient's journey. This work will be completed by the end of March and the group will meet again in April to discuss the outcome of the review. The service has recruited to all vacant posts and overtime is being offered to staff. The service will review internal processes to identify any remaining efficiencies by the end of June 2025. The Scarborough ADHD team remains in business continuity with a recovery plan in place. Whilst some improvement can be made, the demand outstrips the capacity of the service.

2. **Adults waiting for their second contact with Talking Therapies** – *please see Talking Therapies narrative (2) in the National and Local Quality Requirements section on page 5.*

Prior Consideration and Feedback

The individual Care Group IPRs have been discussed and approved by the Care Group Boards and the Board IPR has been discussed and approved by Executive Directors Group 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
- Quality of Care
- Digital – supporting change
- Estates/Physical Infrastructure
- Quality Governance**
- Partnerships & System Working
- Regulatory Compliance
- Financial Sustainability
- Public Confidence

***The introduction of any new Electronic Patient Record has a negative impact on Data Quality. Following the introduction of Cito in February 2024, data quality issues have impacted several patient-based measures across the organisation. The Cito Improvement workstream will be the main driver to address data quality issues that are user related. User confidence sessions are continuing across the organisation, with good uptake (approximately 80% capacity). Sessions for Community, urgent care and specialist services are running well, and inpatient staff concerns regarding the new ways of working are being addressed by the Associate Directors of Nursing. The metrics for the manual Quality Audit and Data Quality Dashboard have been identified, and these are currently being developed. There was limited interest for the recruitment of Support and Optimisation Practitioners and a proposal is now being developed for the alternative provision of intense team support.*

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

Recommendations:

The Board of Directors are asked to:

- either confirm that there is 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 and Waiting Times and that the strategic risks are being managed effectively; or
- identify the levels of assurance it considers to be appropriate; the reasons for this; and any corrective measures/improvements it considers should be put in place.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

As at 28th February 2025

Report produced by: Laura Wheater, Performance Lead and Ashleigh Lyons, Head of Performance
Date the report was produced: 26th March 2025

For any queries on the content of this report please contact: Ashleigh Lyons, Head of Performance
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journey to change

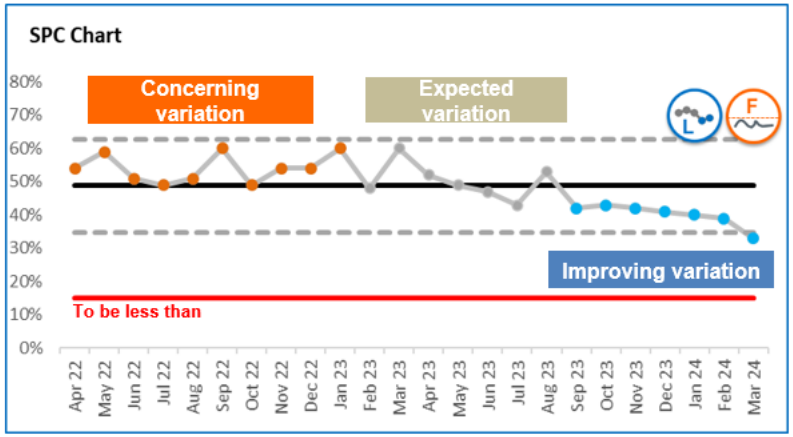
CONTENTS

Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys
NHS Foundation Trust

Within our Board Integrated Performance Dashboard we use Statistical Process Control Charts to determine whether we have any underlying causes for concern. A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly). The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated and improvement actions implemented;
Blue – there is a pattern of improvement which should be learnt from;
Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable.



The thick **black** line on an SPC chart is the average.

The dotted (- - - -) lines are the upper (top line) and lower (bottom line) process limits, which describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard (the **red** line) can be achieved always, never (as in this example) or sometimes.

SPC charts therefore describe not only the type of variation in data, but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

Our Guide To Our Statistical Process Control Charts: Interpreting summary icons

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

These icons provide a summary view of the important messages from SPC charts.

	Variation/Performance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

	Assurance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Our Approach to Data Quality

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 most recent assessment was completed in quarter 3 2024/25. The next assessment will be completed in quarter 1 2025/26.

	Data Quality Assessment		
Icon	***Description***	***What does this mean?***	***What should we do?***
	SUBSTANTIAL assurance; a data quality score of **93% or over**	The measure is reliable.	There is no specific action to take.
	GOOD assurance; a data quality score of **73% - 92%**	The measure is largely reliable; however, there are a small number of improvement actions that need to be undertaken.	**Review** what improvements were identified as part of the assessment and, if possible, take the appropriate action.
	REASONABLE assurance; a data quality score of **47% - 72%**	The measure is reasonably reliable; however, actions are required to improve its construction, data source and/or data.	**Identify** what improvements were identified as part of the assessment and take the appropriate action.
	LIMITED assurance; a data quality score of **46% or under**	The measure is unreliable and there are significant actions required to improve its construction, data source and/or data.	**Investigate** whether the measure is appropriate to be included in the Integrated Performance Report. **Remove** the measure from the Integrated Performance Report to enable improvement actions to be undertaken.

Our Approach to Performance and Controls Assurance

Tees, Esk and Wear Valleys NHS Foundation Trust

Our Performance Assurance

Performance Assurance Rating takes into consideration the Controls Assurance Rating (as per table below), whether we are achieving standard (where appropriate) and any underlying areas of performance.

	Substantial	Good	Reasonable	Limited
	The control is operating effectively in meeting its objective (and managing the associated risk). It is being applied consistently. No remedial action required.	The control is operating effectively in meeting its objective. It is generally being applied consistently. Minor remedial action is required.	The effectiveness of the control in meeting its objective is uncertain. Compliance is variable/inconsistent. Some moderate remedial action is required.	The control is not operatively effectively in meeting its objective. There are low levels of/wide variation in compliance. Immediate and fundamental remedial action is required
Positive	We have Positive Assurance **AND** we are achieving the standard agreed (where relevant)	We have Positive Assurance; **HOWEVER,** we have 1 (or more) underlying areas of concern **OR** we are not achieving standard		
Neutral	We are achieving standard (where relevant); **AND** We have no underlying areas of concern	We are achieving the standard (where relevant) with only 1 area of concern; **OR** There is consistent performance	We have more than 1 underlying area of concern **OR** there is consistent underperformance below the standard	
Negative		We have no underlying areas of concern **AND** there is an improving position visible in the data	We have a small number of areas of underlying concern **OR** there is a deteriorating position visible in the data **OR** performance continues below the mean	We have the Trust and both Care Group/several directorates are all showing a concern **OR** there is a clear deterioration visible in the data **AND** outside the control limits

Our Controls Assurance

Our Controls Assurance is determined based on SPC variance or, where this is not appropriate, using forecast position or national benchmarking data.

Positive	Neutral	Negative
Positive assurance when SPC chart indicates Special Cause Improvement OR • Forecast position is positive • National benchmarking data indicates we are in the lowest (most positive) quartile	Neutral assurance when SPC indicates Common Cause	Negative assurance when SPC indicates Cause for Concern OR • Forecast position is negative • National benchmarking data indicates we are in the highest (least positive) quartile

Glossary of Terms

Tees, Esk and Wear Valleys NHS Foundation Trust

AAR	After Action Review
ADHD	Attention deficit hyperactivity disorder
ALD	Adult Learning Disabilities
AMH	Adult Mental Health
ASD	Autistic Spectrum Disorder
cCBT	Computerised Cognitive Behaviour Therapy
CRES	Cash Release Efficiency Savings
CROM	Clinician Reported Outcome Measure
CYP	Children & Young People
CYPS	Children and Young People Services
DTVFCG	Durham Tees Valley and Forensic Care Group
EDG	Executive Directors Group
EIP	Early Intervention in Psychosis
ESR	Electronic Staff Record
GBO	Goal-Based Outcomes
ICB	Integrated Care Board
ILS	Immediate Life Support
IPD	Integrated Performance Dashboard
MHSOP	Mental Health Services for Older People
MoJ	Ministry of Justice
NENC	North East & North Cumbria Integrated Care Board
Neuro	Neurodevelopmental services
NYYSCG	North Yorkshire, York & Selby Care Group
OAP	Out of Area Placement
PaCE	Patient and Carer Experience
PCN	Primary Care Network
PIP	Performance Improvement Plan
PMH	Specialist Community Perinatal Mental Health
PROM	Patient Reported Outcome Measure
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Framework
PWP	Psychological Wellbeing Practitioner
ROM	Routine Outcome Measures
RPIW	Rapid Process Improvement Workshop
SIS	Secure Inpatient Services
SOCI	Statement of comprehensive income
SPC	Statistical Process Control
STEIS	Strategic Executive Information System
UoRR	Use of Resources Rating
WTE	Whole time equivalent

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%	93.05%	92.00%
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	QAC		?	75.00%	75.23%	75.00%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC		?	75.00%	80.65%	75.00%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	L	F	35.00%	22.18%	35.00%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC		F	55.00%	45.54%	55.00%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	F	50.00%	53.31%	50.00%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	H	F	30.00%	24.32%	30.00%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC	H	F	85.00%	100.64%	85.00%
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	L			141	
10)	The number of Patient Safety Incident Investigations reported on STEIS	QAC	L			25	
11)	The number of Incidents of moderate or severe harm	QAC	L			352	
12)	The number of Restrictive Interventions Used	QAC	L			9,946	
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				5	
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				8	
15)	The number of uses of the Mental Health Act	MHLC				3,805	

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				51.61% (Jul - 2024)	
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				60.51% (Jul - 2024)	
18)	Staff Leaver Rate	PC&D	L	F	11.00%	10.67%	11.00%
19)	Percentage Sickness Absence Rate (month behind)	PC&D		?	5.50%	6.16%	5.50%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	H	?	85.00%	88.51%	85.00%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	H	F	85.00%	87.66%	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				90,324	
23)	Unique Caseload (snapshot)	S&RC	H			64,409	

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	1,125,000	372,374
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	11,243,783	9,363,240
25b)	Agency price cap compliance	S&RC	67.00%	68.74%
26)	Use of Resources Rating - overall score	S&RC	2	3
27)	CRES Performance - Recurrent	S&RC	14,381,323	13,290,675
28)	CRES Performance - Non-Recurrent	S&RC	4,779,167	5,875,667
29)	Capital Expenditure (CDEL)	S&RC	7,403,000	3,839,179
30)	Cash against plan	S&RC	49,528,000	55,265,713

Board Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

- **Patient and Carer Experience:** there is no significant change for all patient and carer experience measures and all are achieving standard. There is special cause improvement in the number of responses received for the patient and carer experience questions; however, there is no significant change for the inpatients feeling safe question.

- **Outcomes:** in CYP there is special cause concern and we are below standard for the PROM; however, there is special cause improvement for the CROM and we are above standard. In AMH/MHSOP there is no significant change for the PROM and special cause improvement for the CROM; however, we are below standard for both. Whilst some of the SPC charts indicate special cause improvement, this remains an area of concern as there is special cause concern in the number of timely paired outcomes recorded for all measures.

- **Bed Pressures:** there is special cause concern for bed occupancy. Whilst there is special cause improvement for the inappropriate out of area bed days, there was 1 active OAP as at the end of February 2025, in Humber & North Yorkshire ICB.

- **Patient Safety:** there is special cause improvement in the number of patient safety incident investigations; however, this is not necessarily an actual improvement, as there was a change in process at the end of January 2024 when we Trust transitioned to the National Patient Safety Incident Framework (PSIRF). There is a reduction (indicated as special cause improvement in the SPC chart) for incidents of moderate or severe harm which looks to align to the new system implementation. There is special cause improvement for restrictive interventions and no significant change for medication errors. There was 1 unexpected inpatient unnatural death reported on STEIS during February.

- **Uses of Mental Health Act:** there is no significant change.

- **People:** There is special cause improvement and we are achieving standard for leaver rate, mandatory training and appraisals; however, there is no significant change for sickness and we are exceeding standard. Whilst we are achieving the standard for mandatory training, we are concerned about the face-to-face training compliance below the 85% standard.

- **Demand:** There is no significant change in referrals. Whilst the SPC chart indicates there is special cause concern for unique caseload, this is not necessarily an actual concern as we know from the new active caseload measure there is no significant change. Unique caseload is impacted by the increase in patients waiting for a first contact which is an area of concern as highlighted in the waiting times section of this report.

- **Finance:** The Trust's 2024/25 financial plan targets delivery of a break-even position. The year-to-date plan at Month 11 reflected a £1.126m deficit. When adjusted to remove technical items that are excluded from assessment of Trusts' financial performance the actual position is a deficit of £0.373m; or £0.753m favourable variance to plan. The position has improved in month, driven largely by additional non-recurrent education income. Whilst financial performance remains better than planned, the year-to-date deficit needs to be recovered in the remaining month of 2024/25, including through Cash Releasing Efficiency Scheme (CRES) targets that are more heavily weighted in the second half of the year, and through ongoing focus, grip and control.

Durham Tees Valley & Forensic Care Group IPD Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

- **Patient and Carer Experience -** no significant change for patients rating their recent experience as good or very good and carer involvement and for inpatients feeling safe. Achieving the standard for carer involvement and for inpatients feeling safe. There is no significant change in the responses received for any of the measures.
- **Outcomes -** special cause concern for CYP for the PROM; however, special cause improvement for the CROM and above standard. AMH/MHSOP no significant change in the PROM and special cause improvement in the CROM. Below standard for both. There is special cause concern for the number of children and young people discharged with a paired outcome measure across all specialties.
- **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, incidents of moderate of severe harm, the number of restrictive interventions used . No significant change for medication errors and for unexpected inpatient unnatural deaths.
- **Uses of Mental Health Act -** special cause concern.
- **Staff -** for recommending the Trust as a place to work we achieved 51.91 % and for staff feeling able to make improvements we achieved 62.57%. Special cause Improvement in staff leaver rate, mandatory and statutory training and appraisals. No significant change in 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 Care Group, planned to spend £240.3m as at February, and actual spend was £248.7m, which is £0.883m more than planned. As at M11 CRES delivery was £1m above plan.

Durham Tees Valley & Forensic Care Group IPD Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

- Inappropriate OAP bed days
- People (leaver rate, appraisals)

Risks / Issues*

- Outcomes
- Bed Occupancy
- Mandatory and Statutory Training
- Financial Plan

Mitigations

Outcomes
The Trustwide clinical outcomes programme continues to progress with 2 key actions completed this month: 1) operational target specific work on neuro-assessment pathways to embed use of ROMs and 2) operational assessing/reviewing the use of Goal-Based Outcome Measures. All other actions are on track; however, 8 actions are on hold, due to the CITO change freeze and cannot commence until the freeze is lifted. Of the 8 actions: 4 are due to complete at the end of April 2025, thus will be overdue at that point. A new action has been added for Execs to promote the importance of clinical outcomes during walkabouts to support culture change.

Bed Occupancy
There are several mitigating actions in place to support the increased need for inpatient beds, in addition to the work of the Urgent Care Programme Board, including daily and weekly operational and executive level oversight. The Managing Director will be presenting the business case for the full roll out of Optica (a digital tool to support flow for inpatient wards) to the March 2025 Executive Directors Group and the plan for a Trust-wide patient flow workforce model to create a clearer escalation structure for operational staff both in and out of hours will be presented to the March EDG; if approved, implementation will be July 2025. There is sustained improvement in our crisis line call pick-up rates and we are developing a process to respond to patients who abandon calls to improve their experience.

Mandatory & Statutory Training - We are continuing to focus on all face-to-face training below the 85% standard. The systematic review of courses is progressing with the review of Immediate Life Support (ILS); initial scoping has been completed and following a meeting with process leads in February areas for improvement have been identified. Across the Care Group all specialities continue to utilise a staff tracking list for booking courses and monitoring DNAs. Daily reviews of staffing continue to ensure that the right staff with the right training are in place to respond to any issues that arise, and staff will be moved to ensure we have the right skill mix available on our wards.

Finance - Financial plan
Actions in place include:

- The Care Group General Managers need to revise recovery roadmaps for unfunded posts to address hot spot areas. These roadmaps will be reported via the finance and resource and business development sub groups of the Care Group Board.
- 25/26 Financial Planning, budget setting and contracting has commenced and will be ongoing to identify pressures and priority areas, which will be updated and reviewed now the planning guidance has been issued.

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

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

- **Patient and Carer Experience:** there is no significant change for all patient and carer experience measures; and inpatients feeling safe are achieving standard. We are achieving standard for percentage of Patients surveyed reporting their recent experience as very good or good.
- **Outcomes:** In CYP, there is special cause improvement, and we are above standard for the CROM. There is no significant change and below the standard for CYP PROM. There is no significant change, and we are below standard in AMH PROM and for AMH and MHSOP CROM we are reporting special cause improvement with AMH above the standard, however, MHSOP is reporting below the standard. Overall, there remains concern in the number of timely paired outcomes recorded for all measures. Slides 14-17 highlight the issues that are impacting these measure. Actions to improve performance are in place.
- **Bed Pressures:** there is special cause concern for bed occupancy. There is concern reported for patients delayed transfers of care in the reporting period for AMH and MHSOP. We are experiencing longer stays within a number of wards, including MoJ restricted patients and pressures resulting from clinically ready for discharge – specifically around accommodation, with a noticeable rise in delayed discharge in the North Yorkshire area.
- **Patient Safety:** there is special cause improvement for patient safety incident investigations; (it should be noted that this is not necessarily an actual improvement, as there was a change in process at the end of January 2024 when the Trust transitioned to the National Patient Safety Incident Framework (PSIRF)). There is a reduction (indicated as special cause improvement in the SPC chart) for incidents of moderate of severe harm and no significant change for restrictive interventions and medication errors. There were no unexpected Inpatient unnatural deaths reported on STEIS during February.
- **Uses of Mental Health Act:** no significant change is reported at Care Group and ALD and AMH is reporting special cause improvement in the reporting period.
- **People:** There is special cause improvement for leaver rate, however, we are above standard for this measure. There is no significant change for sickness absence, and we are below standard except within Management which is reporting continuous deterioration (special cause concern in the SPC chart) and above the standard. There is special cause improvement for mandatory training, and we are just above the standard; however, we are aware the face-to-face training compliance below the 85% standard and understand the reasons for this, actions are in place. There is special cause improvement for appraisals; however, we are below standard within management which is driven by sickness and actions are in place to resolve this.
- **Demand:** There is no significant change in referrals and caseload is reporting special cause for improvement. We know from the detailed analysis previously undertaken, unique caseload is impacted by the increases in demand and patients waiting for a first contact.
- **Finance:** Improved performance relative to control totals set in year to support financial recovery provide increased assurance that the Trust will deliver our 2024/25 breakeven plan by the end of the year, 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.

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

- Outcomes for CYP CROM
- Bed Pressures (Inappropriate OAPs)
- Patient Safety (Incident Investigations reported on STEIS and Incidents of moderate or severe harm)
- People (Staff Leaver Rate, Mandatory & Statutory Training, Appraisals)

Risks / Issues

- Bed occupancy
- Finance (Financial Plan, Agency expenditure, Surplus/Deficit, Agency price cap compliance)

Mitigations

Outcomes

The Trustwide clinical outcomes programme continues to progress with 2 key actions completed this month: 1) operational target specific work on neuro-assessment pathways to embed use of ROMs and 2) operational assessing/reviewing the use of Goal-Based Outcome Measures. All other actions are on track; however, 8 actions are on hold, due to the CITO change freeze and cannot commence until the freeze is lifted. Of the 8 actions: 4 are due to complete at the end of April 2025, thus will be overdue at that point. A new action has been added for Execs to promote the importance of clinical outcomes during walkabouts to support culture change.

Bed Occupancy

The service is being impacted by longer patient stays, including MoJ restricted patients, patients clinically ready for discharge and consultant cover and gaps in leadership posts within inpatient areas. Work is progressing with the leadership team to reduce lengths of stay and delayed transfers of care. Recruitment into leadership posts is ongoing; support is being provided from the senior leadership team. Local Authorities Mental Health Team provision (York) - Ongoing support is being provided by the Local Authority. Following an external meeting end of last year, between ICB and Local Authority, conversations have begun about wider transformation journey across the whole system. To progress this work, a number of workshops are being planned in early 2025.

Finance

The Care Group financial position is forecast to be £681k above plan, with the key factor being out of area patients, which are impacted by delayed discharges.

Improved performance relative to control totals set in year to support financial recovery provide increased assurance that the Trust will deliver our 2024/25 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 • PSII reported on STEIS • Restrictive Intervention Incidents Used ***improved performance and controls assurance*** • Staff in post with a current appraisal	• Adults and Older Persons showing measurable improvement following treatment - clinician reported • Incidents of moderate or severe harm ***reduced performance assurance*** • Staff Leaver Rate • Compliance with ALL mandatory and statutory training • CRES Performance – Non-Recurrent		
Neutral	• Patients surveyed reporting their recent experience as very good or good • Inpatients reporting that they feel safe whilst in our care • Medication Errors with a severity of moderate harm and above • Unexpected Inpatient unnatural deaths reported on STEIS	• Carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for • New unique patients referred • Financial Plan: Agency expenditure compared to agency ***improved controls assurance***	• Adults and Older Persons showing measurable improvement following treatment - patient reported • Uses of the Mental Health Act ***reduced performance assurance*** • 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 • Use of Resources Rating - overall score • Cash balances (actual compared to plan)	• CYP showing measurable improvement following treatment - patient reported CYP showing measurable improvement following treatment - patient reported ***reduced controls assurance*** • Bed Occupancy (AMH & MHSOP A & T Wards) • Capital Expenditure (Capital Allocation)	• Unique Caseload • Agency price cap compliance • CRES Performance - Recurrent

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

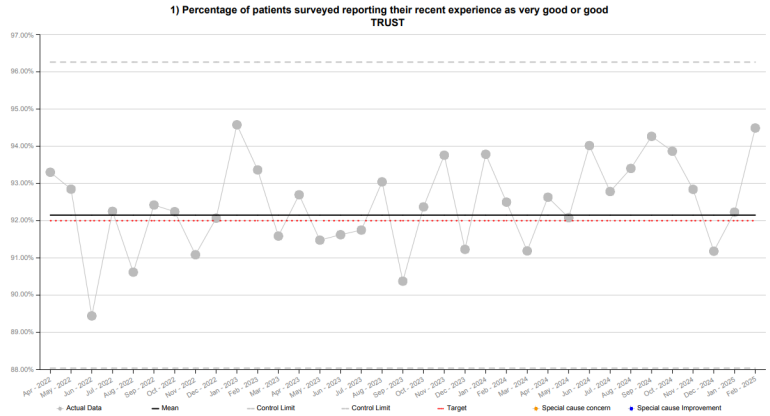
What does the chart show/context:
During February **1289** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **1218 (94.49%)** scored "very good" or "good".

There is no significant change at Trust and Care Group level in the reporting period; however, there is special cause improvement in the number of patients who have responded to this question at Trust level and for North Yorkshire & York Care Group (Adult Mental Health Services and Children & Young Peoples Services). There is special cause improvement for Secure Inpatient Services in relation to the overall experience question.

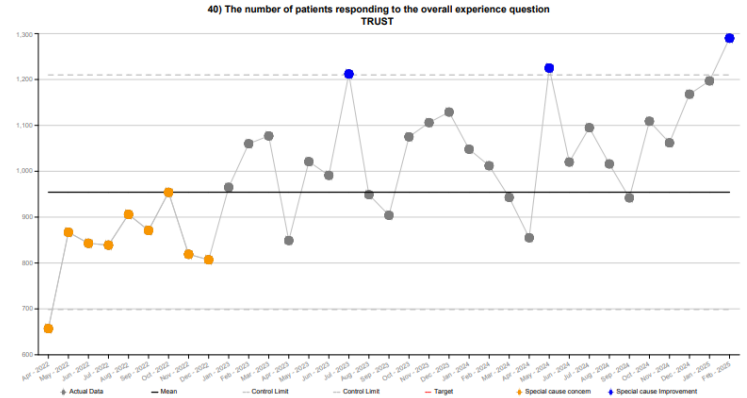
The latest National Benchmarking data (December 2024) shows the England average (including Independent Sector Providers) was **89**% and we were ranked **18** out of 66 trusts (1 being the best with the highest ratings), we were also ranked 2nd highest for total number of responses received.

Underlying issues:
- Not all wards and teams are routinely facilitating completion of the surveys

Actions:
- Each month, the Patient and Carer Experience (PACE) team share with the care group leadership teams a list of those wards/teams who have not provided feedback in the month. This is also reflected in the current Quality Assurance and Improvement Group reports to both Care Groups. In addition, the PACE Team use this intelligence to focus on who we see and when, as part of the quality visit programme. *NB. This is standard work for the PACE Team*
- The Patient & Carer Experience Team to procure a new patient experience system, which will increase the methods by which patients can provide survey feedback with a view to increasing response rates. The "I Want Great Care" system has been approved and will be procured by the end August 2025.



The below chart represents the number of patients who have responded to the overall experience question.



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

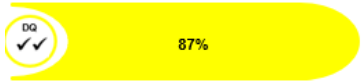
Background / standard description:
We are aiming for 75% of carers reporting they feel they are actively involved in decisions about the care and treatment of the person they care for.

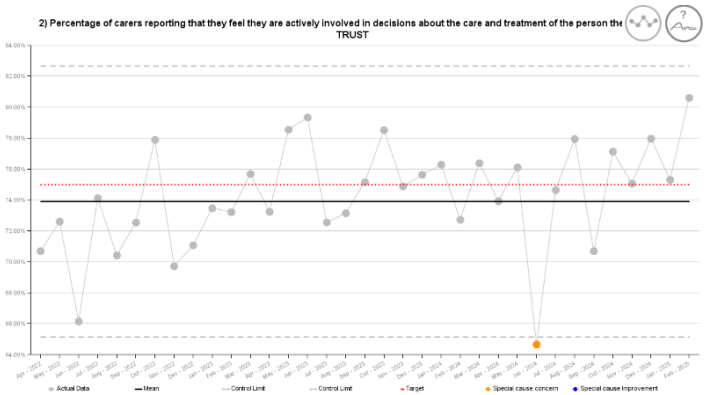
What does the chart show/context:
During February, **526** carers responded to the question in the carer survey: Question: "Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?". Of those, **424 (80.61%)** scored "yes, always".

There is no significant change at Trust and Care Group level in the reporting period; however, there is special cause improvement at Trust level and for Durham, Tees Valley & Forensic Care Group for the number of patients who have responded to this question. There is special cause improvement for Children & Young Peoples Services in both Care Groups in relation to the overall carer experience question; however, there is special cause concern for Adult Mental Health Services in Durham, Tees Valley & Forensic Care Group.

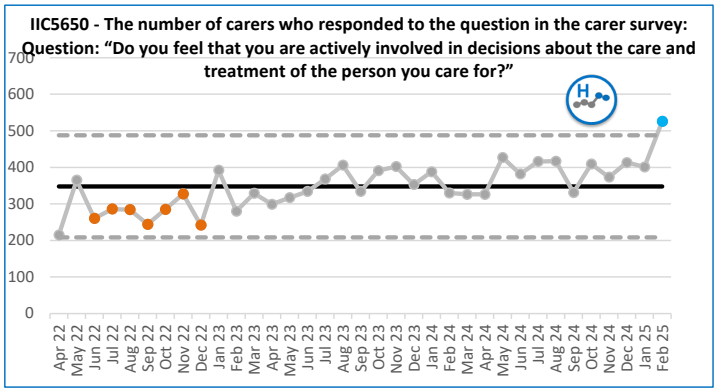
Underlying issues:
- Engagement with various carer groups
- Barriers to collecting feedback include:
  - Access to and up to date surveys through the various mechanisms
  - Up to date carer and team information
  - Lack of feedback including display of feedback
- A lack of awareness of the Triangle of Care within Trust Services
- Low response rates and feedback from carers with family on Elm Ward (DTVFCG AMH services)

Actions:
- The Patient & Carer Experience Team have reviewed the output from the recent Quality Improvement focused work and will develop a work plan by the end of January 2025. **(Not Completed)** A PaCE Strategic Project Group has been formed to support the development of the work plan. An initial meeting will take place in April 2025.
- The Triangle of Care Principles are being relaunched within both Care Groups; Care Group Directors of Nursing & Quality will provide an update on progress to the PACE Team at the end of May 2025 for the 2024/25 submission to the Carers Trust.
- Elm Ward have introduced monthly carers meetings, identified additional training for all staff and identified Carers Champions in response to recent surveys. *NB. This will become standard work for the ward.*





The below chart represents the number of carers that responded to the involvement question.



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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

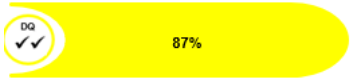
What does the chart show/context:
During February, 191 patients responded to the overall experience question in the patient survey: “During your stay, did you feel safe?”. Of those, **161 (84.29%)** scored “yes, always“ and “quite a lot”.

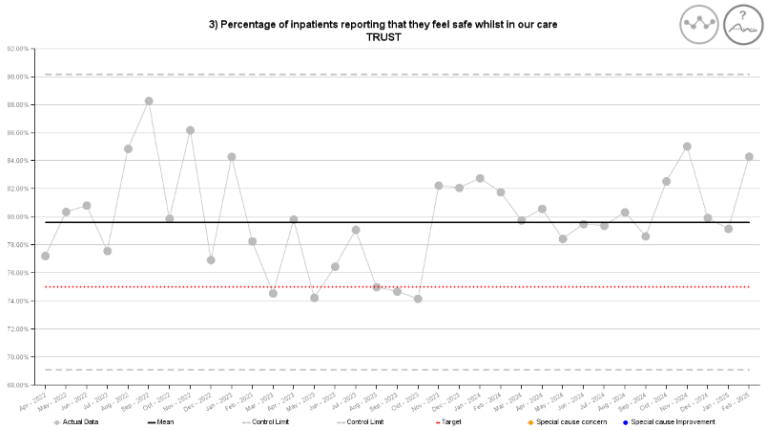
There is no significant change at Trust and Care Group level and in the number of patients who have responded to this question.

There are several factors that can influence whether a patient feels safe, e.g. staffing levels, other patients (including self-harm), environment, the acuity of other patients and violence & aggression and the use of restrictive interventions on wards.

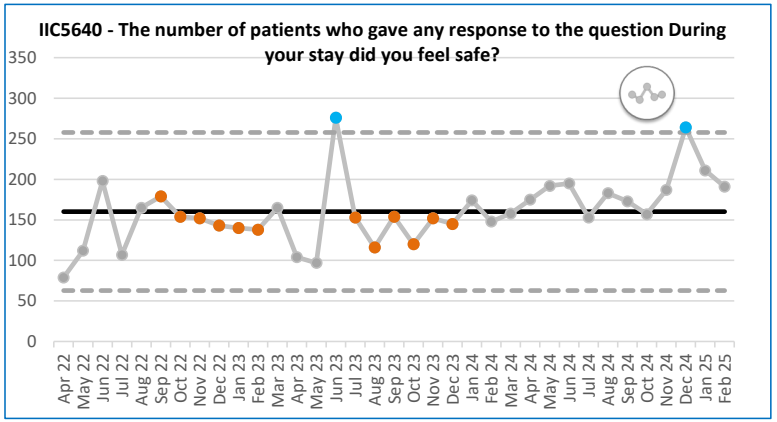
Underlying issues:
There are no underlying issues to report.

Actions:
Whilst there are no specific improvement actions to note, feeling safe on our inpatient wards is one of the core standards of the Culture of Care Programme which we are rolling out as part of the National Inpatient Transformation Programme.





The below chart represents the number of patients that responded to the safety question.



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 February **573** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 114 (19.9%)** made a measurable improvement.

There is special cause concern at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period; there is no significant change for North Yorkshire & York Care Group There is special cause concern at Trust level and Care Group level in the number of patients discharged with a paired outcome measure.

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

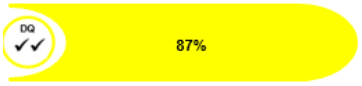
Underlying issues:
There are a range of issues currently impacting this measure.

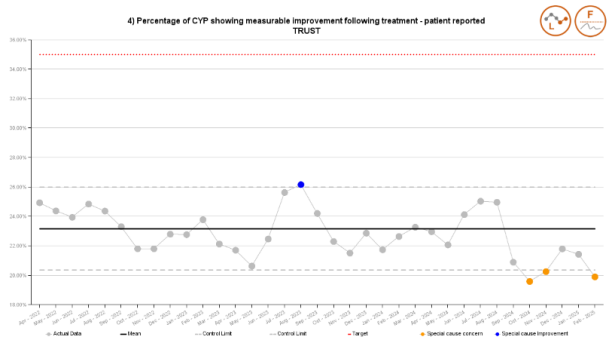
- Analysis shows that collection rates for current caseloads are increasing; however, as some patients have very long journeys, improvements in paired rates will not be visible until the point of discharge (approximately 70% of patients will be discharged within 2 years).
- This measure currently does not report the full suite of patient-related outcomes as a number of measures do not have a reliable change index.
- Patients who transition from CYP to AMH are not counted in the measure until they are discharged from TEWV

Actions:

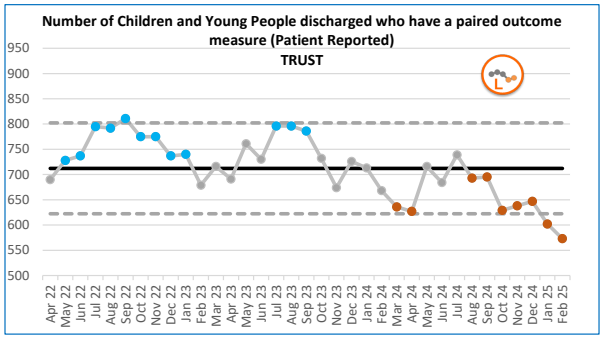
- The Trust wide Clinical Outcomes Improvement Plan is progressing with 2 key actions completed this month:
    - Embed the use of ROMs in neuro assessment pathways – new process in place for use of GBO's at commencement of assessment process
    - Assess the use of GBOs (as an interim solution in the absence of having accurate psychometric outcome tools for all outcomes measures) - principles agreed and communication planned to coincide with CAMHS clinical standards

  Eight actions are on hold due to the CITO change freeze; of these 4 are due to complete at the end of April 2025 and will, therefore, be overdue at that point. There remaining actions are on track. A new action has been added for Executive Directors to promote the importance of clinical outcomes during walkabouts to support culture change.
- The Business Intelligence Team are working with the Child Outcome Research Consortium (CORC) to establish a national reliable change index for EDE-Q. We will be the lead organisation working with Mersey Care NHS Foundation Trust, Coventry & Warwickshire





The below chart represents the number of discharges with paired outcome measures.



Actions continued:

Partnership NHS Trust & Cheshire & Wirral Partnership NHS Foundation Trust. We have developed a template to support this work during February 2025 **(Completed)** and are awaiting feedback from providers.

- Business Intelligence to explore the feasibility of including those patients that transition between CYP and AMH as they are not "discharged" at this point. Timescale to be confirmed.

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

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 February **1291** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 582 (46.08%)** made a measurable improvement.

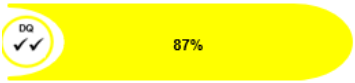
There is no significant change at Trust level and Care Group level in the reporting period. There is special cause concern at Trust and Care Group level in the number of patients discharged with a paired outcome measure. There is special cause concern for Adult Mental Health Services in Durham, Tees Valley & Forensic Care Group and special cause improvement for Mental Health Services for Older People in North Yorkshire, York & Selby Care Group.

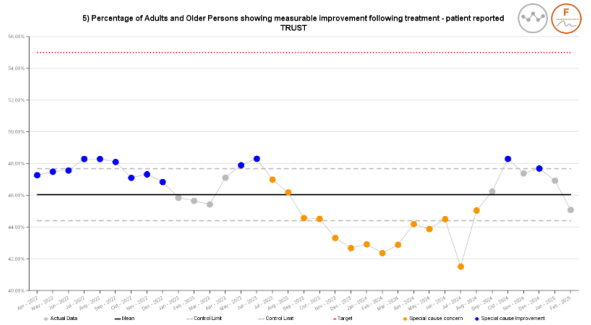
The accepted Patient Rated Outcome Measure is Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS).

Underlying issues:
- Analysis shows that collection rates for current caseloads are increasing; however, as some patients have very long journeys, improvements in paired rates will not be visible until the point of discharge (approximately 70% of patients will be discharged within 2 years).

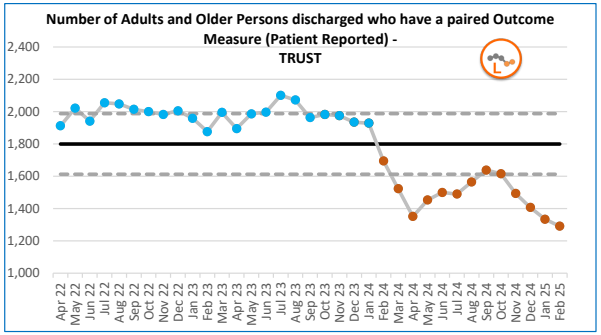
Actions:
- The Trust wide Clinical Outcomes Improvement Plan is progressing with 2 key actions completed this month:
    - Embed the use of ROMs in neuro assessment pathways – new process in place for use of GBO's at commencement of assessment process
    - Assess the use of GBOs (as an interim solution in the absence of having accurate psychometric outcome tools for all outcomes measures) - principles agreed and communication planned to coincide with CAMHS clinical standards

  Eight actions are on hold due to the CITO change freeze; of these 4 are due to complete at the end of April 2025 and will, therefore, be overdue at that point. There remaining actions are on track. A new action has been added for Executive Directors to promote the importance of clinical outcomes during walkabouts to support culture change.





The below chart represents the number of discharges with paired outcome measures.



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

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 February **599** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 335 (55.93%)** made a measurable improvement.

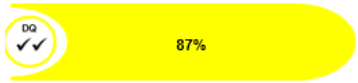
There is special cause improvement at Trust and Care Group level in the reporting period, and performance is above standard at all levels. There is special cause concern at Trust and Care Group level in the number of patients discharged with a paired outcome measure.

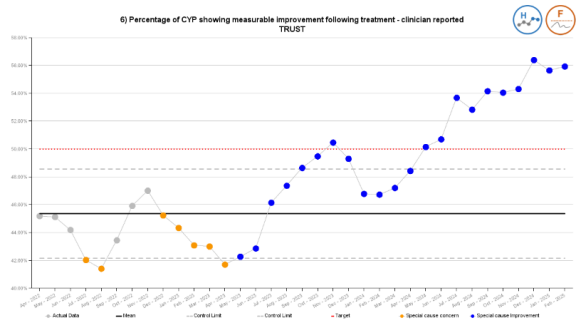
The accepted Clinician Rated Outcome Measures are Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and Children's Global Assessment Scale (CGAS)

Underlying issues:
- Analysis shows that collection rates for current caseloads are increasing; however, as some patients have very long journeys, improvements in paired rates will not be visible until the point of discharge (approximately 70% of patients will be discharged within 2 years).
- Patients who transition from CYP to AMH are not counted in the measure until they are discharged from TEWV

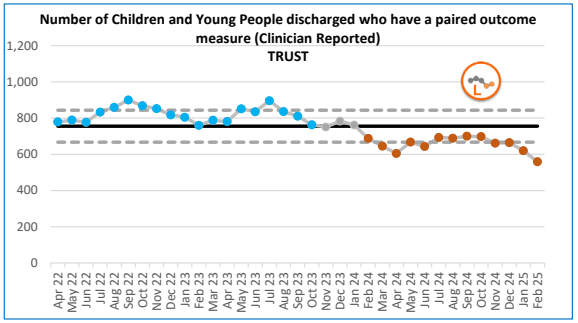
Actions:
- The Trust wide Clinical Outcomes Improvement Plan is progressing with 2 key actions completed this month:
    - Embed the use of ROMs in neuro assessment pathways – new process in place for use of GBO's at commencement of assessment process
    - Assess the use of GBOs (as an interim solution in the absence of having accurate psychometric outcome tools for all outcomes measures) - principles agreed and communication planned to coincide with CAMHS clinical standards

  Eight actions are on hold due to the CITO change freeze; of these 4 are due to complete at the end of April 2025 and will, therefore, be overdue at that point. There remaining actions are on track. A new action has been added for Executive Directors to promote the importance of clinical outcomes during walkabouts to support culture change.
- Business Intelligence to explore the feasibility of including those patients that transition between CYP and AMH as they are not “discharged” at this point. Timescale to be confirmed.





The below chart represents the number of discharges with paired outcome measures.



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

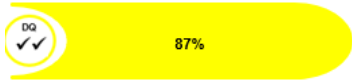
What does the chart show/context:
For the 3-month rolling period ending February **2165** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 542 (25.03%)** made a measurable improvement.

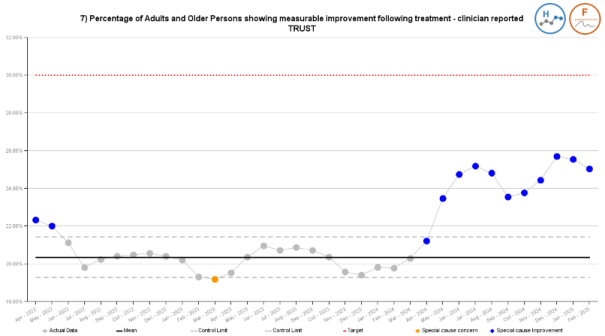
There is special cause improvement at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period; there is no significant change for North Yorkshire, York & Selby Care Group. There is special cause improvement for both specialties in both Care Groups; however, the low performance in MHSOP continues to be a concern. There is special cause concern at Trust and Care Group level in the number of patients discharged with a paired outcome measure.

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

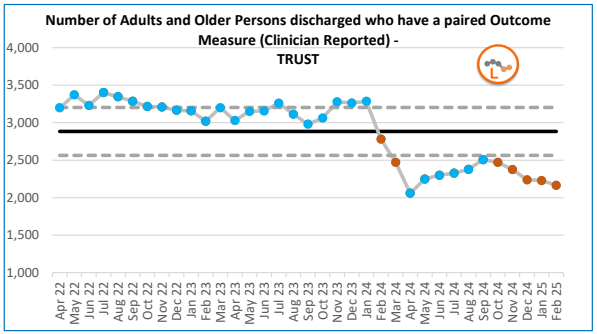
Underlying issues:
See measure 5, Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported.

Actions:
See measure 5, Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported.





The below chart represents the number of discharges with paired outcome measures.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

20To support the transfer Background / standard description:
We are aiming to have a maximum bed occupancy of 85% (commissioned level). (Agreed October 2024)

What does the chart show/context:
During February, **9,800** daily beds were available for patients; of those, **9,845 (100.46%)** were occupied. Overall occupancy <u>including</u> independent sector beds was **100.41%.**

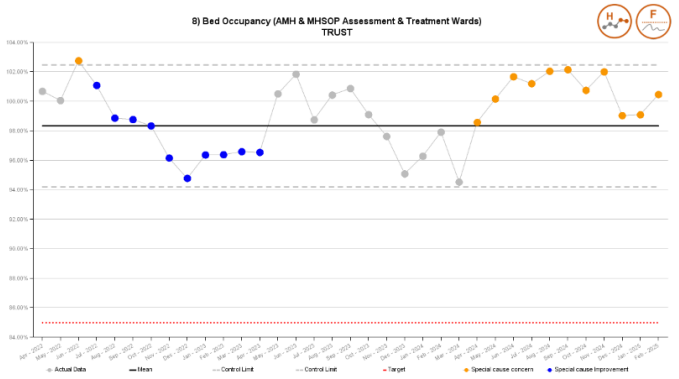
There is special cause concern at Trust level and in North Yorkshire Care Group in the reporting period; there is no significant change for Durham Tees Valley. There is special cause concern for Mental Health Services for Older People in NYYSCG.

Quality Assurance Committee are fully sighted on bed occupancy and focussed on the potential impact on quality.

Underlying issues:
- Delayed transfers of care – specifically the length of time that patients are delayed in Adult Mental Health Services in DTVFCG.
- At Trust level (both Care Groups) patients classified as clinically ready for discharge equated to an average of 34.4 Adult and 35.7 Older Adult beds in February 2025, with an associated direct cost YTD of c.£8.72m (including £1.17m independent sector bed costs). Of the cost, c.£3.48m relates to Adult and c.£4.07m relates to Older Adult. This is the highest combined level recorded and of significant concern.
- Length of stay (linked to above issues)
- Ministry of Justice (MoJ) patients

Actions:
- Care Groups to work together to develop a Trust-wide clinical model for the MHSOP organic bed base by the end of Q4 2024/25.
- Trust-wide groups will be established by the end of April 2025 to progress workstreams for Transforming Patient Flow and Transforming Mental Health Discharge within AMH services as part of the Urgent Care Programme Board.
- A Trust-wide patient flow workforce model is being developed to create a clearer escalation structure for operational staff both in and out of hours. A paper proposing the model will be presented to Executive Directors Group in April 2025; if approved, implementation will be July 2025.
- DTVFCG Managing Director to present the business case for the full roll out of Optica to Executive Directors Group in April 2025.

DQ ✓✓ 80%



Costings attached to patients clinically ready for discharge:

FYTD	Average Beds for Patients Classified as Clinically Ready for Discharge		Associated Cost for Patients Classified as Clinically Ready for Discharge	
	AMH	MHSOP	AMH	MHSOP
2023/24	25.8	16.5	£4.7m (*inc £3.34 IS bed costs*)	£1.96m
2024/25 *(as at February 2025)*	34.4	35.7	£3.48m (inc £1.17 IS bed costs)	£4.07m

Actions continued:
- A Trust-wide process is being developed to respond to patients who abandon calls to our crisis lines, to support the improvement of pick-up rates and patient experience. Timescales will be confirmed once the CITO change freeze has been lifted.
- Durham & Tees Valley Care Group has agreed investment for Safe Havens as part of our admission avoidance work. The Business Case and Specification for this new service will be developed in Q1 2025/26.

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 2025.

What does the chart show/context:
For the 3-month rolling period ending February **141** days were spent by patients in beds away from their closest hospital.

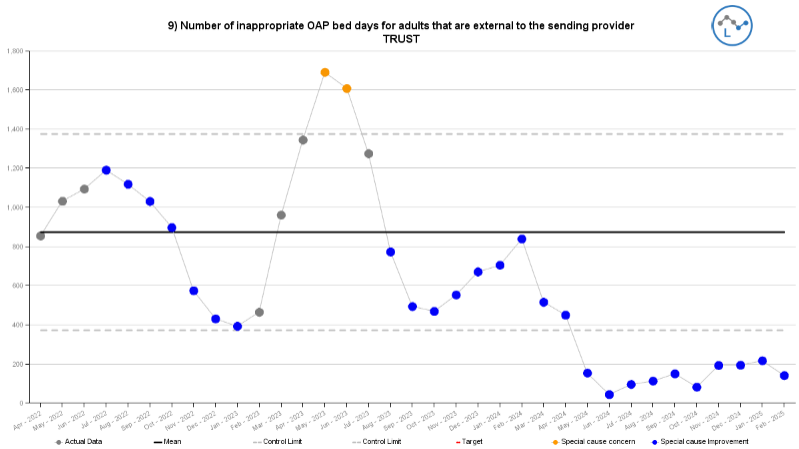
There is special cause improvement at Trust and Care Group level in the reporting period.

There was 1 active OAP placement as at 28th February 2025; the patient has subsequently been repatriated into a Trust bed.

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

Actions:
See measure 8) Bed Occupancy

DQ 73%



ICB Trajectories versus actual performance for Active Inappropriate Adult Acute Mental Health Out of Area 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	**0**	**0**	**0**	**0**	**0**	**2**	**3**	**2**	**1**	**2**	**1**	
North East & North Cumbria ICB	**Plan**	7	7	6	5	4	3	3	3	2	2	1	0
	Actual	**0**	**0**	**0**	**0**	**0**	**1**	**2**	**0**	**0**	**0**	**0**	
Humber & North Yorkshire ICB	**Plan**	3	3	2	2	2	1	1	1	0	0	0	0
	Actual	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**2**	**1**	**2**	**1**	

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

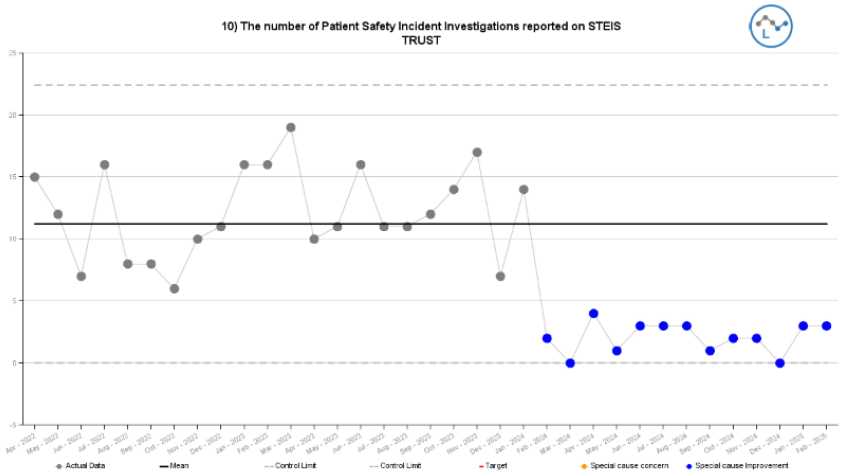
Tees, Esk and Wear Valleys NHS Foundation Trust

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

There is special cause improvement at Trust and Care Group level in the reporting period and for all services. *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.*

Underlying issues:
Once a PSII is identified, it is recorded on StEIS and allocated for investigation. The majority of cases that progress to PSII are identified at the point of the incident being reported. On occasions, some incidents identified as requiring investigation by an After-Action Review (AAR) may need to be escalated to a PSII after the AAR is completed based on information identified. Currently there is a delay in receiving completed AARs and potentially this could lead to a delay in identifying PSIIs.

Actions:
- The Patient Safety Team triage all incidents through a daily huddle. Where an AAR has potential to progress to a PSII, this is noted on the patient safety AAR tracker so these can be actively followed up when due.
- The Patient Safety Team are actively engaged with Care Group leaders. The Care Groups have sight of the AAR tracker and receive reports on the position of overdue AARs into Care Group Board on a monthly basis with a view to addressing blockages to completion.



11) The number of Incidents of moderate or severe harm

Tees, Esk and Wear Valleys NHS Foundation Trust

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

There is a reduction (not necessarily an improvement as indicated in the SPC chart) at Trust and Care Group level in the reporting period, as this change looks to align to the new system implementation. This is mirrored in most services. There is special cause concern for Health & Justice; however, this was related to the complex needs of one patient over a limited period of time and, therefore, at this stage is not an area of concern.

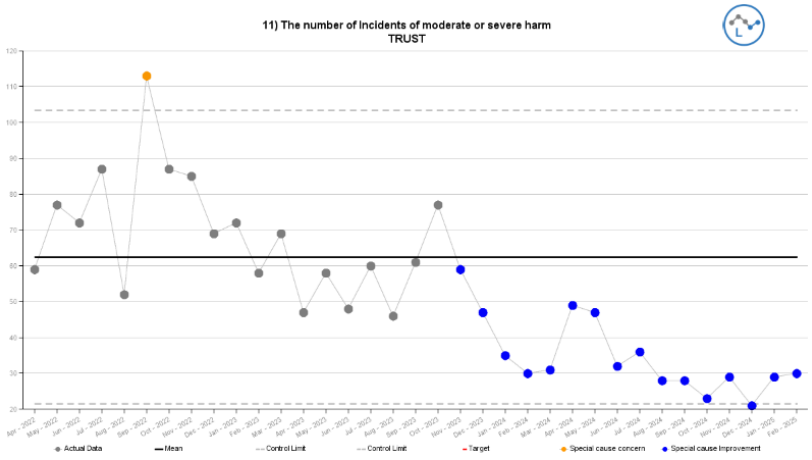
Each incident is subject to a multi-disciplinary after-action review by services. These reviews are then considered in the Patient Safety huddle to determine if any further investigation is required.

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

Underlying issues:
As at the 11th March 2025, there were 685 patient safety incidents in the 'awaiting investigation' stage. All will have been reported as no or low physical harm, as moderate or above severity incidents are reviewed through the Patient Safety huddle process within 1 working day. There may be a very small number of incidents of moderate or severe harm that have not been identified at the reporting stage at this severity level. This means a potential delay as these will not be identified until the incident has its first review which should be within 4 days.

Actions:
- Care Groups and Directorates are asked to embed clear monitoring processes within local governance, taking action as appropriate to support teams that may be struggling to undertake initial reviews in a timely way.
- A Quality Improvement project is underway to enable the development of a robust ward to Board incident management governance and oversight flow.
- New e-learning training has been developed and made available via ESR by the end of February 2025 (originally January 2025). **(Completed)**
- Patient Safety Team to provide bitesize training sessions focussing on key areas to provide additional support to staff when reporting and reviewing incidents. Originally anticipated to be available from February 2025, the first course will be held on the 3rd March. **(Completed)**

DQ ✓✓ 87%



77

12) The number of Restrictive Intervention Used

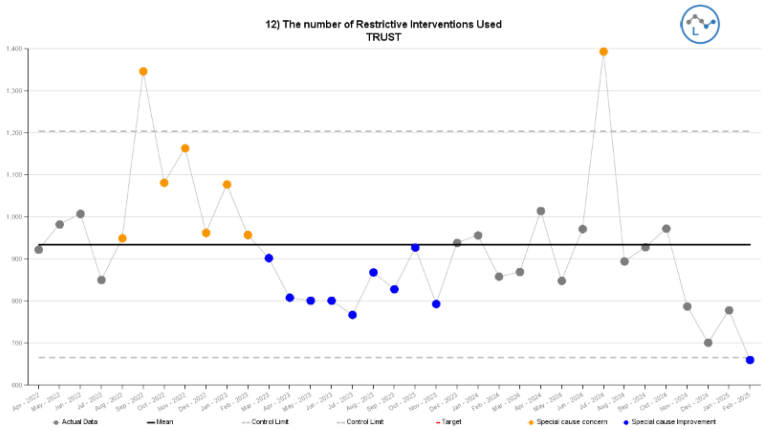
Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
660 types of Restrictive Interventions were used during February.

There is special cause improvement at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period; there is no significant change for North Yorkshire , York & Selby Care Group . There is special cause improvement in Children & Young Peoples Services in DTVFCG and Adult Learning Disabilities in NYYSCG, and whilst there is also special cause improvement indicated for Adult Learning Disabilities in DTVFCG, there are significant concerns (*see underlying issues below*).

Underlying issues:
- Concerns remain on Overdale (DTVFCG AMH Assessment & Treatment). However, the number of interventions used have significantly reduced.
- There is special cause concern for Tunstall Ward, which relates to a small number of patients.
- Concerns remain in DTVFCG ALD where there are a high number of interventions used for a small number of patients presenting with complex needs.

Actions
- There are several actions to support improvement in AMH services, which include:
  - Specialist Practitioner for Positive & Safe continues to work with Overdale Ward, to review the use of restrictive interventions and to provide education. (**Completed)** this will continue as part of business as usual.
  - Trust-wide Autism Team providing an Autism-Informed Care Project into Overdale Ward. This includes allocating Clinical Specialists to all the AMH wards to support Impact Assessments, embedding reasonable adjustments, and attending multi-disciplinary team meetings and formulations to support an autism lens.
  - Clinical Psychologist undertaking a piece of work on Tunstall Ward to reduce the number of headbanging incidents for a small number of patients.
  - Positive & Safe Team are providing support into Tunstall Ward to ensure that the least restrictive interventions are used.
  - DTVFCG ALD services continue to monitor the use of restrictive interventions, seeking support from the Specialist Practitioner for Positive & Safe where appropriate.



Note: The high use noted in July relates to one patient within Adult Eating Disorders Inpatients.

Actions continued:
- Positive and Safe team with senior leaders are running Trust-wide workshops on the Positive & Safe 3-year strategy, to enable services to develop delivery plans by the end of April 2025. **(Completed)**
- Collaborative improvement work across both Care Groups and relevant corporate services is underway regarding our approach to 'incident management'. This will include the decisions and definitions about 'restrictive practice', ensuring that incidents are logged appropriately and identifying what we can safely STOP doing, KEEP doing and START doing with the aim of reducing waste in the process.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

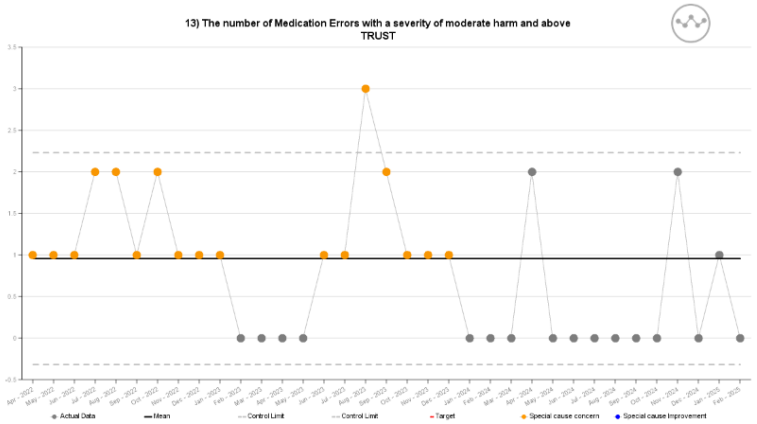
What does the chart show/context:
0 medication errors were recorded with a severity of moderate harm, severe or death during February.

There is no significant change at Trust and Care Group level in the reporting period. There is special cause improvement for Adult Learning Disabilities and Adult Mental Health in Durham, Tees Valley & Forensic Care and for Mental Health Services for Older People within North Yorkshire, York & Selby Care Group.

As incidents are reviewed the severity could be reduced or increased (usually reduced), which would then be refreshed in future reports.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

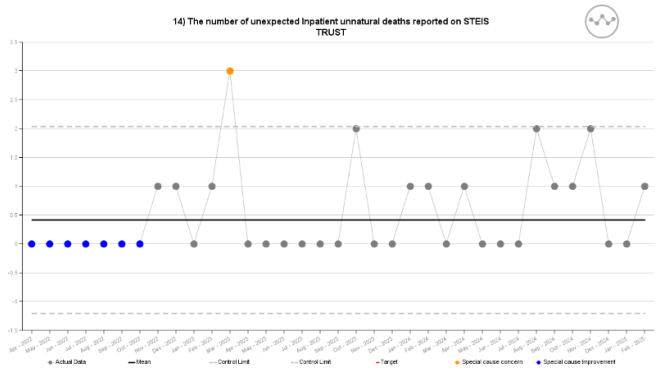
What does the chart show/context:
1 unexpected inpatient unnatural deaths on an inpatient ward whilst on leave were reported on the Strategic Executive Information System (STEIS) during February.

All unexpected and unnatural deaths in inpatient wards are immediately reported in this data. Once the cause of death is confirmed, where necessary the data is refreshed. Therefore, on occasion we might be over reporting the number of unexpected, unnatural deaths.

Underlying issues:
There are no underlying issues to report.

Actions:
A comprehensive multi-disciplinary after-action review is underway and in line with the National Patient Safety Incident Framework, a full Patient Safety Incident Investigation will be completed; a Family Liaison Officer is supporting the family.

DQ ✓✓ 87%



15) The number of uses of the Mental Health Act

Tees, Esk and Wear Valleys NHS Foundation Trust

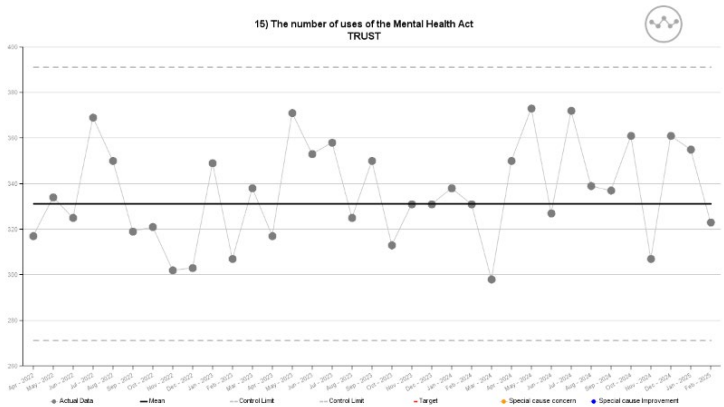
What does the chart show/context:
There were **323** uses of the Mental Health Act during February.

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 for Durham, Tees Valley & Forensic Care Group and for Secure Inpatient Services within that Care Group; however, the Care Group has confirmed there are no underlying issues to report in the reporting period. There is special cause improvement for Adult Learning Disabilities and Adult Mental Health Services within North Yorkshire, York & Forensic Care Group.

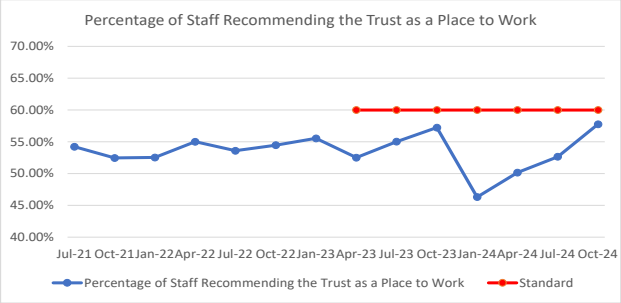
Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

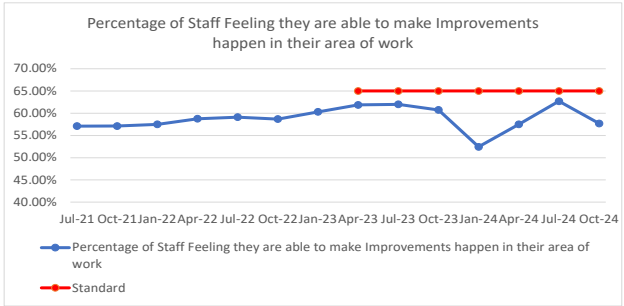
DQ ✓✓ 87%



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



** 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*

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:
3509 staff responded to the October Annual Staff Survey. In relation to the question "I would recommend my organisation as a place to work", **2027 (57.77%)** responded either "Strongly Agree" or "Agree".

The NHS Staff Survey Benchmarking report 2024, shows the "best result" was 78% and the "average result" was 63% for similar organisations.

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:
3513 staff responded to the October Annual Staff Survey. In relation to the question "I am able to make improvements happen in my area of work", **2027 (57.70%)** responded either "Strongly Agree" or "Agree".

The NHS Staff Survey Benchmarking report 2024, shows the "best result" was 66% and the "average result" was 59% for similar organisations.

NB: *We previously identified that the number of responses being used in the calculation was not consistent. All issues have now been resolved, and historic activity has been updated.*

Underlying issues:
We are not capturing the views of all our staff (44% in the October Annual Staff Survey); therefore, this is not a comprehensive picture.

Actions:
- Organisational Development are currently visiting Trust sites to encourage staff to complete the quarter 4 National Quarterly Pulse Survey and are actively promoting the survey through a variety of communication channels, including Team TEWV, email and Trust bulletins. Promotional activity for the Quarter 1 2025/26 survey will be undertaken in April 2025 and for the Quarter 2 survey in July 2025. *This is business as usual for the team.*
- All services/teams to develop team-level Staff Survey improvement plans and to present the actions they are taking forward in 2025/26 at the June Trust Leadership Events (commencing the 9th June 2025). The development of these plans will be supported by Organisational Development and the People Partners.

18) Staff Leaver Rate

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 **7,340.66** staff in post, **782.99 (10.67%)** had left the Trust in the 12-month period ending February 2025.

There is special cause improvement at Trust level and for most Directorates in the reporting period. However, there is special cause concern for the Assistant Chief Executive Directorate, Health & Justice and Children & Young Peoples Services within North Yorkshire, York & Selby Care Group (both areas have confirmed there are no underlying issues).

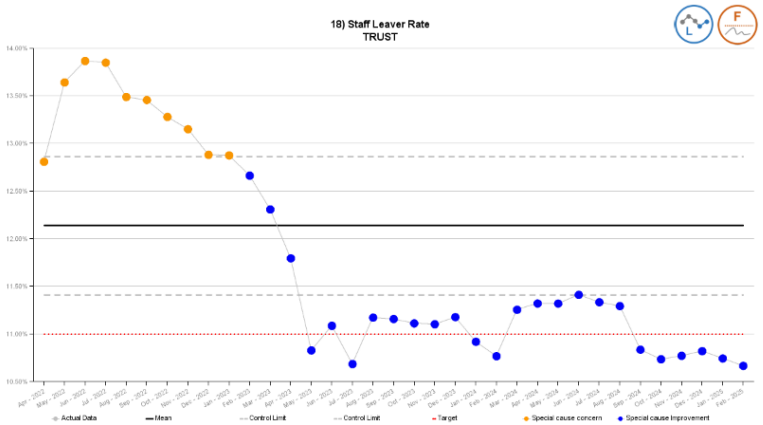
The latest (December 2024) National Benchmarking for NHS Staff Leaver Rate published on NHS England NHS Oversight Framework Dashboard shows we were ranked **33** (previously ranked 30) of 67 Trusts Mental Health & Learning Disability Trusts (1 being the best with the lowest leaver rate) and are placed in the interquartile range.

Reasons our staff have told us why they are leaving, include:
- Promotion
- Work-life balance/wellbeing
- Relocation
- Pay related
- To undertake further training

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

DQ ✓✓ 87%



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)

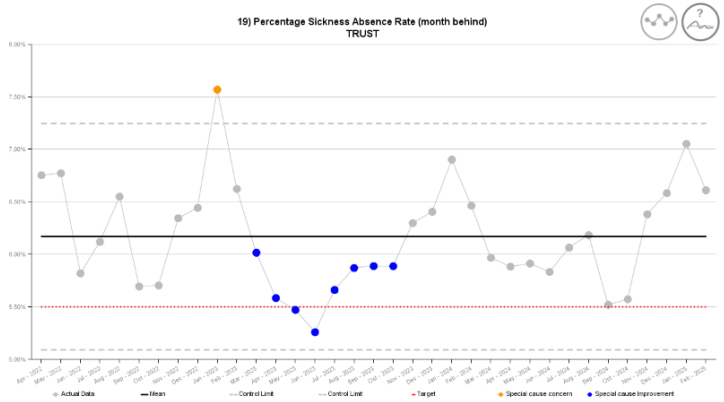
What does the chart show/context:
There were **233,181.27** working days available for all staff during February 2025 (reported month behind); of those, **15,416.04 (6.61%)** days were lost due to sickness.

There is no significant change at Trust and for most Directorates in the reporting period; however, there is an increasing trend visible in the SPC chart at Trust level. There is special cause concern for Estates and Facilities Management. There is also special cause concern for Adult Learning Disabilities and Adult Mental Health Services within Durham, Tees Valley and Forensic Care Group and Management within North Yorkshire, York & Selby Care Group; however, the directorates have confirmed there is no actual concern at this stage.

National Benchmarking for NHS Sickness Absence Rates published 27th February 2025 (data ending October 2024) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is 5.54**%** compared to the Trust mean of **6.07%**, with the Trust ranked 34 of 48 Mental Health Trusts (1 being the best with the lowest sickness rate).

Underlying issues:
- Sickness audits have shown that the Short-Term Sickness Procedure is not being consistently followed through Trust services.

Actions:
- Human Resources Operational Team to develop an escalation process for those services with continued limited assurance within the short-term sickness audits. The process will be in place by the 30th April 2025.
- The Human Resources Operational Team continue to support the management of both short- and long-term sickness via monthly monitoring of sickness for each service, staff who have 5 or more episodes of absence, and teams/wards that have the highest absence rate, liaising with managers to understand and support any concerns. Analysis is undertaken on the numbers of staff citing stress/anxiety within the last 12 months, liaising with managers on any patterns or concerns, and long-term sickness is monitored, focussing on cases that are in excess of 6 months of absence to support any decisions/barriers, ensuring appropriate support is in place. Sickness clinics are established in all areas experiencing high absence, and support, training and guidance is available for all managers. *NB. This is standard work for the team*



20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

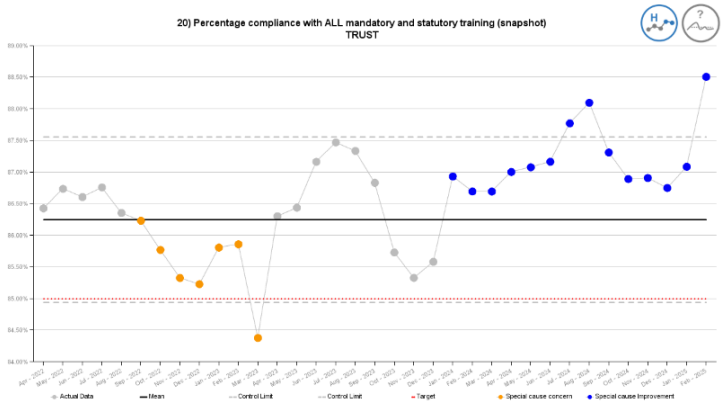
Background / standard description:
We are aiming for 85% compliance with mandatory and statutory training

What does the chart show/context:
149,353 training courses were due to be completed for all staff in post by the end of January. Of those, **132,188 (88.51%)** were completed.

There is special cause improvement at Trust level and for most Directorates in the reporting period. There is also special cause concern for Management in Durham, Tees Valley & Forensic Care Group.

As at the 28th February 2025, by exception compliance levels below 85% are as follows.

	Number of Courses Compliant	Number of Courses Required	Percentage Compliancy
TRUST FINANCING (BANK STAFF)	449	616	72.89%
CHIEF EXECUTIVE OFFICE	71	90	78.89%



Underlying issues:
- A significant number of Bank staff (Trust Financing) have not completed Information Governance Data Security training; the majority of which are not actively working.
- The volume of courses that staff have to complete is extremely time consuming and above the current headroom calculation.

Actions:
- Temporary Staffing Manager was to ensure the outstanding Information Governance training for Bank Staff is undertaken by the end of February 2025 (previously December 2024). **(Not Completed)** Bank staff are being contacted directly, and compliance is anticipated by the end of April 2025.
- The shortfall in performance for the Chief Executive Office relates to two new Non-Executive Directors. The CEO is working through Company Secretaries to make arrangements to ensure these colleagues complete training by end of April 2025.
- Executive Director of Therapies to ensure outstanding training is undertaken by the end of February 2025, where possible. (**Completed**)
- A systematic review of the various training courses has started with Immediate Life support (ILS). Areas for improvement have now been identified, and scoping work is underway to take these forward.

Actions continued:
- An action plan has been developed to rationalise the training portfolio, which includes reducing the duration and frequency of some competencies and the removal of others. This is being led by the Education Governance Group and will be completed by the end of February 2025. **(Partially Completed)** The required actions regarding Rapid Tranquilisation will be confirmed by the end of March 2025.

20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

Lowest 5 Compliance

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

What does the table show/context:
We have **15** courses that are currently below the standard (previously 17 courses). We are currently focusing on the lowest 5 compliance levels.

The trajectory for Resuscitation – Level 3 – Adult Immediate Life Support – 1 Year was recalculated in January following the identification of an error in the calculation of available spaces. At that point, we projected to have 73% of all staff (including Bank) to be compliant by the end of February; as at February we have 70% staff compliant. We project to achieve 85% of all required staff by the end of May 2025

Underlying issues:
- Staff unable to be released to attend training (high DNA rate and wasted spaces). During February 2025 there has been an average of 41% wasted spaces (including 18% DNAs) across the mandatory face to face training courses.
- Reduced capacity for Positive & Safe training courses to manage the backlog

Actions:
- Education & Training Team are currently scoping venues in Malton and York St John to support training within North Yorkshire & York. **(Completed)** Between April and June we will increase the spaces within NYYS by 60 spaces
- Workforce Development Lead has completed a capacity and demand exercise for all face to face or Microsoft Teams training to identify any gaps and to support the production of trajectories for the year. The outstanding trajectories for Moving & Handling training were completed by the end of February 2025. **(Completed)**
- Daily reviews of staffing are in place across the Care Groups to ensure that the right staff with the right training are in place to respond to any issues that arise, and staff will be moved to ensure we have the right skill mix available on our wards.

86

	Number of Courses Compliant	Number of Courses Required	Percentage Compliancy
Rapid Tranquilisation 1	207	306	67.65%
Positive and Safe Care Level 2 Update *	1172	1722	68.06%
Resuscitation - Level 1 - 1 Year *	1842	2618	70.36%
Positive & Safe Care Level 1 *	3112	4383	71.00%
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year *	1451	1976	73.43%
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year	737	936	78.74%
Moving and Handling - Level 2 - 2 Years *	726	902	80.49%
Safe Prescribing	232	288	80.56%
Annual Medicines Optimisation Module	1817	2221	81.81%
MCA - Relationship Between MCA and MHA	3473	4191	82.87%
Mental Health Act Level 2	3288	3948	83.28%
MCA - Restraint	3490	4188	83.33%
MCA - MCA and Young People Aged 16/17	777	929	83.64%
Infection Prevention and Control - Level 2 - 1 Year	5141	6098	84.31%
MCA - Deprivation of Liberty	3547	4183	84.80%

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

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

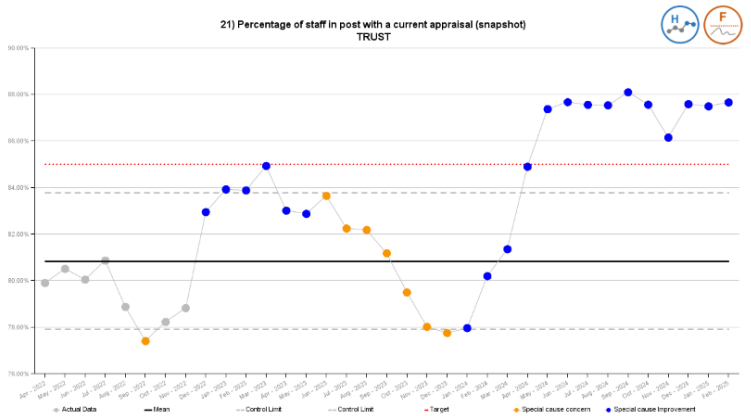
What does the chart show/context:
Of the **6,976** eligible staff in post at the end of February; **6,115 (87.66%)** had an up-to-date appraisal.

There is special cause improvement at Trust level and for most areas in the reporting period. Whilst there is special cause improvement for Digital & Data Services, a decreasing position is seen.

As at the 10th March 2025, by exception compliance levels below 85% are as follows:

	Number of Appraisals Completed	Number of Appraisals Required	Percentage Compliancy
CAPITAL PROGRAMME	7	10	70.00%
THERAPIES	35	47	74.47%
FINANCE	41	55	74.55%
CORPORATE AFFAIRS AND INVOLVEMENT	30	37	81.08%
DIGITAL AND DATA SERVICES	136	161	84.47%

DQ ★ 93%



Underlying issues:
- We possibly have some data quality issues as the Director for Corporate Affairs & Involvement has confirmed all staff have received an annual appraisal.

Actions:
- Outstanding appraisals will be undertaken in Capital Programme by the end of February 2025. **(Not Completed)** These will be completed in March 2025.
- Outstanding appraisals will be undertaken in Therapies by the end of February 2025. **(Not completed)** These will be completed by the end of April 2025.
- Outstanding appraisals to be undertaken in Finance by the end of April 2025.
- Outstanding appraisals to be undertaken in Corporate Affairs & Involvement by the end of February 2025 (previously December 2024). **(Completed)** *Note below action*
- Head of Performance to work with Corporate Affairs & Involvement by the end of March 2025 to identify any issues impacting on this measure.
- Outstanding appraisals to be undertaken in Digital & Data Services by the end of March 2025.

Actions continued:
- The Company Secretariat has been impacted by staff absence on which EDG are fully cited. Team leaders to consider how compliance can be achieved by the end of January 2025. **(Completed)**
- Strategic Lead Workforce Information and Resourcing Systems to provide further advice and guidance on how to log appraisals (and supervision) on TEWV Vision by the end of March 2025

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

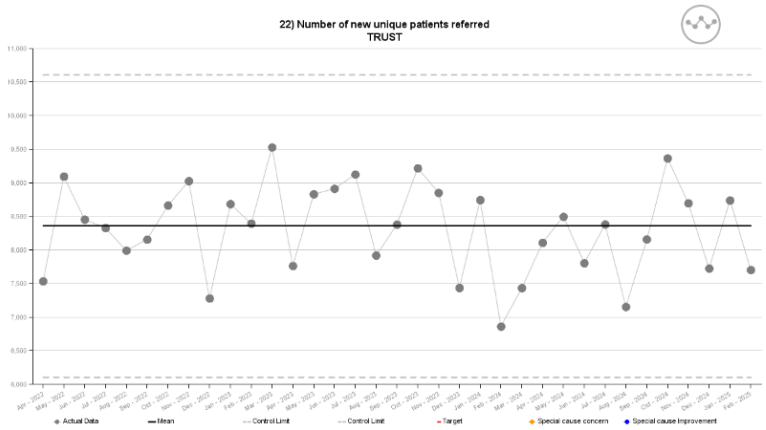
What does the chart show/context:
7,703 patients referred in February that are not currently open to an existing Trust service.

There is no significant change at Trust and Care Group level in the reporting period. However, there are a number of unexpected shifts of referrals. There are low shifts for Children & Young Peoples Services and Health & Justice within Durham, Tees Valley & Forensic Care Group and high shifts for Adult Mental Health in both Care Groups; the Care Groups have confirmed there are no underlying issues.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required

DQ ★ 93%



23) Unique Caseload (snapshot)

Tees, Esk and Wear Valleys NHS Foundation Trust

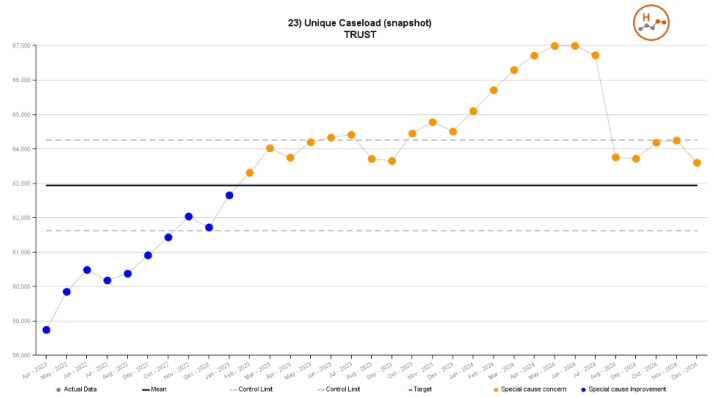
What does the chart show/context:
64,409 cases were open, including those waiting to be seen, as at the end of February 2025; **53,859** were active.

There is special cause concern at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period (including in AMH and CYP in that Care Group). There is also special cause concern for H&J; however, the service has confirmed there is no actual concern. There is special cause improvement for North Yorkshire, York & Selby Care Group and for ALD and AMH in that Care Group. There is also special cause improvement for MHSOP and SIS within Durham, Tees Valley & Forensic Care Group.

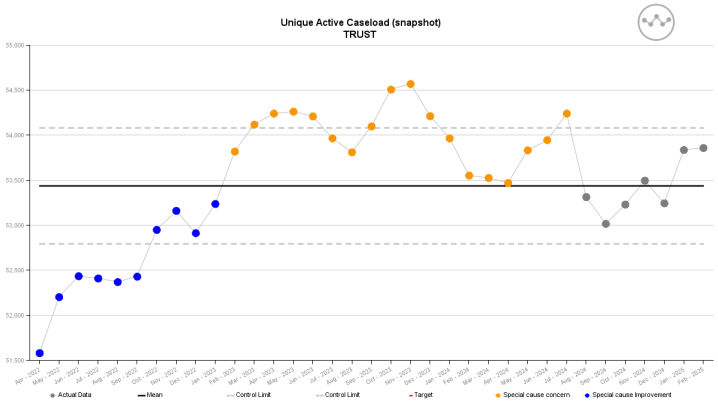
The **new SPC chart** representing **Active Caseload** (excluding patients waiting for first contact) shows no significant change at Trust level, special cause concern for Durham, Tees Valley & Forensic Care Group and special cause improvement for North Yorkshire, York & Selby Care Group.

Underlying issues:
Initial analysis of the new active caseload measure has identified special cause concern for CYP and AMH in DTVFCG; however, further analysis and discussion is required.

Actions:
- Findings of the caseload deep dive on CYP services have been shared with the Care Groups who will now collectively agree next steps by the end of January 2025 and present back to EDG in February. **(Not Completed)** Findings will be discussed at the April 2025 Board to Board meeting.
- Further analysis of the new active caseload measure will be undertaken at team level for CYP and AMH and discussed with the relevant general manager by the end of March 2025.



The below chart represents the active caseload, excluding patients waiting for their first contact.



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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:

The financial position to 28th February 2025 against which Trust performance is assessed is a deficit of **£0.373m which is a £0.753m favourable variance against plan**. The Trust submitted a breakeven plan for 2024/25 which assumes delivery of challenging 4.5% or £21.78m Cash Releasing Efficiency Schemes (CRES).

- **Agency expenditure** for the year to date is £9.36m, which is £1.88m below plan and reflects a broadly consistent downward trajectory. Whilst in month costs were £0.73m and decreased by £0.03m compared to prior month, they remained well below the national cap of 3.2% of paybill; being 2.12% in month, and lower than the year to date average of 2.57%. The Trust has achieved significant agency WTE and expenditure reductions since April 2023. This reflects sustained impacts from actions to exit non-clinical agency assignments, reducing costs relating to complex care packages following the discharge of a small number of adults with a learning disability, and reducing inpatient agency headcount. Ongoing usage includes high premia rate locum costs for cover of Health and Justice nursing and Trustwide medical vacancies. The Temporary Staffing Service is now supporting incremental rate reductions in the former. The trust continues to have **no off-framework agency assignments**.
- **Independent sector beds** - the Trust used 115 non-Trust bed days in month (145 in January); a decrease of 30 bed days compared with the previous month. Year to date costs were £1.17m, which includes estimates for unvalidated periods of occupancy and average observation levels pending billing and is £0.22m below plan. 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 the highest reported average monthly levels of those who are clinically ready for discharge, mean that sustaining low (and delivering nil targeted) independent sector bed utilisation remains very challenging. It is hoped that new OPEL and bed management processes (Monday to Friday) will support optimal daily management and flow.
- **Taxis and Secure Patient Transport** costs were £2.30m (£209k average run rate) to 31st February compared to a plan, based on exit run rates, of £178k per month (or £1.96m for 11 months), and a £340k 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. A quality improvement event was held in 2023 which recommended grip and control actions and development of a new policy. Due to limited sustained impact an improvement workshop took place on 20th November including both Care Groups and corporate teams. Procurements for both taxis and secure transport are expected to reduce unit costs / improve oversight during the later stages of 2024/25.
- 2024/25 plans assume delivery of 4.5% £21.78m **Cash Releasing Efficiency Savings (CRES)** for the year, with £15.7m plans being recurrent and £6.055m non–recurrent. £2.055m unidentified non-recurrent CRES assumed at plan has now been fully identified from corporate, estates/facilities and central directorates. Year to date CRES are £0.005m ahead of plan, but with recurrent schemes delivering £1.091m lower, and non-recurrent schemes delivering £1.097m higher, than planned.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Pay Awards for colleagues were paid in Months 7 and 8. Whilst tariff-based national funding was received for pay awards, this does not cover the higher impact for non-acute providers of our higher pay cost weight. Additional non-recurrent funding was received from Commissioners in 2024/25 to mitigate the impact in-year. Plans have been adjusted to reflect the additional tariff-based income and expenditure, to better reflect the funded position.

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 high occupancy, safe staffing requirements and agency expenditure are impacting our financial plan, with ward staffing remaining above funded levels. Agency price cap breaches at premia rates, with 31% of (a reducing number of overall) agency shifts being above price cap, are impacting overall value for money, with medical and Health and Justice vacancy hotspots.
- 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 achieved 83% of rotas published which is marginally better than the Trust target of 80%. However, the action on annual leave level loading was not completed and EDG approved a further extension to the end of March 2025 (from October 2024).
- The Agency Reduction PIP is progressing. Three actions have been completed and have had the desired impact: an increased number of bank workers to reduce Health Care Assistant Agency usage in DTVFCG, a review of the outsourcing timeframes within DTVFCG, and an increased number of bank workers to reduce Health Care Assistant Agency usage in NYYSCG. In DTVFCG work to reduce the number of shifts filled by agency has been completed and whilst the desired 23% reduction has not been achieved, there has been a 15% reduction. The cessation of accommodation costs has not been completed and an extension to the 30th September 2025 has been approved. An additional action to re-negotiate rates of pay with framework agencies for Health & Justice registered nurses and all new Health & Justice registered nurses to be within price caps will not be completed by the 31st January 2025 and an extension to the end of September 2025 has been approved.
- An Efficiency Hub oversees delivery of CRES and provide support to Care Groups / Directorates.
- 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 costs and Whole Time Equivalents (WTE) has been enhanced and is being shared to support a renewed focus on driving cost efficiency.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

Year to date agency costs of £9.36m at Month 11 are £1.88m below plan. In-month expenditure of £0.73m is £0.17m lower than plan.

NHS planning guidance for 2023/24 introduced system agency cost caps of 3.7% pay bill, reducing to 3.2% pay bill for the current financial year. Performance in month was 2.12%, and 2.57% for the year to date, having reduced from around 4.5% on average through 2023/24 and 5.4% on average through 2022/23.

Reducing reliance on agency shifts and on medical / health and justice shifts paid above national price caps remains a key focus. Agency shifts have reduced by the equivalent of 166 worked Whole Time Equivalent (WTE) since April 2023 (240 WTE) to February 2025 (74 WTE), and related annualised premia reduced from £4.0m in April 2023 to £1.8m in February 2025 (£2.2m reduction). Whilst the trend for medical WTE and price cap breaches was broadly positive between April 2023 and February 2025, assignments increased in October 2024, going against trend and impacting premia incurred. With that exception, run rates demonstrate the positive impacts from actions taken to date and the benefit from sustained focus to improve framework compliance and reduce numbers of shifts filled using agency.

The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to sustained management of sickness absence, but equally to net new recruitment (including to medical, qualified nursing, inpatient, and health and justice hot spots), 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 developed a **Performance Improvement Plan** to track actions 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 (the latter notably to tackle price cap breaches in Health and Justice), to manage high occupancy levels and delayed transfers from inpatient wards (including with system collaboration) and to use temporary staffing more optimally including through improved rostering and by regularly reviewing our safer staffing levels relative to clinical need.

Actions:

The Executive Directors Group (formerly Executive Workforce and Resources Group) will oversee 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 to optimise their use of the roster. Care Groups are being asked to hold monthly governance meetings reviewing roster KPIs such as timely publications of rotas and management of headroom.
- Develop roster training programme (ran 3 x weekly January to March 2024) – Planned Programme Completed and extended on an ongoing basis.

25b) Agency price cap compliance

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:

1,385 agency shifts were worked in February 2025, with **952 shifts compliant** (69%) and **433 non-compliant** (31%) (prior month 1,040 shifts compliant or 64% and 594 non-compliant or 36%) **with national price caps**.

Most price cap breaches during 2024/25 have related to medical or prison nursing cover for hard to fill vacancies. In month 75% of non-compliant shifts (94% by value of breaches) are medical and 18% of non-compliant shifts (5% by value of breaches) are nursing. Of the nursing agency breaches, 100% of all shifts relate to prisons (100% by value of shifts breaching). Medical shifts breaching decreased by 157 shifts, reducing from 495 shifts in January to 338 in February 2025 (100% shifts breach price cap).

249 fewer overall agency shifts were worked this month compared to last, with shifts worked being equivalent to **approximately 49 shifts per day** (53 in January and 49 in December). The 249 shifts decrease includes 157 fewer medical (63% decrease), 77 fewer nursing agency (31% decrease), 5 more AHP agency shifts (0.02% increase), and 20 fewer HCA agency shifts (0.08% decrease). Actions are in train to review the financial forecast, including looking at numbers of medic working days.

This reflects **a reduction in total shifts worked of 1,133 (45%) over the last 12 months** from 2,518 shifts worked in February 2024 and **a reduction of 55% or 526 shifts breaching price cap since February 2024** (959 shifts breached).

- The Trust's ability to reduce price cap breaches now almost entirely stems from recruitment challenges for medical and health and justice vacancies, but with both on downward trajectories currently.
- 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 particularly price cap breaches and rate premia associated with agency expenditure significantly impact 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:
Particularly persistent challenges relate to levels of medical staffing and prison mental health nursing vacancies requiring cover from premia rate locum assignments which have consistently breached price caps during 2024/25.

Actions:
In addition to actions from 25a) supporting improved compliance, the Trust has approved a business case for a second phase of International Recruitment to aim to recruit a more sustainable medical workforce (nursing business case approved previously) and reduce reliance on higher rate agency assignments, targeting SAS locum medical assignments initially. Medical assignments attract the highest value and percentage premia rates. Social media and other targeted recruitment activities are seeking to attract new colleagues to Health and Justice (prison) vacancies.

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26) Use of Resources Rating - overall score

Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:

The overall rating for the trust is a **3** for the period ending 28th February.
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 **4**.
- 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 -0.08% which is a **rating of 3**.
- The Income and Expenditure **(I&E)** margin distance from plan is 0.19% 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 £9.36m are below plan and would therefore be **rated as a 1.** The Trust's year to date agency costs were 2.57% 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 is an **overall UoRR** of **3** for the period ending 28th February compared to a planned UoRR of 2.

Underlying issues:
The Trust's forward liquidity position is of concern, including as cash balances are deployed to progress capital programmes. 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 albeit that the Trust's wider financial strategy and medium term financial plan are subject to continued review.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

Recurrent CRES performance for the period ending 28th February was £13.29m which was below plan by £1.09m. The previous month reported recurrent CRES was £0.95m behind plan, with the £0.14m in month deterioration against plan including impacts from the International Nurse recruitment second cohort not progressing.

2024/25 financial plans assume delivery of 4.5% £21.78m Cash Releasing Efficiency Savings for the year. We planned to deliver **£15.7m or 3.2% recurrent** Cash-Releasing Efficiency Savings (CRES) for the year.

Following the submission of our financial plan, confirmed key recurrent CRES plans 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.
- Schemes that are underperforming include International Nurse recruitment (behind by £0.90m) second cohort not progressing, LED lighting (behind by £0.33m), Over Establishment (behind by £0.40m) and EFM non-pay (behind by £0.24m).

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 the 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

What does the data show/context:

Non Recurrent CRES performance was ahead of plan by £1.10m for the period ending 28th February, with £5.88m having being achieved.

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

The Trust planned to deliver **£6.055m or 1.25% of non-recurrent** Cash-Releasing Efficiency Savings (CRES) for the year.

£4.0m of non-recurrent CRES had been identified in the plan, which left £2.055m to be identified. This has now been fully identified from corporate, estates/facilities and central directorates. Work is ongoing to assess whether any of the additional schemes are recurrent schemes, potentially offering some mitigation to recurrent under performance.

Of the £1.10m overachievement year to date, £0.71m reflects non-recurrent mitigation of the Over Establishment Target, with £0.07m reflecting a negotiated water rebate and an additional £0.30m of non-recurrent actions.

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 **£3.84m** at the end of February and **less than allocated by £3.56m**.

£8.51m 2024/25 capital schemes were approved for funding from nationally allocated capital delegated via North East and North Cumbria Integrated Care Board (ICB). An additional allocation of £0.42m was approved by the ICB in July, resulting in a total capital allocation of £8.93m for 2024/25.

The Trust secured £2.96m of additional cash-backed central funding in 2024/25 to improve Information systems, assist creating our Mental Health hub in North Yorkshire and improve energy efficiency. This is not included in performance measurement against the £8.93m capital allocated to the Trust through North East and North Cumbria ICB.

This means the Trust's **aggregate capital programme for 2024/25 is £12.26m** (including £0.37m PFI life-cycle).

The underspending for the year to date is linked to slippage against schemes and will be managed, including with Integrated Care System Partners, within this financial year. Additional oversight arrangements have been stepped up to ensure weekly tracking of key milestones for the remainder of the financial year.

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, with significant oversight now needed to ensure commitment of resources in the remaining 3 months of the financial year. 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 **£55.27m** at the end of February 2025 which exceeded planned cash balances of **£49.53m** by **£5.74m** (favourable variance).

- This reflects slippage in the capital programme and the favourable revenue plan variance, offset by lower depreciation than planned and working capital variations.
- The Trust has achieved a combined Better Payment Practice Code (BPPC) compliance of 95.1% to date for the prompt payment suppliers, which is marginally above the 95% target. 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 at 28 February 2025 was £2.8m, with debts exceeding 90 days amounting to £0.60m (excluding amounts being paid via instalments and PIPS loan repayments). Progress continues to be made to receive payment for older debts. No outstanding debts have been formally challenged.

Underlying issues:

In addition 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.

Cash has decreased linked to the year-to-date deficit position on revenue budgets, and because capital payments exceed cash generated internally from depreciation charged in year.

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	✓	✓	✓
25a	Financial Plan: Agency expenditure compared to agency target	✓	✓	✓
25b	Agency price cap compliance	✓		✓
26	Use of Resources Rating - overall score	✓	✓	✓
27	CRES Performance - Recurrent	✓	✓	✓
28	CRES Performance - Non-Recurrent	✓	✓	✓
29	Capital Expenditure (CDEL)	✓	✓	✓
30	Cash balances (actual compared to plan)	✓	✓	

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	Measure	1. Safe Staffing	2. Demand	3. Co-Creation	4. Quality of Care	5. Digital - supporting change	6. Estate / Physical Infrastructure	7. Data Security and Protection	8. Quality Governance	9. Partnerships and System Working	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					✓		✓	✓		✓	✓	✓	
25a	Financial Plan: Agency expenditure compared to agency target	✓	✓		✓				✓		✓		✓	
25b	Agency price cap compliance	✓							✓		✓		✓	
26	Use of Resources Rating - overall score	✓	✓		✓				✓		✓		✓	
27	CRES Performance - Recurrent	✓	✓				✓		✓		✓		✓	
28	CRES Performance - Non-Recurrent								✓		✓		✓	
29	Capital Expenditure (CDEL)					✓	✓		✓		✓	✓	✓	
30	Cash balances (actual compared to plan)					✓	✓				✓	✓	✓	

National Quality Standards and Mental Health Priorities Dashboard

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

National Quality Requirements	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care	H	?	80%	85.31%	80%
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%	66.14%	60%
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	L	P	75%	97.41%	75%
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		P	95%	100%	95%
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks (rolling 12 months)	H	F	95%	90.79%	95%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week (rolling 12 months)		F	95%	73.68%	95%
Local Quality Requirements	**Variation**	**Assurance**	**Standard (FYTD)**	**Actual (FYTD)**	**Annual Standard**
Talking Therapies:Percentage of people who have waited more than 90 days between first and second appointments	H	F	<10%	31.02%	<10%
Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting caseness		?	48%	48.82%	48%
Talking Therapies: Reliable improvement rate for those completing a course of treatment		?	67%	67.00%	67%
Number of CYP aged 0-17 supported through NHS funded mental health with at least one contact (rolling 12 months)	L	P	29797	28848	29797
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	L	F	40%	19.74%	40%
Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses (rolling 12 months)	H	F	22955	23132	22955
Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)		?	1	1	0
Number of women accessing specialist community PMH services in the reporting period (rolling 12 months)	H	F	1427	1570	1427

National Quality Standards and Mental Health Priorities Headlines

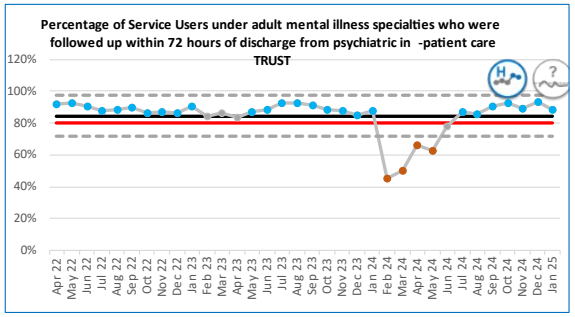
Tees, Esk and Wear Valleys NHS Foundation Trust

- **72 hour follow up** Achieved target in all areas.
- **EIP waiting times** We have failed target in Vale of York and there is no significant change; however, we have achieved target in all other areas.
- **Talking Therapies waiting times (6 and 18 weeks)** Achieved target in all areas.
- **Child Eating Disorders waiting times:** Whilst we have failed target in all areas for **routine** referrals, there is special cause improvement indicated in the SPC charts. We have failed target in County Durham, North Yorkshire and Vale of York for **urgent** referrals and there is cause for concern indicated in all areas. These are not areas of concern as the reasons were patient choice, patients required hospital admission, patients being uncontactable, physical tests not being arranged by primary care in a timely manner, and data quality.
- **Talking Therapies: 1st to 2nd treatment waits** – We have failed target in all areas except for North Yorkshire. There is no significant change for Vale of York and cause for concern in County Durham and Tees Valley. **Reliable Recovery** We have failed target in County Durham and there is no significant change. **Reliable Improvement** failed targets in County Durham and Tees Valley and there is no significant change.
- **Children: 1 contact** We have failed target in North Yorkshire and Vale of York; there is special cause concern for North Yorkshire and there is no significant change for Vale of York. **Paired Outcomes** failed target and special cause concern in all areas, except for North Yorkshire where there is no significant change.
- **Access to transformed community services** We have failed target in all areas except for Tees Valley. Whilst there is special cause improvement in County Durham, there is special cause concern in North Yorkshire and Vale of York.
- **Active OAP (inappropriate)** We have failed target failed for Humber & North Yorkshire ICB.
- **Specialist Community Perinatal Mental Health (PMH) services** We have achieved target in County Durham and Tees Valley. We have failed target in North Yorkshire and Vale of York; however, there is special cause improvement in both areas.

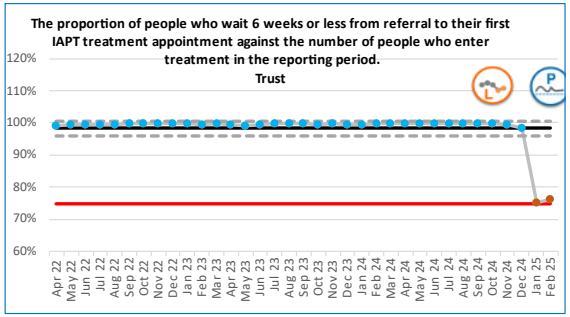
*All headlines are based on financial year to date unless otherwise stated. 102

National Quality Requirements

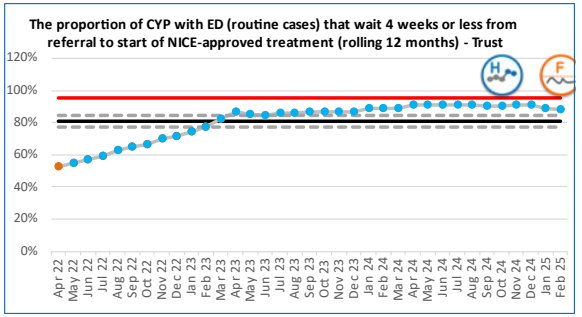
Tees, Esk and Wear Valleys NHS Foundation Trust



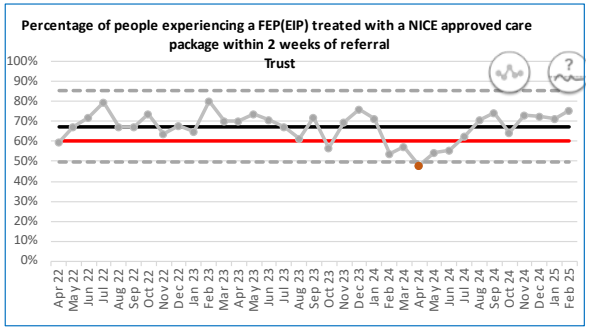
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	80%	85.31%			
County Durham	80%	84.33%			
Tees Valley	80%	84.45%			
North Yorkshire	80%	87.67%			
Vale of York	80%	86.59%			



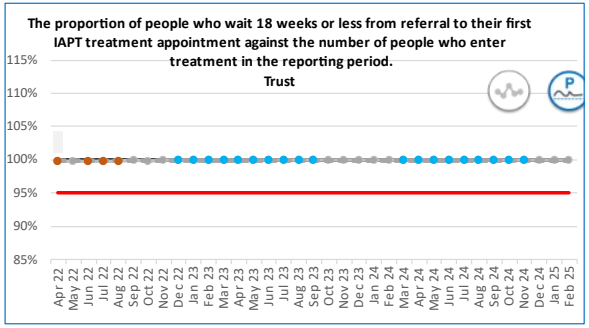
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	75%	97.41%			
County Durham	75%	95.74%			
Tees Valley	75%	95.54%			
North Yorkshire	75%	99.50%			
Vale of York	75%	98.26%			



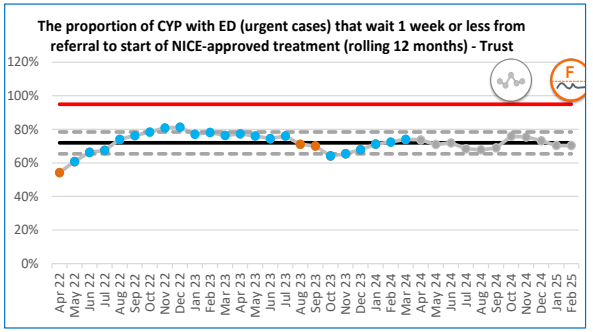
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	95%	90.79%			
County Durham	95%	83.82%			
Tees Valley	95%	92.78%			
North Yorkshire	95%	80.00%			
Vale of York	95%	93.75%			



Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	60%	66.14%			
County Durham	60%	67.71%			
Tees Valley	60%	71.78%			
North Yorkshire	60%	68.97%			
Vale of York	60%	41.18%			



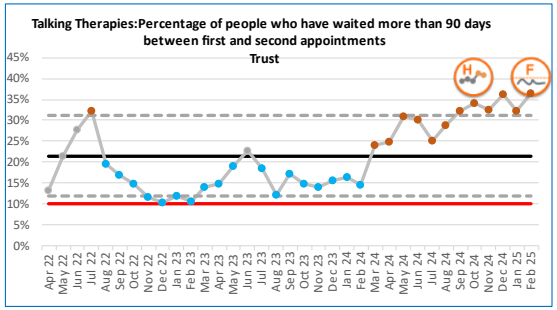
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	95%	99.98%			
County Durham	95%	99.98%			
Tees Valley	95%	100.00%			
North Yorkshire	95%	100.00%			
Vale of York	95%	99.95%			



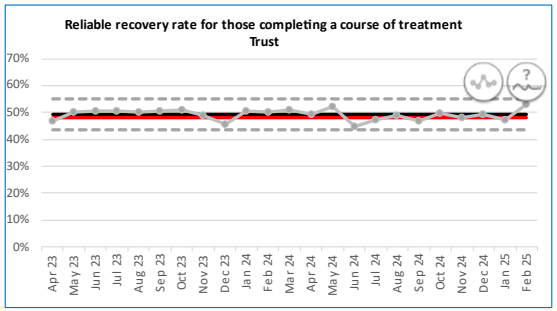
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	95%	73.68%			
County Durham	95%	66.67%			
Tees Valley	95%	100.00%			
North Yorkshire	95%	62.50%			
Vale of York	95%	33.33%			

Mental Health Priorities

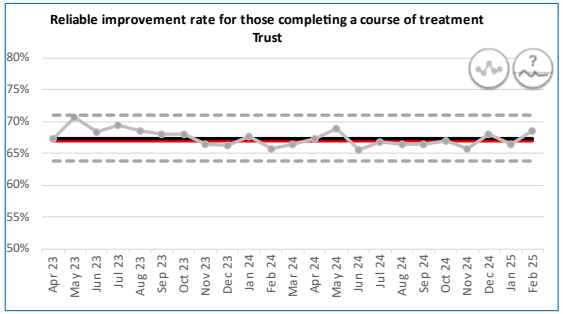
Tees, Esk and Wear Valleys NHS Foundation Trust



Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	<10%	31.02%			
County Durham	<10%	46.55%			
Tees Valley	<10%	51.76%			
North Yorkshire	<10%	8.02%			
Vale of York	<10%	30.93%			



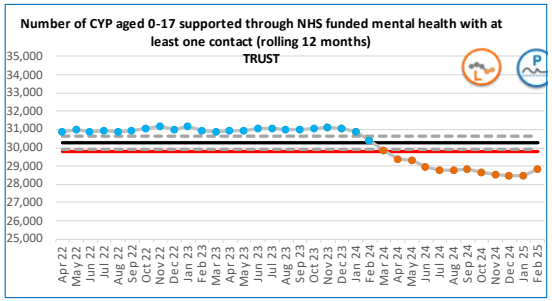
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	48%	48.82%			
County Durham	48%	45.98%			
Tees Valley	48%	48.88%			
North Yorkshire	48%	50.53%			
Vale of York	48%	52.03%			



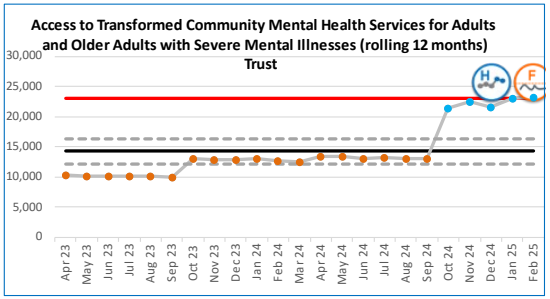
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	67%	67.00%			
County Durham	67%	63.70%			
Tees Valley	67%	64.62%			
North Yorkshire	67%	68.97%			
Vale of York	67%	71.94%			

Local Quality Requirements

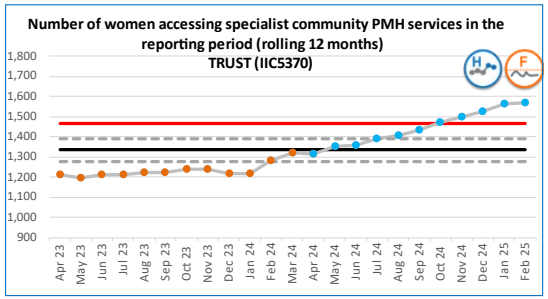
Tees, Esk and Wear Valleys NHS Foundation Trust



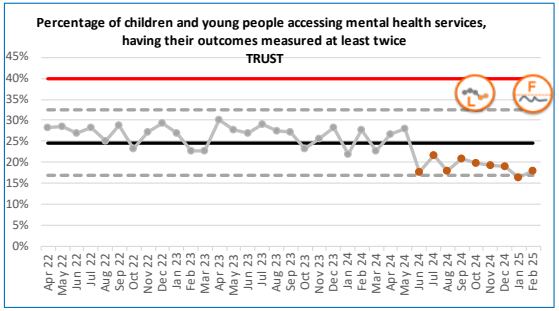
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	29797	28848			
County Durham	10012	10166			
Tees Valley	11218	11347			
North Yorkshire	5429	4510			
Vale of York	3138	2825			



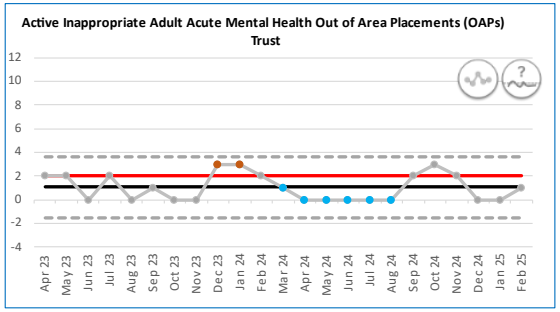
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	22955	23132			
County Durham	8240	7654			
Tees Valley	7535	8927			
North Yorkshire	4853	4484			
Vale of York	2327	2067			



Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	1427	1570			
County Durham	456	639			
Tees Valley	447	484			
North Yorkshire	368	310			
Vale of York	156	137			

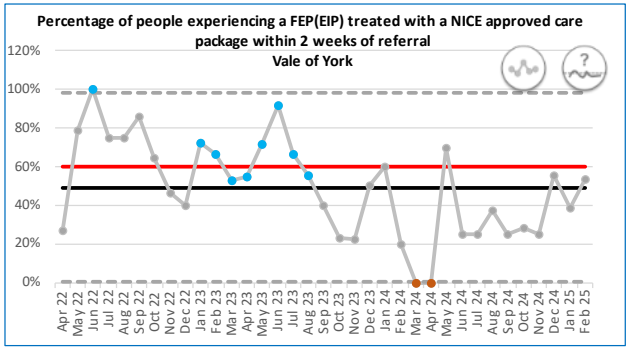


Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	40%	19.74%			
County Durham	40%	17.32%			
Tees Valley	40%	22.22%			
North Yorkshire	40%	23.50%			
Vale of York	40%	14.94%			



Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	1	1			
County Durham	1	0			
Tees Valley		0			
North Yorkshire	0	1			
Vale of York		0			

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 – *by exception*



Background / standard description:
We are aiming to see **60%** of service users experiencing a first episode of psychosis or ARMS (at risk mental state) within two weeks to start a NICE-recommended package of care

What does the chart show/context:
During February **15** patients were placed on Early Intervention of Psychosis (EIP) pathway; of these, **8 (53.33%)** commenced a NICE approved treatment within 2 weeks within **Vale of York**.

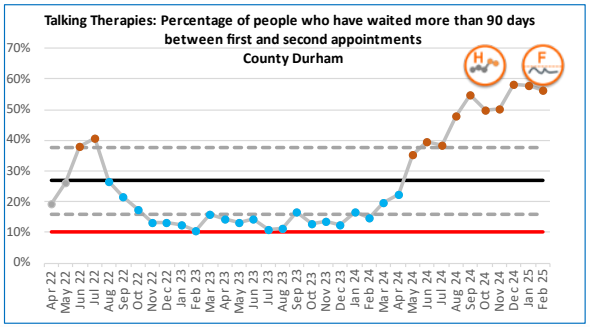
Underlying issues:
The team have been unable to address the backlog of all patients waiting due to booked appointments not being attended.

Actions:
- It was expected that the backlog of patients waiting would be addressed by the end of January (originally end of December 2024) and that new patients would start treatment within 2 weeks. (**Not achieved)** All patients that were waiting on the backlog have now been seen and all patients waiting for an appointment currently will start receiving treatment within 2 weeks.
- We are developing an EIP Waiters Dashboard on our Integrated Information Centre (IIC) with a corresponding patient tracker list so there is oversight and full transparency of the patients waiting and whether they have appointments booked that can initiate treatment (Currently this is a manual dashboard which is only updated once each week) This work will be completed by the end of April 2025.

106

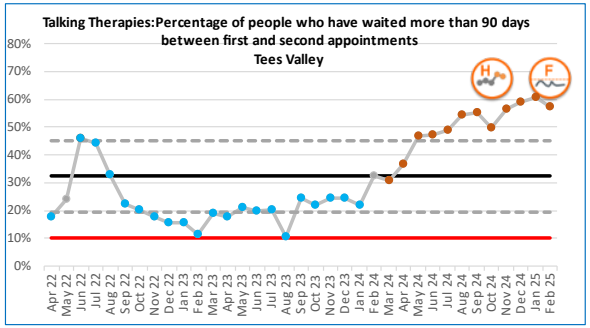
Talking Therapies: Percentage of people who have waited more than 90 days between first and second appointments – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust



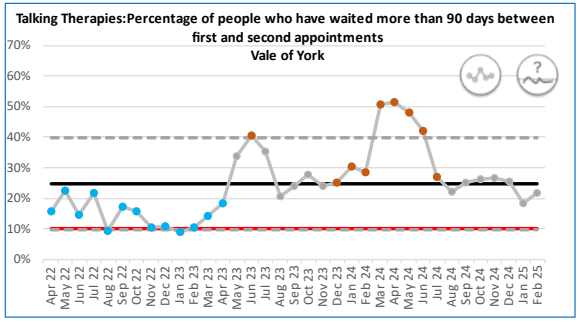
Background / standard description:
We are aiming to have less than 10% of people waiting more than 90 days between their first and second Talking Therapies appointment.

What does the chart show/context:
During February **616** people had a second appointment with our services, of those **346 (56.17%)** waited over 90 days between their 1st and 2nd appointment within **County Durham**.



Background / standard description:
We are aiming to have less than 10% of people waiting more than 90 days between their first and second Talking Therapies appointment.

What does the chart show/context:
During February **115** people had a second appointment with our services, of those **66 (57.39%)** waited over 90 days between their 1st and 2nd appointment within **Tees Valley**.



Background / standard description:
We are aiming to have less than 10% of people waiting more than 90 days between their first and second Talking Therapies appointment.

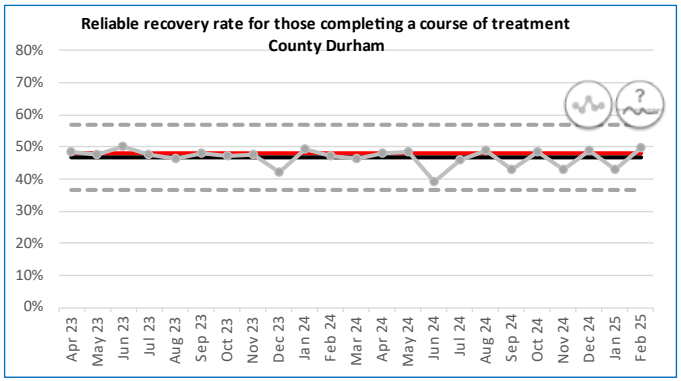
What does the chart show/context:
During February **202** people had a second appointment with our services, of those **44 (21.78%)** waited over 90 days between their 1st and 2nd appointment within **Vale of York**.

Underlying issues:
- Capacity of Psychological Wellbeing Practitioner (PWP) (high levels of step 2 vacancies/absence/sickness)
- High levels of people accessing Step 3 care, bypassing Step 2 appropriately
- Fewer people being allocated to Computerised Cognitive Behaviour Therapy (cCBT) and workshops due to their complexity of need
- Higher demand for face-to-face appointments in specific localities
- Counselling for Depression demand exceeds capacity
- High levels of priority group (perinatal, veterans, high risk) patients

Underlying issues:
Underfunding within Step 2 and Step 3

Actions (Trust-wide):
A Task & Finish Group was established to oversee a Trust-wide deep dive in relation to these areas of concern. Data has been sourced from a staffing, finance, activity and clinical outcomes perspective, however this needs to be triangulated to understand the different services. This is intended to inform the development of a Trust-wide action plan by the end of March 2025. In addition, DTVFCG are finalising their service recovery plan, which will be taken to the March Care Group Combined Governance Meeting for approval. In NYYSCG, Care Group Directors have requested additional information regarding the impact on quality and waiting times to inform further PIP actions; this will be completed by the end of February 2025 (previously January). **(Not Completed)** A meeting has been arranged during March to progress the original options paper and agree next steps.

Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting caseness – *by exception*



Background / standard description:
We are aiming for 48% of patients to demonstrate reliable recovery following completion of a course of treatment.

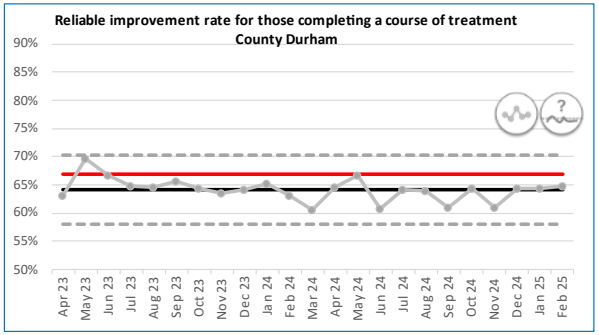
What does the chart show/context:
During February **539** patients completed a course of treatment, of which **268 (49.72**%) demonstrated reliable recovery within **County Durham**.

Underlying issues:
- Increase in complexity and severity of patient's presentation, which makes it more challenging to see a 6-point (Patient health questionnaire - PHQ9) or a 4-point (Generalised anxiety disorder - GAD) shift.
- A high number of patients do not attend appointments and, therefore, are not attending enough appointments to enable reliable recovery to be achieved.
- High levels of sickness is resulting in caseloads being reallocated or patients being added back to the waiting list which is impacting on reliable recovery.

Actions:
A Task & Finish Group was established to oversee a Trust-wide deep dive in relation to these areas of concern. Data has been sourced from a staffing, finance, activity and clinical outcomes perspective, however this needs to be triangulated to understand the different services. This is intended to inform the development of a Trust-wide action plan by the end of March 2025. In addition, DTVFCG are finalising their service recovery plan, which will be taken to the March Care Group Combined Governance Meeting for approval.

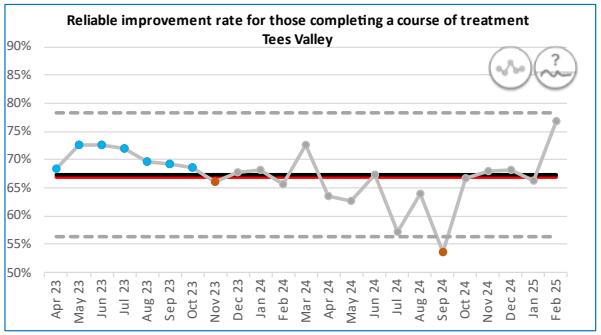
Talking Therapies: Reliable improvement rate for those completing a course of treatment – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust



Background / standard description:
We are aiming for 67% of patients to demonstrate reliable improvement following completion of a course of treatment.

What does the chart show/context:
During February **598** patients completed a course of treatment, of which **388 (64.88%)** demonstrated reliable improvement within **County Durham**.



Background / standard description:
We are aiming for 67% of patients to demonstrate reliable improvement following completion of a course of treatment.

What does the chart show/context:
During February **99** patients completed a course of treatment, of which **76 (76.77%)** demonstrated reliable improvement within **Tees Valley**.

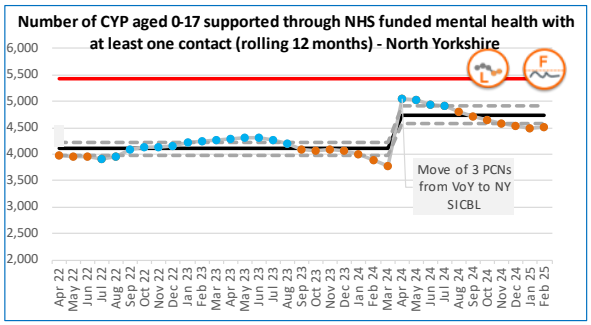
Underlying issues:

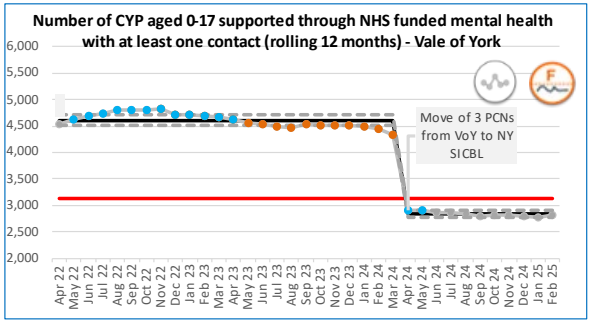
- High levels of complex patients are seeing a reliable improvement on two outcome measures (Patient health questionnaire - PHQ9 and Generalised anxiety disorder - GAD7); however, if an Anxiety Disorder Specific Measures (ADSM) is also undertaken and does not report an improvement, that supersedes the other scores.
- The measure includes patients that are not at clinical caseness (as per national construction) and therefore, may not show reliable improvement.
- A high number of patients do not attend appointments and, therefore, are not attending enough appointments to enable reliable improvement to be achieved.
- High levels of sickness is resulting in caseloads being reallocated or patients being added back to the waiting list which is impacting on reliable improvement.

Actions:
A Task & Finish Group was established to oversee a Trust-wide deep dive in relation to these areas of concern. Data has been sourced from a staffing, finance, activity and clinical outcomes perspective, however this needs to be triangulated to understand the different services. This is intended to inform the development of a Trust-wide action plan by the end of March 2025. In addition, DTVFCG are finalising their service recovery plan, which will be taken to the March Care Group Combined Governance Meeting for approval.

Number of CYP aged 0-17 supported through NHS funded mental health with at least one contact (rolling 12 months) – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust





Background / standard description:
We are aiming for **5429** children or young people to be supported through NHS funded mental health with at least one contact in a 12-month rolling period.

What does the chart show/context:
In the 12-month period ending February 2025 **4510** children and young people aged between 0-17 were supported through NHS funded mental health with at least one contact within **North Yorkshire**.

Background / standard description:
We are aiming for **3138** children or young people to be supported through NHS funded mental health with at least one contact in a 12-month rolling period.

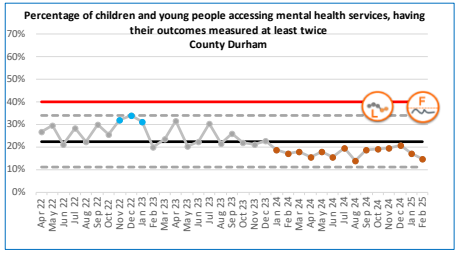
What does the chart show/context:
In the 12-month period ending February 2025 **2825** children and young people aged between 0-17 were supported through NHS funded mental health with at least one contact within **Vale of York**.

Underlying issues:
- Staff vacancies within the Single Point of Access teams
- New staff within the Single Point of Access team are taking time to learn processes and, therefore, not completing as many assessments as full-time staff.

Actions:
Business Intelligence to lead in-depth analysis to support the Service in identifying any underlying reasons for a reduction in access. This work will be completed by the end of March 2025.

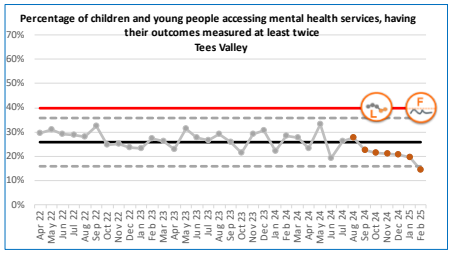
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust



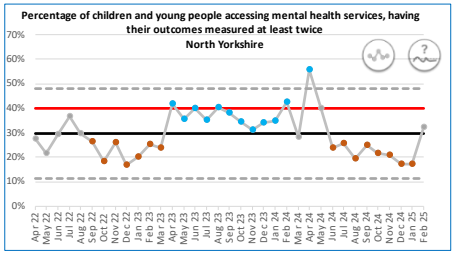
Background / standard description:
We are aiming for **40%** of closed referrals that have at least two contacts with a paired outcome measure completed.

What does the chart show/context:
During February **518** patients were discharged with at least two contacts; **77 (14.86%)** of these had a paired outcome measure within **County Durham**.



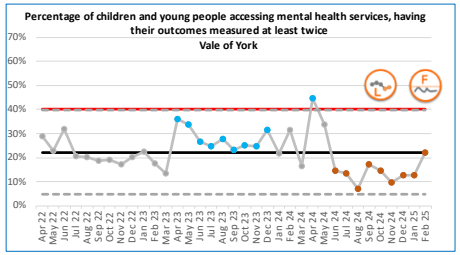
Background / standard description:
We are aiming for **40%** of closed referrals that have at least two contacts with a paired outcome measure completed.

What does the chart show/context:
During February **495** patients were discharged with at least two contacts; **72 (14.55%)** of these had a paired outcome measure within **Tees Valley**.



Background / standard description:
We are aiming for **40%** of closed referrals that have at least two contacts with a paired outcome measure completed.

What does the chart show/context:
During February **190** patients were discharged with at least two contacts; **61 (32.11%)** of these had a paired outcome measure within **North Yorkshire**.



Background / standard description:
We are aiming for **40%** of closed referrals that have at least two contacts with a paired outcome measure completed.

What does the chart show/context:
During February **117** patients were discharged with at least two contacts; **26 (22.22%)** of these had a paired outcome measure within **Vale of York**.

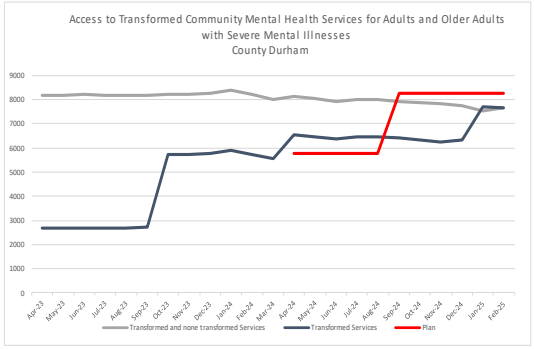
Underlying issues:
- Staff are not completing paired outcomes.
- It is taking significantly longer to record an outcome measure on Cito than on Paris, which increases dependent on the number of outcomes that are measured with a patient during a contact.
- The rollout of Cito is impacting on performance due to issues with activity recording and lack of understanding of document sign off procedures.

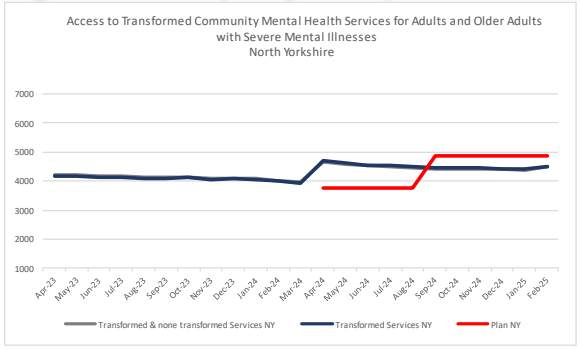
Actions (Trust-wide):
- The Trust wide Clinical Outcomes Improvement Plan is progressing with 2 key actions completed this month:
  - Embed the use of ROMs in neuro assessment pathways – new process in place for use of GBO's at commencement of assessment process
  - Assess the use of GBOs (as an interim solution in the absence of having accurate psychometric outcome tools for all outcomes measures) - principles agreed and communication planned to coincide with CAMHS clinical standards

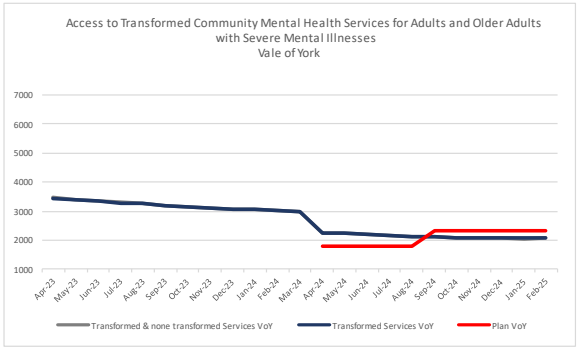
  Eight actions are on hold due to the CITO change freeze; of these 4 are due to complete at the end of April 2025 and will, therefore, be overdue at that point. There remaining actions are on track. A new action has been added for Executive Directors to promote the importance of clinical outcomes during walkabouts to support culture change.
- Outcomes was a focused discussion at the February EDG led by the Section Head of Research & Statistics, Clinical Outcomes and Business Analytics. **(Completed)**

Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses (rolling 12 months) – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust







Background / standard description:
We aim to have **8240** adults and older people with severe mental illness accessing transformed community mental health services in a 12-month rolling period.

What does the chart show/context:
In the 12-month period ending February 2025 **7654** adults and older people were accessing Transformed Community Mental health services within **County Durham**.

Underlying issues:
Findings from a deep dive have not highlighted any areas of concern.

Actions:
The remaining three PCNs will be transformed by the end of March 2025; however, the chart above shows that were all PCNs transformed the target would still not be achieved.

Background / standard description:
We aim to have **4853** adults and older people with severe mental illness accessing transformed community mental health services in a 12-month rolling period.

What does the chart show/context:
In the 12-month period ending February 2025 **4484** adults and older people were accessing Transformed Community Mental health services within **North Yorkshire**.

Underlying issues:
- Ripon and Scarborough Community teams are impacted by vacancies and long-term sickness absence.

Actions:
- Ripon Community team is in business continuity with a recovery plan in place. Recruitment of staff is underway; however, 3 clinician vacancies remain which are being mitigated by agency staff.
- Scarborough Community Team has a recovery plan in place. Recruitment to 1 psychology post remains and further recovery options are being considered.

Background / standard description:
We aim to have **2327** adults and older people with severe mental illness accessing transformed community mental health services in a 12-month rolling period.

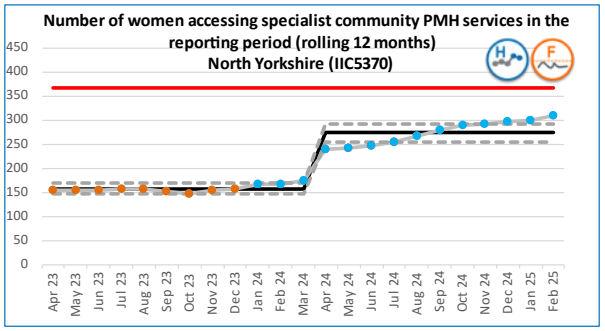
What does the chart show/context:
In the 12-month period ending February 2025 **2067** adults and older people were accessing Transformed Community Mental health services within **Vale of York**.

Underlying issues:
There are a number of teams demonstrating special cause concern (a reduction in the number of people accessing services).

Actions: *See below Trust-wide action*

Actions (Trust-wide): Data has been sourced to provide a triangulated understanding of access to our adult and older adult services and to inform the identification and development of any required improvement actions. The review by the Performance Senior Leadership Team to aid next steps was not completed during February. **(Not Completed)** This will be now completed by the end of March 2025.

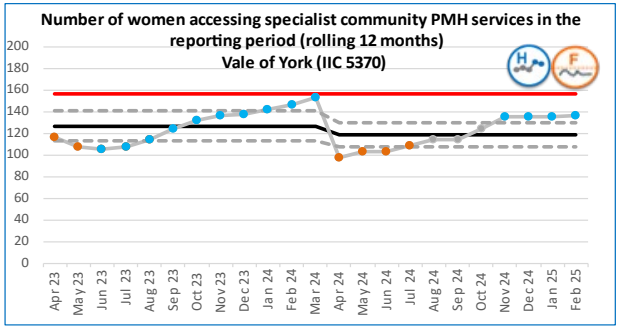
Number of women accessing specialist community PMH services in the reporting period (rolling 12 months) – *by exception*



Background / standard description:
We are aiming to achieve **368** number of women to access a specialist community Perinatal Mental Health Service within a 12-month rolling period.

What does the chart show/context:
In the 12-month period ending February 2025 there were **310** women accessing a specialist community Perinatal Mental health services.

There is special cause improvement as indicated in the SPC chart above.



Background / standard description:
We are aiming to achieve **156** number of women to access a specialist community Perinatal Mental Health Service within a 12-month rolling period.

What does the chart show/context:
In the 12-month period ending February 2025 there were **137** women accessing a specialist community Perinatal Mental health services.

There is special cause improvement as indicated in the SPC chart above.

Underlying issues:
- Capacity issues within the Perinatal services, including short term sickness and vacancies.

Actions:
The Perinatal teams are currently being supported through a service recovery plan in line with business continuity processes. Mitigating actions are:
- Short term sickness and vacancy is currently being mitigated by support from the wider Multi-Disciplinary Team for care co-ordination and implementation of a Band 5-6 run-through post to mitigate against the difficulties to recruit to a B6 care-coordination post.
- The Service Manager is working with the Planning Team to undertake a capacity and demand exercise to inform the ongoing actions for the recovery of the longer term structural and capacity pressures. The first draft has been further delayed; it was to be produced by the end of February 2025 (originally December 2024) (**Not completed**) and will now be completed by the end of April.

Waiting Times Dashboard

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Waiting Times Dashboard (Assessment and Treatment)	Variation	Actual Number Waiting (Snapshot)	0-1 months	1-2 months	2-3 months	3-6 months	6-9 months	9-12 months	1-2 years	2-3 years	Over 3 years	Average Wait (weeks)	Longest Wait (weeks)
Adults Waiting for an Assessment		2921	1113	679	315	555	154	47	58	0	0	10	88*
Adults with a learning disability Waiting for an Assessment		80	54	17	5	4	0	0	0	0	0	4	22*
Children and Young People Waiting for an Assessment		998	611	205	54	80	15	8	23	2	0	7	117
Children and Young People Waiting for Treatment (excluding Neuro)		1846	148	333	216	535	172	101	167	84	90	36	312
Adults in Health and Justice services Waiting for an Assessment		51	33	10	7	1	0	0	0	0	0	5	21*
Older People Waiting for Assessment		2603	826	638	234	570	268	65	2	0	0	12	62

Waiting Times Dashboard (Neuro Services)	Variation	Actual Number Waiting (Snapshot)	0-1 months	1-2 months	2-3 months	3-6 months	6-9 months	9-12 months	1-2 years	2-3 years	Over 3 years	Average Wait (weeks)	Longest Wait (weeks)
Adults waiting for an ADHD Assessment		4379	152	195	101	375	262	255	1526	927	586	86	341*
Adults waiting for an Autism Assessment		3879	78	95	61	200	196	213	1362	1052	622	98	285*
Children and young people waiting for an Autism Assessment		5914	126	168	164	454	526	538	2630	1170	138	72	193
Children and young people waiting for an ADHD Assessment		4739	206	264	218	517	542	693	1388	647	264	65	239
Children and young people waiting for both Autism/ADHD Assessment or Not Categorised		2228	36	38	77	222	302	144	369	977	63	83	191

Waiting Times Dashboard (National Waiting Times)	Variation	Actual Number Waiting (Snapshot)	0-1 Week	1-2 Weeks	2-4 Weeks	4-6 Weeks	6-8 Weeks	8-12 Weeks	Over 12 Weeks	Average Wait (weeks)	Longest Wait (weeks)
Children & Young People Waiting for Eating Disorders Services - Urgent Referral (1 week standard)		3	0	0	1	1	0	0	1	19	48*
Children & Young People Waiting for Eating Disorders Services - Routine Referral (4 week standard)		55	20	8	16	3	2	0	6	5	44*
Adults Waiting for EIP Treatment (2 week standard)		72	43	18	7	1	1	0	2	2	26

Waiting Times Dashboard (Talking Therapies)	Variation	Actual Number Waiting (Snapshot)	0-4 weeks	4-6 weeks	6-12 weeks	12-18 weeks	18-28 weeks	Over 28 weeks	Average Wait (weeks)	Longest Wait (weeks)
Adults waiting for their second treatment contact in Talking Therapies		4068	579	451	1023	866	843	306	14	67

NOTE: *an asterisk denotes a data quality issue*

Waiting Times Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

Waiting Times Assessment & Treatment

- **AMH** There is special cause improvement (a reduction) in the numbers waiting for an assessment. Our longest genuine wait time is **85 weeks** in NYYSCG. The majority (91%) of adults are waiting less than 6 months for an assessment.
- **ALD** There is special cause improvement (a reduction) in the numbers waiting for an assessment. Our longest genuine wait time is **19 weeks** in NYYSCG. The majority (89%) of adults are waiting less than 2 months for an assessment.
- **CYP** There is special cause improvement in the number waiting for an assessment. Our longest wait time is currently **117** weeks in DTVFCG. The majority (82%) of children and young people are waiting less than 2 months for an assessment.
- **CYP** There is special cause improvement (a reduction) in the number waiting for treatment (excluding Neuro). Our longest wait time is currently **312** weeks in DTVFCG. The majority (61%) of adults are waiting less than 6 months for treatment.
- **H&J** There is no significant change in the numbers waiting for an assessment. Our genuine longest wait time is **12** weeks in DTVFCG. The majority (84%) of adults are waiting less than 2 months for an assessment.
- **MHSOP** There is no significant change in the numbers waiting for an assessment. Our longest wait time is currently **62** weeks in NYYSCG. The majority (97%) of older adults are waiting less than 9 months for an assessment.

Waiting Times Neuro Services

- **AMH ADHD** There is special cause improvement (a reduction) in the number of waiting for an ADHD assessment. Our longest genuine wait time is **324** weeks (6.2 years) in DTVFCG. The majority (56%) of adults are waiting between 1-3 years for an assessment.
- **AMH Autism** There is no significant change in the number waiting for an autism assessment. Our longest genuine wait time is **258** weeks (4.9 years) DTVFCG. The majority (62%) of adults are waiting between 1-3 years for an assessment.
- **CYP Autism** There is special cause concern (an increase) in the numbers waiting for an autism assessment. Our longest wait time is **193** weeks (3.7 years) in DTVFCG. The majority (64%) of children and young people are waiting between 1-3 years for an autism assessment.
- **CYP ADHD** There is special cause concern (an increase) in the numbers waiting for an ADHD assessment. Our longest wait time is **239** weeks (4.6 years) in DTVFCG. The majority (58%) of children and young people are waiting between 9 months and 3 years for an assessment.
- **CYP both/not yet categorised** There is special cause concern (an increase) in the numbers waiting for a neuro assessment. Our longest wait time is **191** weeks (3.7 years) in DTVFCG. The majority (60%) of children and young people are waiting between 1-3 years for an assessment.

National Waiting Times

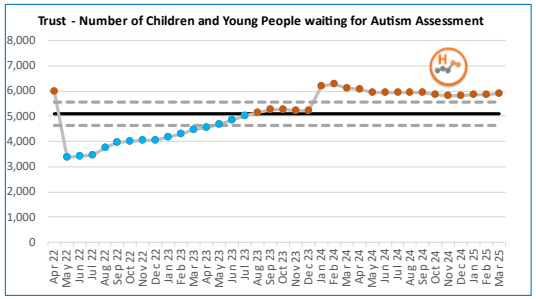
- **CED Urgent** There is no significant change in the number waiting from an urgent referral within our Eating Disorder Service. Our longest genuine wait time is **6** weeks in NYYSCG.
- **CED Routine** There is no significant change in the number waiting from a routine referral within our Eating Disorder Service. Our longest genuine wait time is **8** weeks in DTVFCG. The majority (80%) of children and young people are waiting less than 4 weeks for treatment.
- **EIP** There is no significant change in the number of waiting for EIP Treatment. Our longest wait time is currently **26** weeks in DTVFCG. The majority (85%) of adults are waiting less than 2 weeks for treatment.

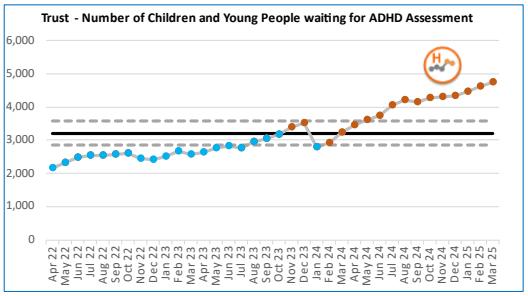
Waiting Times Talking Therapies

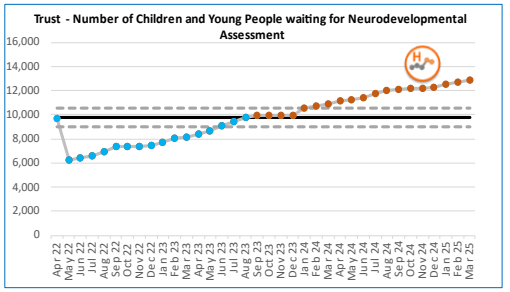
- There is special cause concern (an increase) in the number of adults waiting for their second contact with Talking Therapies. Our longest wait time is currently **67** weeks in NYYSCG. The majority (67%) of adults are waiting between 6 and 28 weeks for their second appointment.

Waiting Times Neuro Services: Children & Young People

Tees, Esk and Wear Valleys NHS Foundation Trust







Children and young people waiting for an Autism Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	5914	72	193	
DTVF Care Group	4994	77	193	
NYY&S Care Group	920	43	111	

Commentary on Longest waits

DTVF: Genuine Wait - Specialist Assessment Booked
NYY&S: Genuine Wait - Specialist Assessment Booked

Children and young people waiting for an ADHD Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4739	65	239	
DTVF Care Group	3920	69	239	
NYY&S Care Group	819	45	113	

Commentary on Longest waits

DTVF: Genuine Wait - Specialist Assessment Required
NYY&S: Data Quality - Specialist Assessment commenced (longest genuine wait - 744 days - specialist assessment required)

Children and young people waiting for both Autism/ADHD Assessment or Not Categorised

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	2228	83	191	
DTVF Care Group	1735	99	191	
NYY&S Care Group	493	24	131	

Commentary on Longest waits

DTVF: Genuine wait - Specialist Assessment Required
NYY&S: Data Quality - Specialist Assessment Complete (longest genuine wait - 631 days - Specialist Assessment Required)

Underlying issues:

- High levels of demand outweighing capacity
- High levels of inappropriate referrals
- Long wait times and projected waiting times in the County Durham areas.
- Long-term sickness absences and vacancies within the Scarborough ADHD team

Actions (Partnership-wide):

- The newly established all-age neurodiversity group across the NENC ICB have both providers reviewing their current processes, levels of demand and activity, financial positions and clinical thresholds.
- The specification to facilitate partnership-working for children and young people's neurodevelopmental services with alternative, accredited private providers, has been approved. **(Completed)** There is anticipation that the first group of young people will be transitioned in April 2025.
- The North Yorkshire & York service continues to engage with commissioners, Humber & North Yorkshire ICB and the Provider Collaborative regarding capacity within our CYP services versus demand and the subsequent impact on waiting times. The ICB is reviewing the process around "Right to Choose"' with a view to aligning assessment pathways across providers; the working group is looking at what teams will look like if the assessment pathways are aligned, and what budget is available to enable this.

Waiting Times Neuro Services: Children & Young People

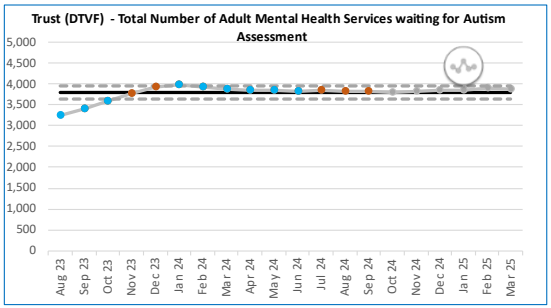
Tees, Esk and Wear Valleys NHS Foundation Trust

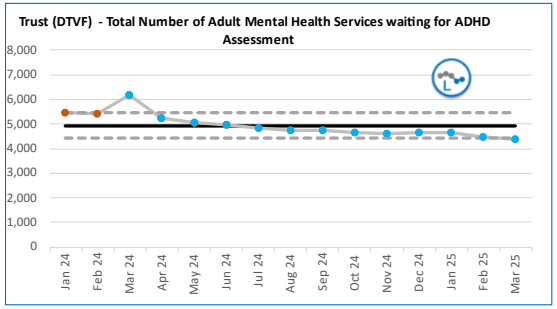
Actions (Trust):

- DTVFCG have a recovery plan in place with Phase 2 testing on dual assessments now underway in Darlington with the full evaluation of the clinical protocol due to be completed by the end of April 25. All actions within the recovery plan are progressing however demand currently continues to outweigh capacity. In addition, a trajectory has been submitted to NENC ICB which tracks performance against plan, factoring in the additional assessments that have been funded. We are currently waiting approval of this trajectory.
- The DTVFCG Board have agreed to establish an all-age ADHD and Autism Clinical Transformation Group and Terms of Reference will be developed in the coming months.
- A review of operational and clinical working within the Selby and York teams has been completed and it has been agreed that the teams will explore sharing resources to manage neuro waiters. A Task and Finish group are reviewing the existing model for the assessment and treatment of neurodevelopmental conditions to see if there are more efficient ways to deliver services which improve the patient's journey; this work will be completed by the end of March and the group will meet again in April 25. The service have recruited to all vacant posts and overtime is being offered to staff. The service will review internal processes to identify any remaining efficiencies by the end of June 2025. The
- Scarborough ADHD team remains in business continuity with a recovery plan in place. Whilst some improvement can be made, it is clear that the demand outstrips the capacity of the service, and this has been raised with commissioners and will be subject to ongoing discussion.
- Management Group supported the proposal to establish an all-age neurodevelopmental steering group to lead and oversee work internally and align with the work externally, across our respective ICB areas and for this group to align to the Community Transformation Programme Board.

Waiting Times Neuro Services: Adult Services

Tees, Esk and Wear Valleys NHS Foundation Trust





Adults waiting for an Autism Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
Trust (DTVF Care Group)	3879	98	285	

Commentary on Longest waits

DTVF: Data Quality - Assessment complete (longest genuine wait - 1806 days - specialist assessment required).

Adults waiting for an ADHD Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
Trust (DTVF Care Group)	4379	86	341	

Commentary on Longest waits

DTVF: Data Quality - Assessment complete (longest genuine wait - 2265 days - specialist assessment required).

Underlying issues:

- High levels of demand outweighing capacity

Actions (Partnership-wide):

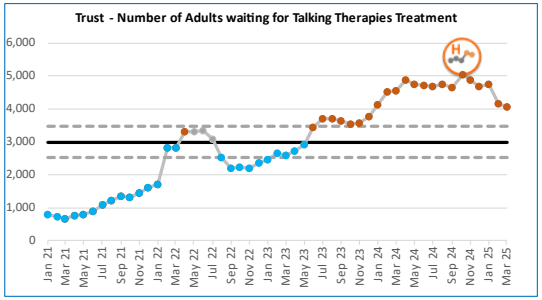
- The newly established all-age neurodiversity group across the NENC ICB have both providers reviewing their current processes, levels of demand and activity, financial positions and clinical thresholds.

Actions (Trust):

- The current KIT process is being redesigned as part of restructure of community services and will align to the process in CYP and CNTW with implementation planned for 1st April 2025.
- A trajectory has been submitted to NENC ICB which tracks performance against plan, factoring in the additional assessments that have been funded. This trajectory has been approved and we are currently on plan.
- Management Group supported the proposal to establish an all-age neurodevelopmental steering group to lead and oversee work internally and align with the work externally, across our respective ICB areas and for this group to align to the Community Transformation Programme Board.

Waiting Times Talking Therapies

Tees, Esk and Wear Valleys NHS Foundation Trust



Talking Therapies - adults waiting for their second treatment contact*

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4068	14	67	
DTVF Care Group	2321	15	51	
NYY&S Care Group	1747	12	67	

Commentary on Longest waits

DTVF: Genuine Wait - 1st Treatment Booked
NYY&S: Genuine Wait - 1st Treatment Required

Underlying issues (DTVFCG):

- Capacity of Psychological Wellbeing Practitioner (PWP) (high levels of step 2 vacancies/absence/sickness)
- High levels of people accessing Step 3 care, bypassing Step 2 appropriately
- Fewer people being allocated to Computerised Cognitive Behaviour Therapy (cCBT) and workshops due to their complexity of need
- Higher demand for face-to-face appointments in specific localities
- Counselling for Depression demand exceeds capacity
- High levels of priority group (perinatal, veterans, high risk) patients

Underlying issues (NYYSCG):

Underfunding within Step 2 and Step 3

Actions (Trust-wide):

A Task & Finish Group was established to oversee a Trust-wide deep dive in relation to these areas of concern. Data has been sourced from a staffing, finance, activity and clinical outcomes perspective, however this needs to be triangulated to understand the different services. This is intended to inform the development of a Trust-wide action plan by the end of March 2025. In addition, DTVFCG are finalising their service recovery plan, which will be taken to the March Care Group Combined Governance Meeting for approval. In NYYSCG, Care Group Directors requested additional information regarding the impact on quality and waiting times to inform further improvement actions; originally due for completion by the end of January 2025, a meeting has been arranged during March to progress the original options papers and agree next steps.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

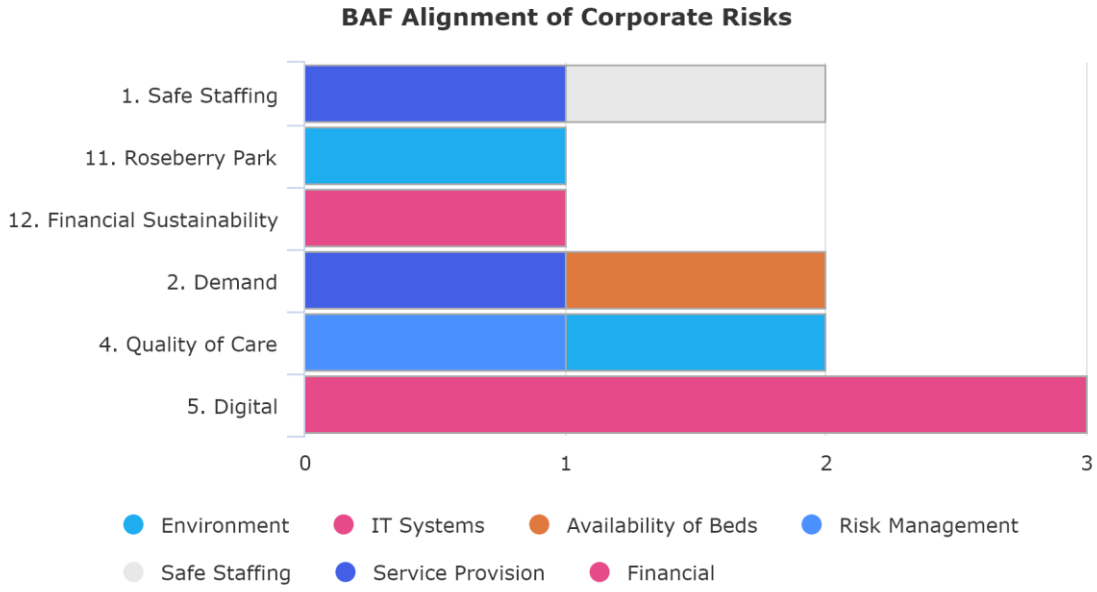
Meeting of:	**Board of Directors**
Date:	**April 2025**
Title:	**Corporate Risk Register**
Executive Sponsor(s):	**Beverley Murphy, Chief Nurse**
Author(s):	**Kendra Marley, Head of Risk Management**

Report for:				
	Assurance	✓	Decision	
	Consultation		Information	

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

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

Strategic Risks relating to this report:



Executive Summary:

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

Overview: This paper presents to the Board the risks that are rated ≥15 on the Corporate Risk Register as of 4th April 2025, reflecting any movement and changes since 5th December 2025.

There are currently 11 risks on the Corporate Risk Register, an increase of 1. This reflects removal of 1 risk which was reduced below 15, the closure and replacement of 1 risk, and 2 new risks which have been added.

The 1 removal includes:
Aligned to Quality Assurance

- Risk 1131 – Nursing & Governance - 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. (previously reduced from 16 to 12)

The closed and replaced risk related to:

Aligned to Resources and Planning

Closed -

- Risk 860 – Digital & Data - 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. (Which had a current rating of 15)

Replaced by -

- Risk 1646 – Digital & Data - There is a risk that cyber and operational incident response is inadequate due to insufficient cyber security resources, skills and enforced cyber security policies and procedures, along with technical audit and assurance; resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. (Current rating 10)

2 new risks have been added to the register:

Aligned to Resources and Planning

- Risk 1632, Digital & Data - There is a risk that the benefits of CITO are not realised due to poor performance/stability and a limitation of functionality of the system resulting in a reduced ability to effect clinical change, leading to reduced: efficiencies, staff engagement, poor record keeping, patient safety, reputation, confidence in the system and increased: staff absence, leavers. (current rating 16)

- Risk 1636, Digital & Data - There is a risk that the CITO system does not display a complete or accurate patient record to TEWV staff and partners, due to system performance and/or corruption of existing data, or data not saving, resulting patient care decisions being misinformed, quality of care being impacted, or requiring additional manual mitigations to be put in place and limiting clinical capacity. (current rating 20)

1 risk has been recently reduced, but not yet been to the Executive Risk Group for review or agreement for removal.

- 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. (reduced from 16 to 12)

There has been ongoing success with recruitment and the resulting position is much stronger. This will be reviewed at the next Executive Risk Group for full consideration of the rationale.

The review of static risks has proved beneficial in the last 6 months with detailed review aiding the way for the successful mitigation and reduction of 17 of the 33 risks considered during the cycle. Of those remaining there are a number that are longer term risks that cannot be easily mitigated, however ongoing review will aid identification of any blockages as well as providing assurance that mitigating controls in place are effective.

The Executive Risk Group agreed to continue this cycle of detailed review.

This Risk review compliance for corporate risks had been sustain at 100% following a dip over the festive season.

A summary breakdown for each committee is included at the end of the report, which now includes an overview of current risk rating across the last 12 months, as well as an action extract, and a summary of each risk.

There is work to do to embed our improved processes for controls and actions 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 good assurance over the risk management processes in place, the consideration of risks for addition to the Corporate Risk Register and the ongoing management of these risks.

Further Information

1. Introduction and Purpose

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

2. Background Information and Context

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

3. Purpose of the Corporate Risk Register

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

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

4. Current Reporting Period

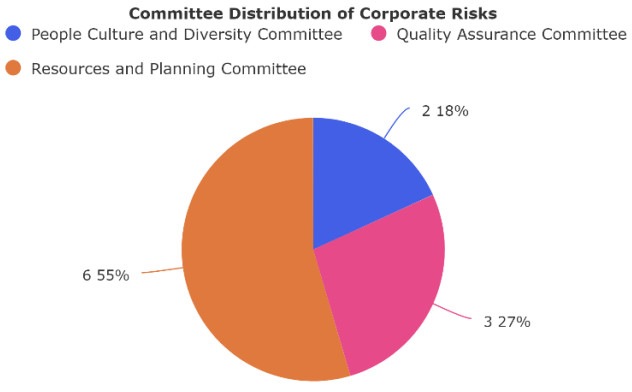
This paper presents to the Board the ≥15 risks on the Corporate Risk Register as of 4th April 2025, reflecting any movement and changes since 4th December 2024.

5. Corporate Risk Register

There are currently 11 risks on the Corporate Risk Register, an increase of 1. This reflects removal of 1 risk which was reduced below 15, the closure and replacement of 1 risk, and 2 new risks which have been added.

5.1 Committee & Care Group Alignment

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

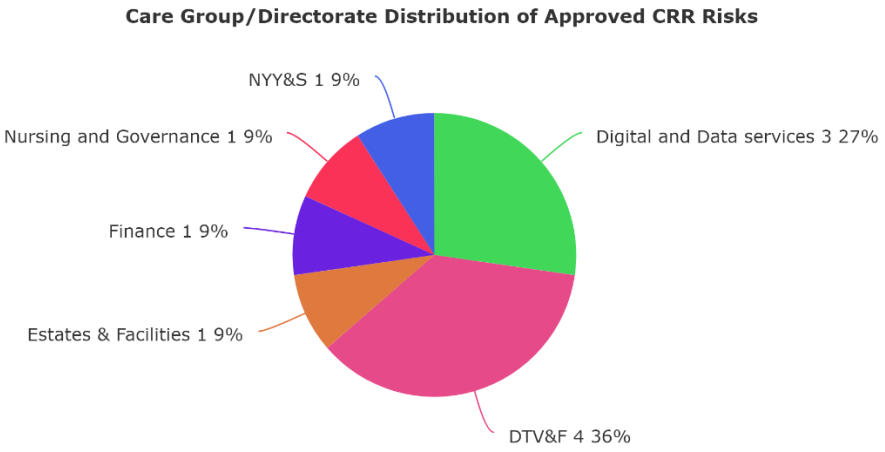


This shows that there are now

- 3 risks aligning to the Quality Assurance Committee
- 6 risks aligning to the Resources and Planning Committee
- 2 risks aligning to the People, Culture and Diversity Committee

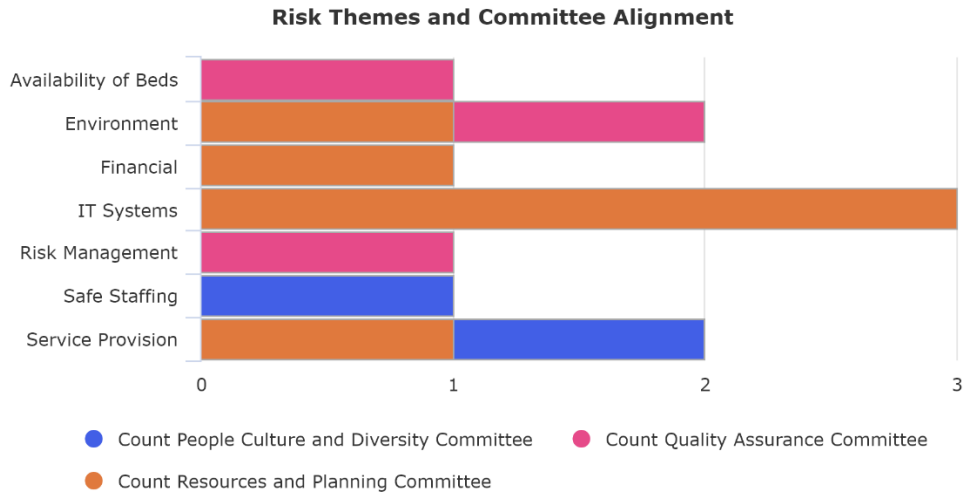
There are currently no risks aligning to the Mental Health Legislation Committee.

Focussing on the Care Group and Directorate breakdown of the Corporate Risk Register shows us that 36% of the current Corporate Risk Register is made up of risks from Durham Tees Valley and Forensics Care Group, 27% Digital and Data, with others at 9%.



5.2 Risk Themes

The 11 risks fall under the following themes within the Committee Alignment, with higher numbers of risks relating to IT systems, Environment and Service Provision.



5.3 Risk Movements

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

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 8 risks on the register that remain static and are shown on the matrix below.

Corporate risks at ≥15 remaining static in period

Risks are shown based on current risk rating

While these risks remain static all have been reviewed where required.

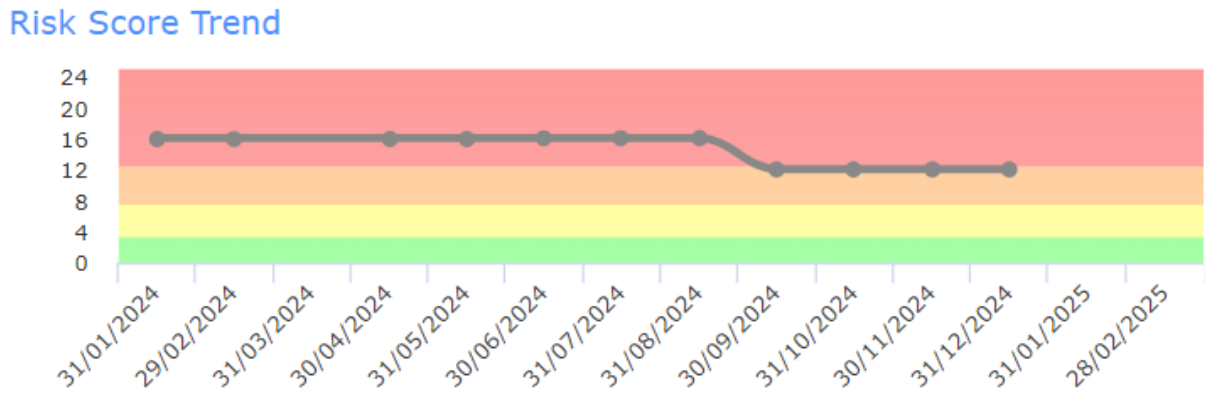
Risk Reductions and Removals

Risks closed/ replaced & reduced in the period

Aligned to Quality Assurance

One risk reduced has been removed. This was aligned to Quality Assurance Committee.

- Risk 1131 – Nursing & Governance - 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. (previously reduced from 16 to 12)



Rationale for change - Rationale for reduction - Risk rating reduced to 12 as the likelihood of the risk and consequences occurring have been reduced with the established team, new system, revised policy, new telephone line and work underway on logging all assets.

There is now an asset managed system in place (Equip), this enables the team to log all assets and tag them for easy identification. A technical audit officer is now in post, support the initial process and future audits. This enables a much more confident approach to responding to national patient safety alerts in medical devices.

A direct telephone reporting line is in place, alongside email reporting, providing immediate response to queries and issues as well as supporting staff with purchasing decisions.

Work with loaned equipment supplier has been undertaken to enable this equipment to be ordered via Cardea, which simplifies the ordering process. Work has also been undertaken on critical areas ECT, beds, rails etc, reducing risk to the organisation

Executive risk group decision – agreed to remove as significant progress made.

Closed and replaced, but reduced

1 risk was closed and replaced following significant overhaul of the Digital and Data risk register. The new risk has been added at a lower current rating and work is underway to fully populate the risk entry to fully reflect all controls and assurances. As this is the case the Executive Risk Group agreed to add the replacement risk onto the Corporate Risk register until clear mitigation and rationale for reduction is shown.
Aligned to Resources and Planning

Closed -

- Risk 860 – Digital & Data - 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. (Which had a current rating of 15)

Replaced by -

- Risk 1646 – Digital & Data - There is a risk that cyber and operational incident response is inadequate due to insufficient cyber security resources, skills and enforced cyber security policies and procedures, along with technical audit and assurance; resulting in loss of digital services and

systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. (Current rating 10)

Reduced but currently on Corporate Risk Register

1 risk has been recently reduced, but not yet been to the Executive Risk Group for review or agreement for removal.

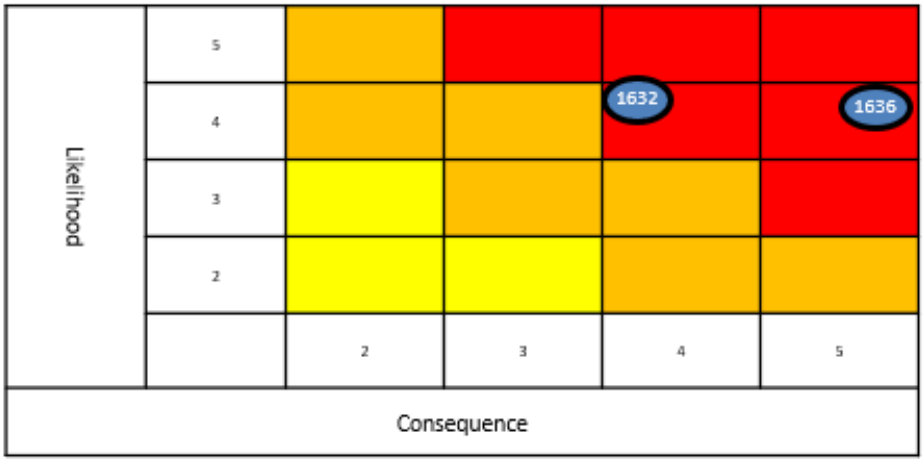
- Risk 909, NYY Management - There is a risk due to difficulties in recruitment to vacant posts in the consultant workforce across NYYS due to local and national shortages, resulting in the potential impact on; safe care delivery, teaching and training of junior staff and students, OOH on call rota, research, existing staff morale and wellbeing, finances. (reduced from 16 to 12)

There has been ongoing success with recruitment and the resulting position is much stronger. This will be reviewed at the next Executive Risk Group for full consideration of the rationale.

New risks

2 new risks were agreed by the Executive Risk Group for addition to the register.

Risks new in the period



- Risk 1632, Digital & Data - There is a risk that the benefits of CITO are not realised due to poor performance/stability and a limitation of functionality of the system resulting in a reduced ability to effect clinical change, leading to reduced: efficiencies, staff engagement, poor record keeping, patient safety, reputation, confidence in the system and increased: staff absence, leavers. (current rating 16)

- Risk 1636, Digital & Data - There is a risk that the CITO system does not display a complete or accurate patient record to TEWV staff and partners, due to system performance and/or corruption of existing data, or data not saving, resulting patient care decisions being misinformed, quality of care being impacted, or requiring additional manual mitigations to be put in place and limiting clinical capacity. (current rating 20)

A full risk register in excel is provided as well as a breakdown by Committee at the end of this report. As development and improvements in the use and reporting from the risk register are made, additional data to provide further assurance will be visible. Control effectiveness is being introduced and will be reflected on reports as the process embeds.

Static Risk Review

The review of static risks has proved beneficial in the last 6 months with detailed review aiding the way for the successful mitigation and reduction of 17 of the 33 risks considered during the cycle. Of those remaining there are a number that are longer term risks that cannot be easily mitigated, however ongoing review will aid identification of any blockages as well as providing assurance that mitigating controls in place are effective.

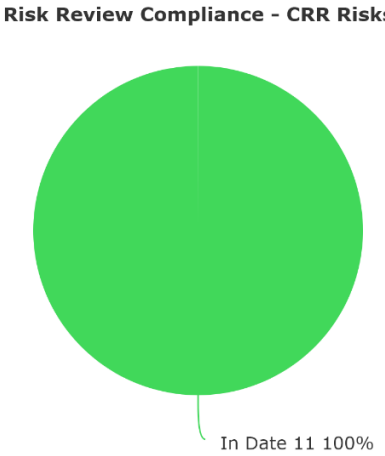
The Executive Risk Group agreed to continue this cycle of detailed review.

5.4 Risk Review Compliance

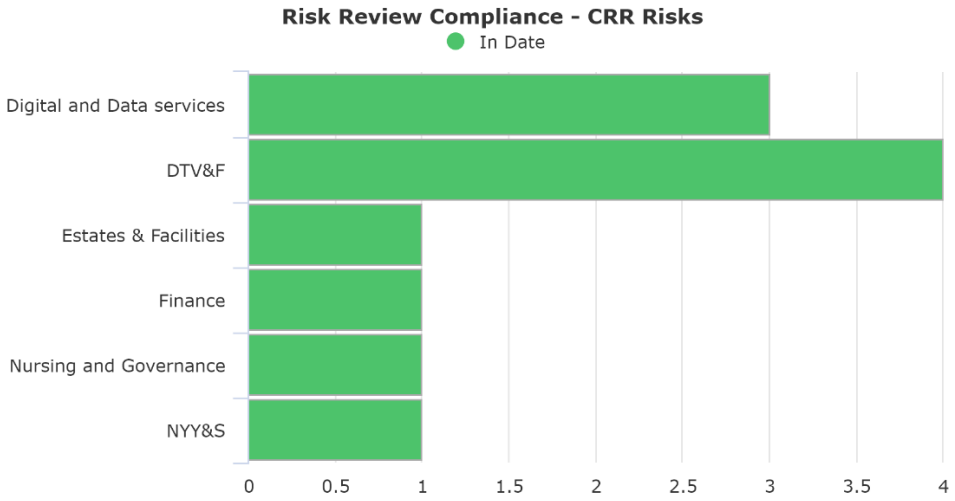
The policy includes appendices that outline the process in more detail, including the timing of risk review. This is shown below:

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 100% (previously 90%). This dipped over the festive period but has been maintained at 100% since then.



The breakdown by directorate is shown below.



Work underway to report on the overall position of all actions has made progress and while an action summary has not yet been completed, a full report on action position is provided.

6. Conclusions

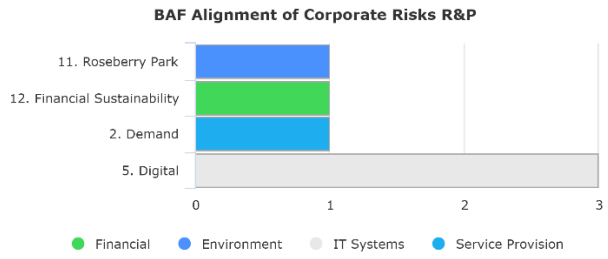
Governance meetings are being undertaken in line with policy and risks reviewed. We have some static risks that may take time to mitigate, however progress is being made. A new cycle of review of all 15+ risks has been agreed and commenced in March. This will more closely align review with BAF risks to enable a more interlinked approach.

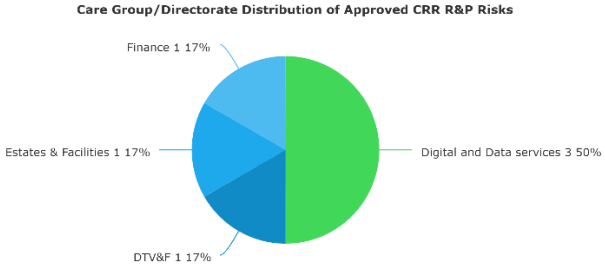
Compliance with review has remained at 100% following a dip over the festive period.

7. Recommendations

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

Strategy & Resources Aligned Risks





The current summary of the register is shown below

Note while the closed risk has been removed from the below listing, the replacement is not yet reflecting in the listing shown.

Closed -

- Risk 860 – Digital & Data - 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. (Which had a current rating of 15)

Replaced by -

- Risk 1646 – Digital & Data - There is a risk that cyber and operational incident response is inadequate due to insufficient cyber security resources, skills and enforced cyber security policies and procedures, along with technical audit and assurance; resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. (Current rating 10)

Risk CRR summary

Risk - Care Group/Directorate	Current	Risk - Specialty/ Department	Risk - Ward/Team	BAF Risk Alignment
All 12 selected	All 18 selected	All 40 selected	All 64 selected	All 14 selected

Risk Committee	Secondary Committee Alignment (Impact)	Risk Stage	CRR	Measure Name
Resources and Planning Committee	All 2 selected	All 5 selected	Yes	All 2 selected

Id	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	30 Apr 2025 RM03 Risk Rating Current	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	24/03/2025	Simon Adamson	15		Phase 2 rectification works	15	10
Risk 00001219	There is a risk that children and young people may experience deterioration in their presentation which is likely to impact on their mental health and wellbeing, resulting in an increase in demand for mental health support, specialist secondary services and urgent care. As a consequence, children, young people and their families are likely to have unsatisfactory patient experience due to the unacceptable waits for neurodevelopmental assessments. This in turn causes delay to ADHD treatment which is exacerbated by national medication supply issues. This may result in Dissatisfactory experience for families Complaints Knock on effect of long waits for diagnosis-specific support Reputational damage YP open to the service for a significant period of time with no completed care documentation and/or risk assessments (non compliance with Harm Minimisation Policy) The pathways currently are unlikely to meet standards in relation to new National Access Standards.	01 Apr 2021	27/03/2025	Jamie Todd	16	▪ Activity levels and outputs ▪ Capacity and demand ▪ Capacity and demand work ▪ Clinical prioritisation ▪ Closely monitoring the changing picture nationally re ADHD meds supply. ▪ KiT processes ▪ PTLs ▪ Support whilst waiting and signposting	Undertake impact assessment to prioritise cases for assessment within core GMH teams.	15	6
Risk 00001530	There is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory breaches / interventions and / or adversely impact quality of services.	30 May 2024	27/03/2025	Liz Romaniak	15		▪ Deliver 2024/25 Recurrent and Non Recurrent CRES plans, with monthly monitoring at FSB ▪ Report on financial performance vs plan ▪ Report detailed position to Board and escalate additional reporting as required ▪ Improve level loading of headroom and all rosters to be approved on time ▪ EDG to approve all new investments £10k+ ▪ Vacancy panel to approve all posts	15	8
Risk 00001632	There is a risk that the benefits of CITO are not realised due to poor performance/stability and a limitation of functionality of the system resulting in a reduced ability to effect clinical change, leading to reduced: efficiencies, staff engagement, poor record keeping, patient safety, reputation, confidence in the system and increased: staff absence, leavers.	13 Jan 2025	04/04/2025	Nick Black	20	▪ Cito Stablisationa and Improvement Project active ▪ Service desk ▪ Shared issue resolution plan ▪ Staff usability survey completed ▪ System speed issues addressed	▪ R1632 - Data Retention/Saving Requirements ▪ R1632 - Cito benefits realisation ▪ R1632 - Performance/stability management ▪ R1632 - Clinical change/ engagement tasks to support end users ▪ R1632 - Clarify and reinforce documentation requirements	16	8
Risk 00001636	There is a risk that the CITO system does not display a complete or accurate patient record to TEWV staff and partners, due to system performance and/or corruption of existing data, or data not saving, resulting patient care decisions being misinformed, quality of care being impacted, or requiring additional manual mitigations to be put in place and limiting clinical capacity.	15 Jan 2025	02/04/2025	Nick Black	25	▪ Access to Great North Care Record an Yorkshire Care Record ▪ Cito training mandated for new starters from 1 Jan 2025 ▪ Data migration (documents) completed ▪ Robust test scripts developed ▪ Speed issues with the system resolved ▪ Stabilisation programme in place for release management ▪ Standard Operating Procedures in place ▪ User confidence training underway ▪ User guides updated	▪ R1636 Cito Improvement Programme ▪ R1636 Develop and publish team based data quality reports ▪ R1636 Assess gaps in Cito training uptake ▪ R1636 Compete data rectification ▪ R1636 Enhance automated testing ▪ R1636 Delivery bug fixes - R3 ▪ R1636 Delivery bug fixes - R4	20	10

Current Risk Rating Movements

The following table shows the current risk rating at each month across the last year. Where there is no rating shown, this means a review was not undertaken in the period. However, while period information is not yet shown for all for November there is often a period lag, with these being populated at the next update. These risks are within their review dates.

All static risks are undergoing cyclic review in the Executive Risk Group.

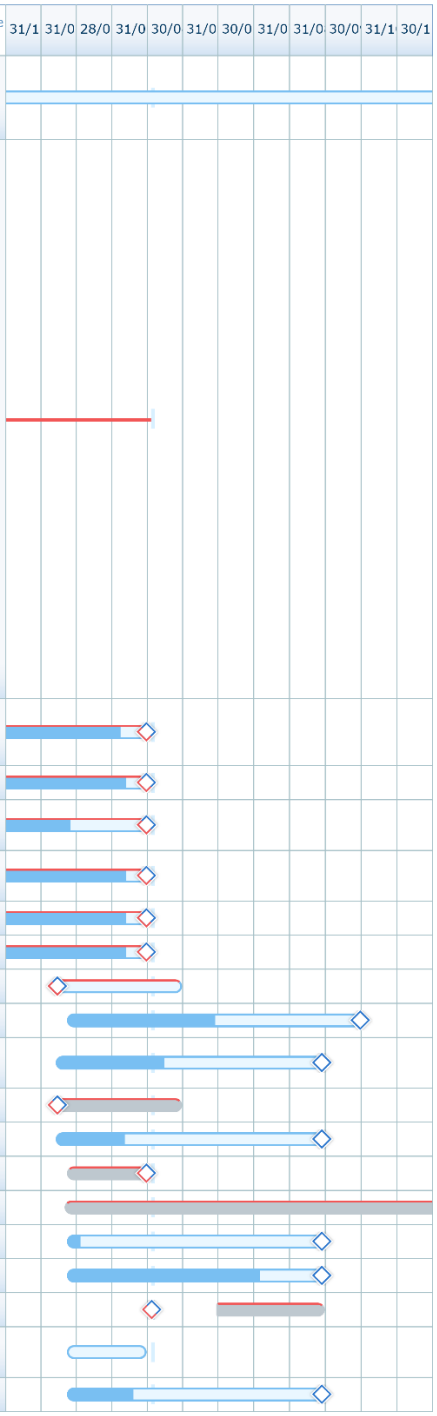
CRR risks - monthly current rating

	Risk Number	Risk Title	Current Risk Rating	30 Apr 2024	31 May 2024	30 Jun 2024	31 Jul 2024	31 Aug 2024	30 Sep 2024	31 Oct 2024	30 Nov 2024	31 Dec 2024	31 Jan 2025	28 Feb 2025	31 Mar 2025	30 Apr 2025
Resources and Planning Committee	Risk 00000219	Risk of a H&S incident at Roseberry park Hospital	Actual	15	15		15	15	15	15	15	15		15		
	Risk 00001219	CAMHS Neurodevelopmental assessment and treatment pathways.	Actual	15		15	15	15	9	15		15		15	15	
	Risk 00001530	Delivery of financial plan	Actual	n/r	15		15	15	15	15	15	15	15	15		
	Risk 00001632	Risk that CITO benefits are not realised	Actual	n/r	n/r	n/r	n/r	n/r	n/r	n/r	n/r	n/r	16			16
	Risk 00001636	Incomplete or inaccurate patient record displayed on Cito	Actual	n/r	n/r	n/r	n/r	n/r	n/r	n/r	n/r	n/r	20	20		
	Risk 00001646	Cyber and operational incident response gaps	Actual	n/r	n/r	n/r	n/r	n/r	n/r	n/r	n/r	n/r	10	10		10

The following table shows all current actions related to these risks. 1 is showing overdue.

Current Actions

Risk ID	Risk Description	Action Name	Due Date	Planned Completio Date	Owner	Percentage Complete
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.	Phase 2 rectification works	18 Sep 2026	18 Sep 2026	Simon Adamson	5%
Risk 00001219	▪ There is a risk that children and young people may experience deterioration in their presentation which is likely to impact on their mental health and wellbeing, resulting in an increase in demand for mental health support, specialist secondary services and urgent care. As a consequence, children, young people and their families are likely to have unsatisfactory patient experience due to the unacceptable waits for neurodevelopmental assessments. This in turn causes delay to ADHD treatment which is exacerbated by national medication supply issues. This may result in Dissatisfactory experience for families ▪ Complaints ▪ Knock on effect of long waits for diagnosis-specific support ▪ Reputational damage ▪ YP open to the service for a significant period of time with no completed care documentation and/or risk assessments (non compliance with Harm Minimisation Policy) ▪ The pathways currently are unlikely to meet standards in relation to new National Access Standards.	Undertake impact assessment to prioritise cases for assessment within core GMH teams.	31 Dec 2024	19 Sep 2024	Mita Saha	25%
Risk 00001530	There is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory breaches / interventions and / or adversely impact quality of services.	Deliver 2024/25 Recurrent and Non Recurrent CRES plans, with monthly monitoring at FSB	31 Mar 2025	31 Mar 2025	Mathew Norman	92%
		EDG to approve all new investments £10k+	31 Mar 2025	31 Mar 2025	Mathew Norman	92%
		Improve level loading of headroom and all rosters to be approved on time	31 Mar 2025	31 Mar 2025	Mathew Norman	70%
		Report detailed position to Board and escalate additional reporting as required	31 Mar 2025	31 Mar 2025	Mathew Norman	92%
		Report on financial performance vs plan	31 Mar 2025	31 Mar 2025	Mathew Norman	92%
		Vacancy panel to approve all posts	31 Mar 2025	31 Mar 2025	Mathew Norman	92%
Risk 00001632	There is a risk that the benefits of CITO are not realised due to poor performance/stability and a limitation of functionality of the system resulting in a reduced ability to effect clinical change, leading to reduced: efficiencies, staff engagement, poor record keeping, patient safety, reputation, confidence in the system and increased: staff absence, leavers.	R1632 - Cito benefits realisation	15 Jan 2025	30 Apr 2025	Jo Turner	0%
		R1632 - Clarify and reinforce documentation requirements	30 Sep 2025	30 Sep 2025	Gemma Pickering	50%
		R1632 - Clinical change/ engagement tasks to support end users	29 Aug 2025	29 Aug 2025	Gemma Pickering	40%
		R1632 - Data Retention/Saving Requirements	15 Jan 2025	30 Apr 2025	Andrea Shotton	0%
		R1632 - Performance/stability management	29 Aug 2025	29 Aug 2025	Vianne Chapman	25%
Risk 00001636	There is a risk that the CITO system does not display a complete or accurate patient record to TEWV staff and partners, due to system performance and/or corruption of existing data, or data not saving, resulting patient care decisions being misinformed, quality of care being impacted, or requiring additional manual mitigations to be put in place and limiting clinical capacity.	R1636 Assess gaps in Cito training uptake	31 Mar 2025	31 Mar 2025	Jo Turner	0%
		R1636 Cito Improvement Programme	16 Jan 2026	27 Feb 2026	Gemma Pickering	0%
		R1636 Compete data rectification	29 Aug 2025	29 Aug 2025	Vianne Chapman	5%
		R1636 Delivery bug fixes - R3	29 Aug 2025	29 Aug 2025	Vianne Chapman	75%
		R1636 Delivery bug fixes - R4	04 Apr 2025	31 Aug 2025	Vianne Chapman	0%
		R1636 Develop and publish team based data quality reports	not set	31 Mar 2025	Brian Cole	0%
		R1636 Enhance automated testing	29 Aug 2025	29 Aug 2025	Vianne Chapman	25%



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 6 January 2032.

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

Assurance – Good Assurance – This risk was subject to the new static risk review at the Executive Risk Group in September. As a result a recommendation made to change this risk to reflect a sub set of risks

which are contained within this instead of a broad H&S risk. This work is underway and will enable clear controls and actions to be more specific, resulting in the ability to more effectively demonstrate risk reduction in each risk. This will be combined into the work to align BAF and identify Corporate Risks.

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 31 March 2025. (to be reviewed)

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

Assurance – Reasonable Assurance – the risk has been fully reviewed and controls are reflected in the risk, as well as actions previously completed being added to the risk to reflect the full progress made. New actions currently underway and completed have also been added. Target date to be reviewed.

Risk 1530 – FIN Financial Management - There is a risk the Trust does not deliver its financial plan due to CRES not delivered to the required levels, or in year realised pressures are not mitigated by other underspends, resulting in regulatory breaches /interventions and/or adversely impact quality of services. (15)

Owner – Liz Romaniak

Initial rating 15 (C5, L3), Current Rating 15 (C5, L3), Target Rating 4 (C4, L2), Date to reduce risk 31 March 2025. (this risk will be replace with 2025/26 risk in due course)

Risk Review – in date, Action Delivery – 2 actions completed, 6 ongoing, extended to cover year end.

Assurance – Good Assurance – while the entry can be strengthened with controls reflected, regular updates are being undertaken, and clear actions identified and underway.

Risk 1632 – Digital and Data - There is a risk that the benefits of CITO are not realised due to poor performance/stability and a limitation of functionality of the system resulting in a reduced ability to effect clinical change, leading to reduced: efficiencies, staff engagement, poor record keeping, patient safety, reputation, confidence in the system and increased: staff absence, leavers. (current rating 16)

Owner – Nick Black

Initial rating 20 (C4, L5), Current Rating 16 (C4, L4), Target Rating 8 (C4, L2), Date to reduce risk 22 October 2026.

Risk Review – in date, Action Delivery – 5 actions ongoing, in date.

Assurance – Limited Assurance – the entry requires strengthening with clear controls, sources of assurance and actions.

Risk 1636 – Digital and Data - There is a risk that the CITO system does not display a complete or accurate patient record to TEWV staff and partners, due to system performance and/or corruption of existing data, or data not saving, resulting patient care decisions being misinformed, quality of care being impacted, or requiring additional manual mitigations to be put in place and limiting clinical capacity. (current rating 20)

Owner – Nick Black

Initial rating 25 (C5, L5), Current Rating 20 (C5, L4), Target Rating 10 (C5, L2), Date to reduce risk 322nd April 2026.

Risk Review – in date, Action Delivery – 7 actions underway, in date.

Assurance – Reasonable Assurance – controls effectiveness are being reflected and actions identified.

Risk 1646 – Digital and Data - There is a risk that cyber and operational incident response is inadequate due to insufficient cyber security resources, skills and enforced cyber security policies and procedures, along with technical audit and assurance; resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. (10)

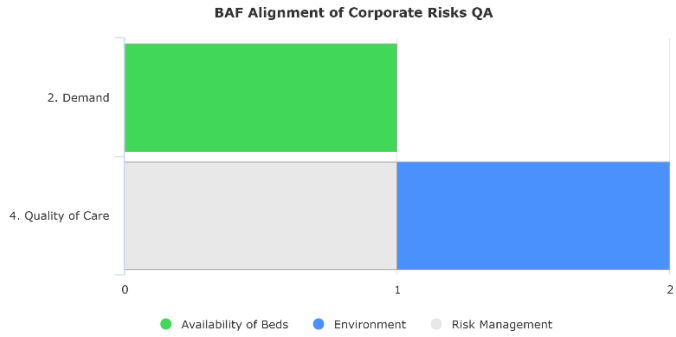
Owner – Nick Black

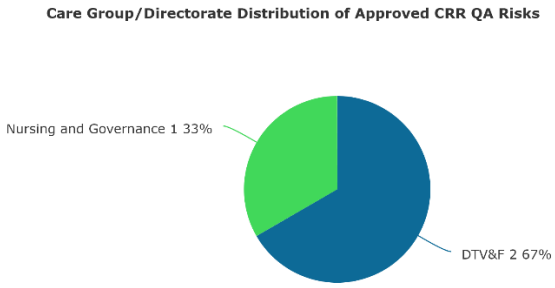
Initial rating 15 (C5, L3), Current Rating 10 (C5, L2), Target Rating 4 (C5, L1), Date to reduce risk 30 November 2028.

Risk Review – in date, Action Delivery – 0 actions identified.

Assurance – No Assurance – this risk requires detailed completion to enable assessment of controls, assurances and actions.

Quality Assurance Aligned Risks





The current summary of the register is shown below

Risk CRR summary

Id	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	30 Apr 2025			
								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	26/03/2025	Naomi Lonergan	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	27/03/2025	Rachel Weddle	20	▪ INC - Patient Safety Huddle Daily - reviews moderate and above incidents ▪ Staff understand the initial review process and timelines	R1044 - QI work on operational management and governance of incidents from ward to board	Amber 31 >50%	Yellow 51>84%	15	10
Risk 00001529	Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards.	29 May 2024	04/04/2025	Shaun McKenna	20	▪ Incident Data ▪ Patient Flow Work ▪ Performance reporting	▪ Develop Patient Flow Transformation workstream ▪ Develop an electronic live visual bed state in conjunction with IT and our digital journey to change ▪ Policy Review ▪ Develop the "Transforming Mental Health Discharge" workstream ▪ Development of Business Case ▪ Evaluation of Pilot			16	9

Current Risk Rating Movements

The following table below shows the current risk rating at each month across the last year. Where there is no rating shown, this means a review was not undertaken in the period. However, while period information is not yet shown for all for November there is often a period lag, with these being populated at the next update. These risks are within their review dates.

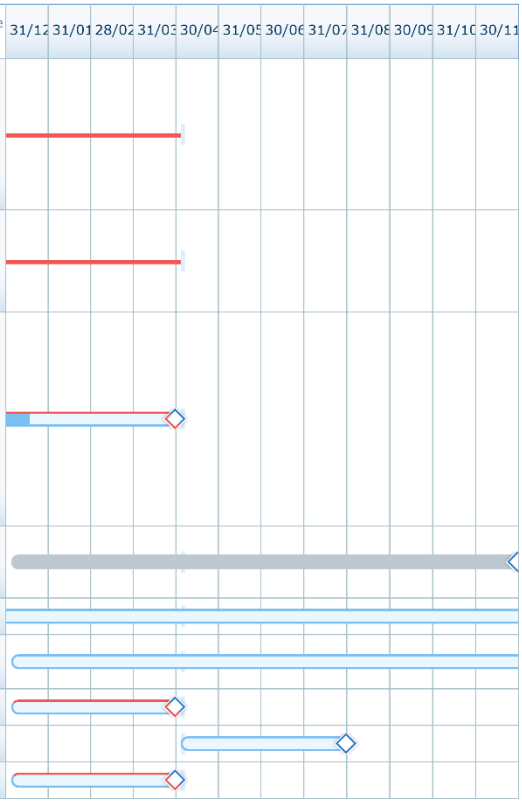
CRR risks - monthly current rating

	Risk Number	Risk Title	Current Risk Rating	30 Apr 2024	31 May 2024	30 Jun 2024	31 Jul 2024	31 Aug 2024	30 Sep 2024	31 Oct 2024	30 Nov 2024	31 Dec 2024	31 Jan 2025	28 Feb 2025	31 Mar 2025	30 Apr 2025
Quality Assurance Committee	Risk 00000811	Patients may attempt suicide using potential ligature points within clinical areas	Actual	15	15	15	15	15	15	15		15		15	15	
	Risk 00001044	Incidents that are more serious than initially reported are not identified within appropriate timescales	Actual	15		15	15	15	15		15	15		15		
	Risk 00001529	Risk if increased length of stay across AMH acute wards	Actual	n/r	16	16	16	16	16	16	16	16	16	16	16	

The below table show the actions ongoing in relation to the risks, 2 are showing overdue.

Current Actions

Risk ID	Risk Description	Action Name	Due Date	Planned Completio Date	Owner	Percentage Complete
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. ▪	R903 - Implement phase 2 of the ligature reduction programme	30 Jun 2024	30 Sep 2024	Simon Adamson	95%
		R903 - Phase 3 delivery	16 Oct 2024	16 Oct 2024	Simon Adamson	0%
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.	R1044 - QI work on operational management and governance of incidents from ward to board	31 Mar 2025	31 Mar 2025	Kendra Marley	65%
Risk 00001529	Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards.	Develop an electronic live visual bed state in conjunction with IT and our digital journey to change	30 Nov 2025	30 Nov 2025	Shaun McKenna	0%
		Develop Patient Flow Transformation workstream	31 Mar 2026	31 Mar 2026	Shaun McKenna	0%
		Develop the "Transforming Mental Health Discharge" workstream	31 Mar 2026	31 Mar 2026	Shaun McKenna	0%
		Development of Business Case	31 Mar 2025	31 Mar 2025	Shaun McKenna	0%
		Evaluation of Pilot	31 Jul 2025	31 Jul 2025	Polly Mennell	0%
		Policy Review	31 Mar 2025	31 Mar 2025	Shaun McKenna	0%



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 – Naomi Longergan

Initial rating 20 (C5, L4), Current Rating 15 (C5, L3), Target Rating 10 (C5, L2), Date to reduce risk 30 September 2025.

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

Assurance – Reasonable Assurance – while it is clear that work on the ligature reduction programme progresses the risk action does not reflect progress and requires update. The current controls and

management as well as actions are discussed regularly in the Environmental Risk Group, and the risk has been transferred to enable operational input and focus.

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 15 (C5, L3), Target Rating 10 (C5, L2), Date to reduce risk previously revised from 30 September 2024 to 31 March 2025. (to be reviewed)

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

Assurance – Good Assurance – the risk has been updated and includes detail of progress made. While central controls are effective, local review management needs strengthening, and numbers of unreviewed incident need to reduce to a 'routine' level. hence the risk remaining at 15 at present. This is expected to show increased stability as a result of the ongoing QI work. A new target date for reduction is to be set for June 2025.

Risk 1529 – DTVF AMH - Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards.

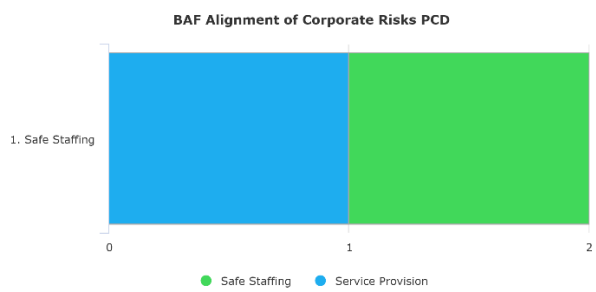
Owner – Jamie Todd

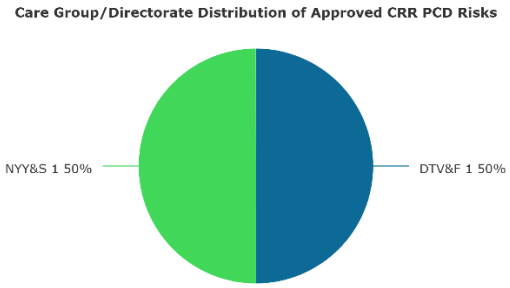
Initial rating 16 (C4, L4), Current Rating 16 (C4, L4), Target Rating 9 (C3, L3), Date to reduce risk – June 2025.

Risk Review – in date, Action Delivery – 6 actions now identified and ongoing, all in date.

Assurance – Reasonable Assurance – There has been considerable work to update the risk to reflect controls and assurances in place as well as identify all actions to be undertaken.

People, Culture & Diversity Aligned Risks





The current summary of the register is shown below

Risk CRR summary

Id	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	30 Apr 2025			
								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	02/04/2025	Parthipan Sivaraman	20	▪ Employment of international fellowship Doctors to fil gaps and reduce locun mind the gap ▪ Mind the Gap arrangement ▪ Retention of Existing Consultant workforce	R1001 - Develop non-medic colleague skills to ensure consistent service delivery	Green =>85%	Green =>85%	12	9
Risk 00001137	The current system (TEWVision) is unable to provide compliance and assurance of supervision. The Trust currently do not have assurance that staff and team are receiving appropriate levels of clinical and line management supervision to support their wellbeing and quality of care. Reliability is on team recordings as TEWVision is not performing assurance from the system. TEWVision is based on ESR and therefore individual teams need to be corrected to support the function.	22 Mar 2022	03/04/2025	Jo Nadkarni	15		▪ R1229 - All ward team managers to be using the same clinical supervision recording system ▪ Q&P meeting to be provided with a monthly specialty position in relation to clinical supervision ▪ Routine performance monitoring of clinical			15	9

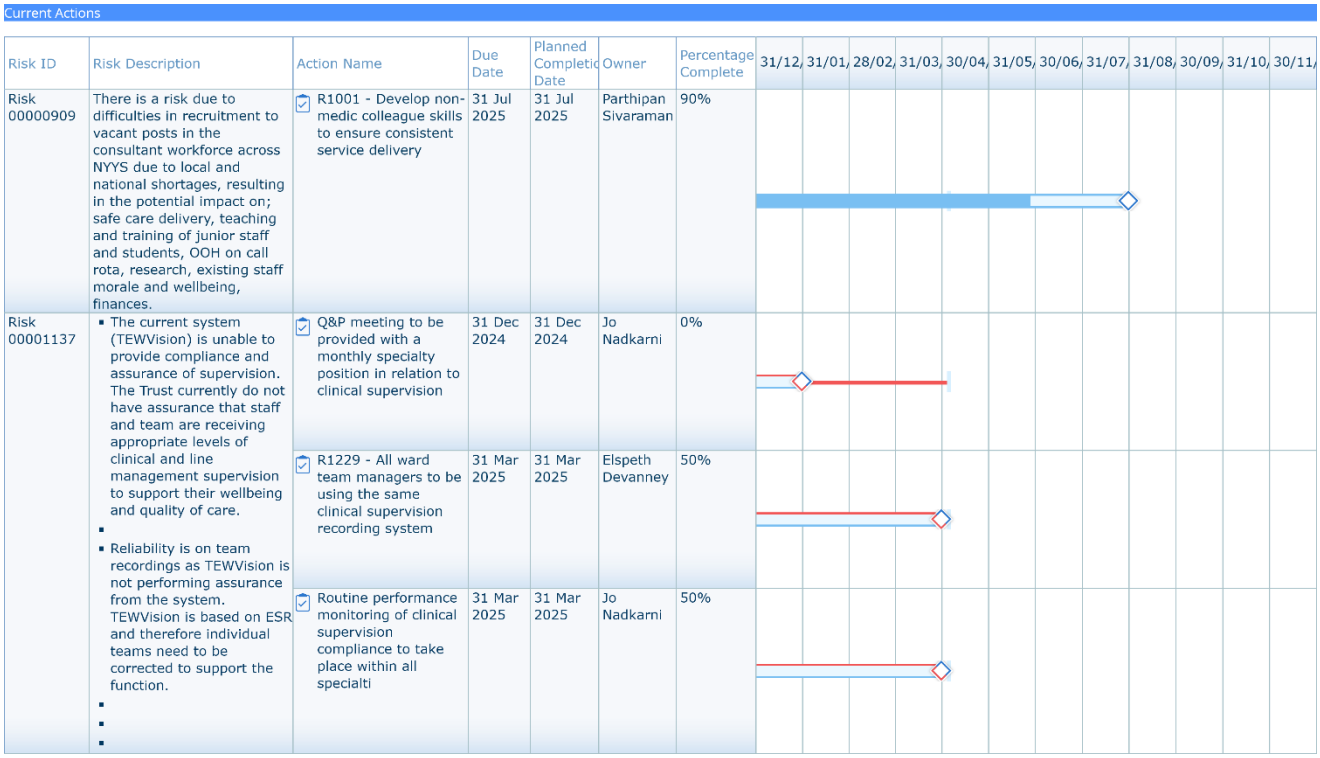
Current Risk Rating Movements

The table below shows the current risk rating at each month across the last year. Where there is no rating shown, this means a review was not undertaken in the period. However all risks are up to date and current period will 'capture' as risks are updated.

CRR risks - monthly current rating

	Risk Number	Risk Title	Current Risk Rating	30 Apr 2024	31 May 2024	30 Jun 2024	31 Jul 2024	31 Aug 2024	30 Sep 2024	31 Oct 2024	30 Nov 2024	31 Dec 2024	31 Jan 2025	28 Feb 2025	31 Mar 2025	30 Apr 2025
People Culture and Diversity Committee	Risk 00000909	Inability to recruit to vacant consultant posts	Actual	16		16	16	16	16		16		16	16	12	12
	Risk 00001137	The current system (TEWVision) is unable to provide compliance and assurance of supervision.	Actual	15		15	15	15	15	15	15	12	12	15		15

The below table shows current actions for the risks, all are in date.



Current Actions

Risk ID	Risk Description	Action Name	Due Date	Planned Completic Date	Owner	Percentage Complete
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.	R1001 - Develop non-medic colleague skills to ensure consistent service delivery	31 Jul 2025	31 Jul 2025	Parthipan Sivaraman	90%
Risk 00001137	▪ The current system (TEWVision) is unable to provide compliance and assurance of supervision. The Trust currently do not have assurance that staff and team are receiving appropriate levels of clinical and line management supervision to support their wellbeing and quality of care. ▪ ▪ Reliability is on team recordings as TEWVision is not performing assurance from the system. TEWVision is based on ESR and therefore individual teams need to be corrected to support the function. ▪ ▪ ▪	Q&P meeting to be provided with a monthly specialty position in relation to clinical supervision	31 Dec 2024	31 Dec 2024	Jo Nadkarni	0%
		R1229 - All ward team managers to be using the same clinical supervision recording system	31 Mar 2025	31 Mar 2025	Elspeth Devanney	50%
		Routine performance monitoring of clinical supervision compliance to take place within all specialti	31 Mar 2025	31 Mar 2025	Jo Nadkarni	50%

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 – Parthipan Sivaraman

Initial rating 20 (C4, L5), Current Rating 16 (C4, L3), Target Rating 9 (C3, L3), Date to reduce risk - 30 September 2025.

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

Assurance – Good Assurance – Significant work is reflected and the risk reduced as a result of the improvements in recruitment.

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 - Jo Nadkarni

Initial rating 15 (C3, L5), Current Rating 15 (C3, L5), Target Rating 9 (C3, L3), Date to reduce risk previously changed from 30 September 2024 to 31 April 2025.

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

Assurance – Reasonable Assurance - there is some work to do on the risk entry to reflect controls, assurance sources, and assess effectiveness of current controls, however updates are being reflected.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	Board of Directors
Date:	10th April 2025
Title:	Our Journey to Change Delivery Plan quarter 3 (October – December 2024) update
Executive Sponsor(s):	Patrick Scott, 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 2024/25* 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. This is an increase on the 61 deliverables (previously called projects) in the 23/24 delivery plan.

Proposal: **Board members are asked to review the updates on journey, priority and deliverable progress over the third quarter of 24/25.** The report also provides a summary delivery position as a percentage at a deliverable and overall journey level. **Management Group approved 16 extensions to deliverable timescales outlined in this report** at their March meeting.(marked in red font).

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, Q2 and Q3* 2024/25
- *Deliverable status overall for Q1, Q2 and Q3* 2024/25
- *Journey updates as at Q3. 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.

Implications: There are a 16 deliverables which are at risk of not being delivered within agreed timescales. These have been flagged in **RED** within the OJTC delivery update tables and any requests for changes in timescales in **red.**

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, Q2 & Q3

Completed Projects per Journey for 2024/2025 (Q1-Q3)						
	Journey RAG status					
	Complete	In progress / continuing	Delayed		Paused	Not reported
Clinical	29%	41%	16%	14%	0%	0%
Q&S	69%	19%	6%	6%	0%	0%
Co-Creation	71%	29%	0%	0%	0%	0%
People	50%	50%	0%	0%	0%	0%
Infrastructure	21%	21%	21%	24%	14%	0%

Table 2: % of deliverables completed overall for Q1, Q2 & Q3

% of Completed Projects Overall for 2024/2025 (Q1-Q3)					
Complete	In progress/ continuing	Delayed		Paused	Not reported
38%	**33%**	**13%**	**13%**	**3%**	**0%**

Recommendations: **Board members are asked to:**

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

Clinical Journey – Quarter 3 24/25

Transforming Community Services: there are 32 deliverables within this piece of work, 5 are already complete at the end of Q2. 5 are due to complete at Q3, 3 of which are red and 2 complete.

The 2 completed actions are (North Yorkshire and York actions counted separately):

- *Undertake service review of single Point of access* – (covering North Yorkshire & York) BCP actions included the undertaking of a review which was completed in December. All actions from review now implemented and all vacancies fully recruited to. Decision to be taken in January to remove from BCP recovery (NOTE: supported and approved in January)

The 3 red actions are:

- *To review PCN ARSS roles and explore options to have full coverage across DTV* - Mapping of current provision (6 roles) and gap analysis completed - item to be discussed at specialty governance in February 2025 in relation to next phase expansion of service and resource allocation and prioritisation by PCNs for the roles. **An extension to this timescale to Q4 24/25 was approved at Management Group in March.**

- To expand MH support team in schools' provision in County Durham - Expansion linked to national programme and alignment with local requirements. This item is tabled for discussion at specialty governance in February 2025 to plan for future waves. This priority will therefore run into 2025-26. **An extension to this timescale to Q4 24/25 was approved at Management Group in March.**
- *Physical healthcare model in place across all 5 Tees Valley localities* – Several issues with recruitment has caused a delay in completing this action. The posts are out to advert for Hartlepool, Stockton and Middlesbrough and interviews are scheduled for 23rd January. **An extension to this timescale to Q4 24/25 was approved at Management Group in March.**

Transforming Urgent Care: there are 5 deliverables within this piece of work, with 1 due at the end of Q1 which is complete. There are no milestones due at Q3, one deliverable which is due by March 2025 is red

- *Implementation and embedding of the OPTICA system* - Optica is now in use by the Central Bed Management Team, 4 AMH wards & 2 MHSOP wards across the Trust. Service Managers in Urgent Care and Rehab are using the system to facilitate their long length of stay meetings. A business case will be presented for further roll out in March 2025. There is a technical delay in the pilot phase in relation to the digital platform which NHSE are managing due to affects across numerous providers. Dashboards are now 'live'.

NENC Secure Services Provider Collaborative Bed Model - there are 8 deliverables within this piece of work, 2 due at the end of Q3 which are complete and 5 due by end of Q3 of which are 5 are red.
The 5 red actions are:

- Female Model – there are delays with obtaining national feedback. **An extension to this timescale to Q4 24/25 was approved at Management Group in March.**
- Individualised Care Area Model of Care - Dr Keith Reid to present paper to Bed Model Workstream in February. **An extension to this timescale to Q4 24/25 was approved at Management Group in March.**
- Medium Secure Male Mental Health TEWV – this deliverable was delayed due to issues with RC cover which is now resolved and beds due to open mid-January. **An extension to this timescale to Q4 24/25 was approved at Management Group in March.**
- Medium secure Male Expansion Mental Health Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust - Position monitored via Bed Model Workstream however action is out of TEWV control. There are delays due to signoff of overall bed model and current occupancy of environment. **An extension to this timescale to Q2 25/26 was approved at Management Group in March.**
- Low Secure Male Mental Health Expansion Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust - There are delays due to signoff of overall bed model and current occupancy of environment. This is out of TEWV's control. **An extension to this timescale to Q2 25/26 was approved at Management Group in March.**

Expanding our Health & Justice services - there are 3 deliverables within this piece of work, with 1 due at the end of Q1 which was completed on track. There are no deliverables due at Q3 however there are 3 ongoing until the end of 24/25 which are on track.

Autism: there are 4 deliverables within this piece of work, with 1 which was complete at Q1 and 3 ongoing until the end of 24/25 which are on track.

Young Adult Services: there are 7 deliverables within this piece of work with 2 due at the end of Q1 which are complete. 2 deliverables are due by Q4 and are on track. One deliverable was due by the end of Q3 and is red.

- This is to: *Develop revised proposals for how we oversee services for young adults*. Proposed next steps for this work are being taken through CGB and Transformation Programme governance in February 24 to maintain oversight, alignment and agree priorities. Draft proposals to take this work forward have been developed. **An extension to this timescale to Q2 25/26 was approved at Management Group in March.** This will allow the draft proposals for taking forward this work to be agreed at various governance groups and these draft proposals to be worked up.

Reducing health inequalities: there are 10 deliverables within this piece of work. 6 of these deliverables are complete up to the end of Q2. There are a further 4 deliverables due by the of Q4. 3 are on track and one is amber

- *Trial a mode of closing the gap on did not attend/was not brought by* – a pilot team have been identified, and project initial project trialled. There have been a number of challenges in implementing both in terms of capacity and available technology. The team are adopting an alternative approach to review compliance with the new DNA/WNB policy. This work is on track to complete by Q4.

Quality & Safety Journey – Quarter 3 24/25

Personalised Care Planning: there are 7 deliverables within this piece of work with 3 `due by the end of Q1 and which are complete and one due in Q2 which is also complete. There is one deliverable due in January 24/25 which was on track.

There are 2 deliverables which are ongoing until the end of 24/25, one of which is on track and the other amber. The amber deliverable is:

- *Work with ICBs to establish effective interoperability between systems* - Workshops have taken place with CNTW where the role of partners and key worker in personalising care plans was reviewed. However, there is a different approach between the 2 ICBs and there may need to be some tolerance in variation. Internal standards will be consistent, but system practices will vary.

Physical Health: there are 4 deliverables within this piece of work 3 are now complete and 1 is on track for delivery by the end of Q4.

Improved patient safety: there are 5 deliverables within this piece of work of which 4 of which are now complete up to the end of Q2. One deliverable due in Q3 is red

- This is: *Implementation of further InPhase modules* – this deliverable was not achieved due to delays and capacity from supplier and internally. There is an new target date March 25. **An extension to this timescale to Q4 24/25 was approved at Management Group in March.**

Key updates for this work are:

- Audit Oversight - is now in test phase from December 24, goes live January 2025.
- Audits - Application live, rapid tranquilisation audit continues, North Yorkshire to go fully live on this in January 25. Quality assurance schedule (inpatients) pilot of two wards from Jan 25.
- CAS - Application in test phase through December 24 and live with Business Managers from January 25. Further development of more distribution to be piloted in Feb 25 with two specialties.
- NICE - Data cleanse completed. Upload by company awaited. Verification to be undertaken and finalisation of reports. Expected to be live by end Jan 25.
- CQC - Discussion and agreement on use and potential roll out plan to be agreed.

Co-creation Journey – Quarter 3 24/25

Further develop our co-creation infrastructure: there are 5 deliverables within this piece of work, 4 deliverables were complete up to the end of Q2, there are no deliverables due at Q3 however,1 deliverable is due by Q4 is on track

One deliverable is due by Q4 is on track *Co-creation framework development complete and roll-out to commence*

Lived Experience/ Peer Roles: there are 6 deliverables within this piece of work, 3 deliverables were complete up to the end of Q2 there are no deliverables due at Q3 however, 3 remaining deliverables are due at Q4 and are on track.

Improve Patient Experience: there are 6 deliverables within this piece of work, 1 was complete up to the end of Q2, there are no deliverables due at Q3 however, 5 remaining deliverables are not due until August 2025 but are all on track.

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People Journey – Quarter 3 24/25

Deliver our people plan: There are 4 deliverables within this piece of work, 2 are complete up to the end of Q2, there are no deliverables due at Q3 however 2 remaining deliverables are due at Q1 25/26 and Q3 25/26, these are both on track.

- *Newly procured Occupational Health Service in place* – progressing well.
- *Development and launch of TEWV Leadership Academy Dec 24 with annual implementation review* - Progressing well, LaMA board met formally in December for the first time and agreed priorities for 2025.

Infrastructure Journey – Quarter 3 24/25

Estates: There are 10 deliverables within this piece of work, 2 of which are due at Q3, 1 is complete and 1 is red, however, a further 6 are due at Q4, 2 are on track, 2 amber and 2 red.

Due at Q3:

- *OPE pipeline Business case developed for Billingham public services hub* – this deliverable is red. This is not led by TEWV and there is a delay to this action due to ongoing planning work in the lead partner organisation. **An extension to this timescale to Q1 25/26 was approved at Management Group in March.**

Due a Q4:

- *Medical Education service operating from LRH* – this deliverable is red. In view of the reduced demand, the project is being re-scoped to incorporate a simulation suite in a smaller footprint of space. This does not necessitate the relocation of other services but does require a revised specification and re-tender and is therefore not achievable within the 2024/25 financial year. The capital position for 2025/26 is challenging. **Therefore this priority will move to 25/26. Once scoping has been carried out a revised timescale can be agreed.**
- *Assistive Technologies (Sensor Doors-Phased/continuous handover throughout programme) (red)* - This work is ongoing but are now scheduled to complete June 2026 as per revised business case to include all inpatient areas. Phases 3 and 4 works have recommenced. Programme has been revised for RPH following discussions with Forensic Services as to the scheduling of works for the remaining wards. Ivy/Clover works to start on 27/1/25, then followed by Swift and Kestrel/Kite .Remaining wards to be confirmed over the next month once progress has been reviewed. **An extension to this timescale to Q1 26/27 was approved at Management Group in March.**

The Green Plan: There are 7 deliverables within this piece of work, 2 of were complete at the end of Q2. There are no deliverables due at Q3 however there are 4 due at the end of Q4. One is on track, 2 are amber and one is red. One deliverable is ongoing into 25/26.

- *Reduction in carbon following installation of LED lighting to be monitored through utility reports (red).* Future opportunities to be explored in anticipation of further central funding - Monitoring of energy and carbon reduction from 2024 installations is ongoing. A further round of central NEEF funding was made available in Dec 24. Two bids were submitted, one for £338k for LED at Roseberry Park and an £11k bid for BMS upgrade at Cross Lane and both were successful. Equipment needs to be procured and delivered to site by end March 25 and installed by the same date or as soon as possible after. NHSE have requested expression of interest applications for renewables projects for possible funding in FY25/26 by 31st Jan 25 so work is underway to develop potential solar PV projects for selected sites to reduce electricity consumption and carbon. Central funding is announced in March 2026. **An extension to this timescale to Q4 24/25 was approved at Management Group in March.**

Digital and Data: There are 12 deliverables within this piece of work, 3 deliverables were complete up to the end of Q2. For Q3, 1 is complete, 3 deliverables are red and 1 is grey, there are 3 on track and 3 grey which are due at Q4.

- *Clinical records that have achieved retention will be identified and appraised for destruction* red - Still awaiting full scope from NHSE. Business Analyst resource working with Head of IG to progress and work is expected to be completed by end March 2025. **An extension to this timescale to Q4 24/25 was approved at Management Group in March.**
- *Move Business Intelligence system to cloud. deliver network bandwidth across 20 Trust sites experiencing performance issues and deliver MFA* red - change of plan agreed at Digital Programme Board Q3 to move planned implementation date to February 2025 due to ongoing technical issues. Third party suppliers are meeting with the Trust project team daily to resolve issues as a matter of urgency. **An extension to this timescale to Q4 24/25 was approved at Management Group in March.**
- *Pilot wards have inpatient internet and a review of this will have been undertaken* red - Ward areas have confirmed their requirements for either tablet or pc devices. Procurement for pc's and supporting infrastructure hardware have been placed. However wards would like more time to test devices. **An extension to this timescale to Q4 24/25 was approved at Management Group in March.**
- *An updated Digital and Data strategy will be written and approved* grey - Work has not yet started and will align with the Trusts refreshed strategy
- *A Trust EDMS will be written and approved* grey - Agreed via EDG in December 2024 that this project would not commence due to changes to plan in the frontline digitisation programme.
- *Requirements for a patient portal will have been co*-created grey - Work has not yet started, and EDG agreed in December 2024 to delay this until 25/26.
- *CITO technical developments will mean that development of appropriate clinical apps and further pathways will be achieved, clinical input into SCR is possible, and an integration engine will have been procured with a proof of concept undertaken*. grey - Work has not yet started and is not now intended to be delivered until 25/26. The current focus is on stabilisation and improvement of CITO functionality with a CITO Stabilisation project PID approved at Digital Programme Board in Q3 and now reporting in progress to DPB and the Cito Improvement Group. This work is initially focussed on the delivery of a series of system releases by the supplier to address high priority issues, alongside a programme of works to increase user confidence in use of the system.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**10 April 2025**
Title:	**Our Journey to Change: The Next Chapter**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Author(s):	**Chris Lanigan, AD Strategic Planning & Programmes**

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*
		Our Journey to Change (OJTC) is our strategic framework and hence relates to all of the risks in the BAF

Executive Summary:

Purpose: The purpose of this report is for the Board to consider and approve the revised version of our strategic framework, Our Journey to Change (OJTC) – i.e. *Our Journey to Change: The Next Chapter*.

Proposal: It is proposed that the Board of Directors approve the suggested text of *Our Journey to Change: The Next Chapter.*

Overview: Our Journey to Change, the Trust's strategic framework was approved by the Board of Directors in January 2021 following extensive engagement with the community, staff and partners during 2020 (including the initial Big Conversation). It was intended to be in place for 3-5 years.

Since January 2021, successful implementation of Our Journey to Change has included:

Co-creating a great experience for patients, carers and families

- Waiting list for children needing to access support for mental health or emotional wellbeing needs down by nearly half
- Carers Charter launched and being embedded in the Trust. It sets out our commitment to working with and supporting carers.
- Co-Creation framework developed, agreed and launched
- Invested in our estates by opening a new community mental health hub in Northallerton and a new centre for young people in York
- We're better placed to support members of the Armed Forces since signing the Armed Forces Covenant

- Increased numbers of people with severe and enduring mental illness have been helped into employment by our Individual Placement Service
- Recruited two lived experience directors and a head of co-creation who are supporting teams to put patient experience at the heart of decision making

Co-creating a great experience for colleagues

- Recruited 700 more staff since start of COVID in 2020
- Introduced large scale recruitment events for Health Care Assistants (HCAs) and nurses, including international recruitment
- Streamlined our processes, reducing the time it takes to hire
- Developed our staff networks to give everyone a voice in our Trust
- Invested in the health and wellbeing of our people
- Introduced a staff awards and recognition scheme

Being a great partner

- More mental health nurses are working in GP surgeries across our region – supporting people to get the right help early on and close to home
- 27 more schools are part of our mental health support programme helping young people and training teachers
- Our innovative and world-class research team is part of a vital COVID-19 vaccine trial along with NHS partners and the University of York
- Together with Hartlepool Borough Council we supported rough sleepers with their mental health
- Our apprenticeship team has developed a strong partnership with Derwentside College to deliver a range of apprenticeship training to colleagues
- Working with City of York local authority and other partners we achieved national pilot status (and investment) for the Acomb mental health hub. We have also made good progress in setting up multi-agency hubs across Tees Valley and County Durham and in Harrogate.

Nevertheless, once the third anniversary of the approval of OJTC had passed, work started to develop a process that would update and refresh it. The Board's view was that a refresh rather than a totally new strategic framework was required, and the appropriate managers were asked to develop and implement a process to achieve this.

To inform the refresh of OJTC, a lived experience strategy and planning reference group was set up and started monthly meetings / discussions. A new *big conversation* was held in July 2024 to augment existing intelligence about the impact of work since January 2021. 990 people took part in this 752 TEWV colleagues, 143 people with lived experience (service users / ex-service users and family members), and 95 people in partner organisations.

The Board also held a strategy focussed board workshop on 14 September which considered the feedback from the big

conversation and changes in our strategic and operational environment such as the Darzi Report. Board members' views about progress and impact against each of the 3 goals were logged.

Since that September workshop an iterative process to develop a revised set of words for OJTC has taken place. This has included a further board workshop discussion, reports to the Council of Governors, continued engaged with the lived experience reference group, discussions with the Trust's leadership and management network members and a check and challenge internal and external stakeholder survey.

This process has produced the final, formal draft of *Our Journey to Change: The Next Chapter* which is attached at **Appendix A**. The 2020 version of OJTC is on the left of that page and the proposed *Next Chapter* version on the right. This formal draft has been considered by the Trust's Council of Governors and the Chair of the Resources and Planning Committee and neither have suggested any further changes.

The main differences between the Board's *next chapter* version and the 2021 Our Journey to Change are:

- Much shorter, more memorable vision statement which does not duplicate other parts of OJTC.
- Goal 1 now has a broader quality focus, partly due to lived experience reference group feedback that the outcomes of treatment need to be good as well as experience of being treated by our Trust, and that they expect our staff to be knowledgeable and competent as well as having in line with our values and offering good "customer service".
- In goal 2, the main change is the inclusion of the objective, "Feel safe to challenge, innovate and celebrate". This reflects both the national agenda (e.g. freedom to speak up) but also a view that after several years of progress it is important to celebrate excellent practice to both support staff morale, aid recruitment and support share and spread
- Goal 3's revised objectives recognise the increased national emphasis on neighbourhood-level integration and on reducing health inequalities compared to 2021. We also recognise our role as a major employer or "anchor institution".
- The behaviours attached to the responsibility value place more emphasis on staff doing their duties well and recognise the need for staff to be productive and support innovation and change. The emphasis on openness, accountability and reliability was particularly important to the lived experience reference group (as is the importance of not just listening but acting on what is heard in the compassion value), while productivity is now a national NHS priority.

If the wording of *Our Journey to Change: The Next Chapter* is approved than a communications plan will be enacted and Trust processes that reference the goals, objectives and values will be updated over time. Delivery and implementation of the Trust's

	strategy will continue to be via the implementation of Care Group and corporate plans, including transformation programmes.
Prior Consideration and Feedback	This is set out in the report above, but there have been specific progress reports to the Council of Governors in October 2024 and January 2025. The check and challenge engagement gathered comments from 30 stakeholders, including internal stakeholders, service users and partners which was fed back to board members at a workshop on 13 March. Board members suggested further wording changes based on this feedback and to reflect recent NHS policy direction. The version of the document in the appendix includes these changes. The Council of Governors held a final discussion on the new strategic framework at their meeting on 26 March. They did not identify any changes that they wished to recommend to the Board of Directors.
Implications:	There are no immediate legal, financial or equalities implications connected with updating Our Journey to Change. However, this strategic framework will shape the Trust's policies, plans and management decisions in the years to come at which point implications will be considered.
Recommendations:	**The Board of Directors are recommended to approve the wording of *Our Journey to Change: The Next Chapter* as set out in the right column in the appendix.**

Appendix: Our Journey to Change: Original version and the *Next Chapter*

	January 2021 OJTC	***OJTC The Next Chapter (2025)***
Mission	We want people to lead their best possible lives.	We want to support people to lead their best possible lives.
Vision	We will co-create safe and personalised are that improves the lives of people with mental health needs, a learning disability or autism, involving them and their careers as equal partners. We will listen, learn improve and innovate together with our communities and will always be respectful, compassionate and responsible	We provide consistently good healthcare which helps our communities become healthier and safer
Goal 1	**To co-create a great experience for our patients, carers and families so you will experience:**	**We will co-create high quality care. Therefore, people who use our services and their carers will experience:**
Goal 1 Objectives	• *Outstanding and compassionate care all of the time* • *Access to care that is right for you* • *Support to achieve your goals* • *Choice and control*	• *A timely response with help when you need it* • *Consistently patient-centred care, with positive outcomes* • *Involvement in planning and personalising care and opportunities to help improve services*
Goal 2	**To co-create a great experience for our colleagues, so you will be**	**We will be a great employer. Our colleagues will:**
Goal 2 objectives	• *Proud because your work is meaningful* • *Involved in decisions that affect you* • *Well led and managed* • *That your workplace is fit for purpose.*	• *Feel pride in what we do and the impact of our work* • *Be supported and empowered to do our job well* • *Feel safe to challenge, innovate and celebrate*
Goal 3	**To be a great partner, so we will**	**We will be trusted partner. Our partners will experience us working with them to:**
Goal 3 Objective3	• *Have a shared understanding of the needs and straights of our communities* • *Be working innovatively across organisational boundaries to improve services* • *Be widely recognised for what we achieve together*	• *Deliver integrated services and improve population wellbeing* • *Reduce health inequalities* • *Offer training, job and career opportunities*
Value 1	**RESPECT**	**RESPECT**
	• Listening	• Inclusive
	• Inclusive	• Considerate
	• Working in partnership	• Open and honest
Value 2	**COMPASSION**	**COMPASSION**
	• Kind	• Kind
	• Supportive	• Fair
	• Recognising and celebrating	• Listening and acting
Value 3	**RESPONSIBILITY**	**RESPONSIBILITY**
	• Honest	• Accountable
	• Learning	• Reliable and productive
	• Ambitious	• Challenging and improving

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NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Committee Key Issues Report		
Report Date to Board of Directors – 10 April 2025		
Date of last meeting: 6 March 2025	**Report of: The Quality Assurance Committee**	
	Quoracy was achieved.	
1	**Agenda -** The Committee considered the following matters: • Minutes of meetings held on 6 February 2025 • Summary of the Executive Review of Quality Group meeting held on 25 February 2025 • Quality Dashboard • Waiting Times • NYYS Occupancy and patient flow and the impact on Quality (Corridor Care) • DTVF Patient Flow across AMH Acute Care Services • Safer Staffing • DTVF Adult Learning Disabilities • Rehabilitation Service Model – deferred • Draft Quality Assurance and Improvement Programme • Quality Assurance and Improvement Programme and NICE Guidance Implementation • Drug and Therapeutics • Process for the development and Assessment of Progress against Quality Transition Criteria • Board Assurance Framework • Committee workplan	
2a	**Alert**	The Committee alerts the Board on the following matters: **From the DTVF Care Group:** • One use of tear proof clothing, one mechanical restraint, which was appropriate. Two unintended prone restraints occurred and being explored. **From NYYS Care Group:** • Two incidents of infants being harmed linked to parents in receipt of mental health care in NYY, the standard of care is being reviewed. A substantive paper will go to Exec. Directors Group. Care group clinical leaders are assured of safety. • One non planned prone restraint (patient put self to the ground, one minute to re-position). **Other business matters:** • Limited assurance on the known impact of those people waiting to access our services in the community. The committee asked for an update on how "keeping in touch" options were being considered. Areas of concern are waiting for neurodevelopmental assessments and adults waiting for their second contact with Talking Therapies. Discussions continue through a newly established all-age neurodiversity group across NENC ICB to review processes. • Ongoing concerns over people being ready for discharge with no onward placement. • Bed occupancy remains high in AMH and older adults. This is being driven by delayed transfers of those patients ready to be discharged. • The committee requested further assurance on the extended support to the Perinatal Mental Health Service in North Yorkshire and York Care Group.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: **From the Care Groups:** • Both care groups had no breaches in mixed sex accommodation and 72 hour follow up target was met.

		DTVF: • Crisis services have now come out of recovery arrangements. • 91.47% patients reporting their experience as good. • 76% of carers reporting they felt involved in care in January. • Continued downward trend in rapid tranquilisation. • No remote seclusion reviews in month. • Over 80% of teams compliant with Quality Review audit. **NYYS:** • Assurance of good quality care can be evidenced for those individuals who might be delayed in a 136 suite waiting for transfer to an appropriate inpatient bed. • No mechanical restraint and no seclusion. • 93% of patients reported feeling safe in MHSOP. • 85% compliant with safe wards MHSOP, 80-90% in male 50-60% female AMH. • Continued downward trend in restrictive interventions in month, majority in female AMH. • Four consecutive months of improvement for compliance with section 17 leave and planning time away from the ward. • Increasing number of returns for Quality Assurance audits. **Other business matters:** • There is special cause improvement demonstrated in the quality dashboard for the percentage of complaints completed within originally agreed timescales. • There is special cause improvement for the percentage of children and young people showing measurable improvement following treatment. • There is good assurance on the progress that our Adult Learning Disabilities services have made against the original improvement plan with compelling stories. There was concern expressed with six delayed discharges. This is being progressed with ICB support. • There is good assurance in relation to the proposed delivery and monitoring of the clinical effectiveness and quality assurance activities for 2025/26 and the annual Programme. • Good assurance relating to the operational and strategic oversight of clinical effectiveness activities with 34.5% (10/29) of audits completed. • There is good assurance on the six-monthly overview of progress with agreed priorities from the medicines optimisation and pharmacy framework (MO&PF), including the ongoing electronic prescribing and medicines administration (EPMA) project. • The Committee workplan has been reviewed and refreshed to ensure it reflects mandatory fundamental standards, escalated risks and is aligned with the strategic risks of the organisation. • Committee members were sighted on the slide deck for the development and Assessment of Progress against Quality Transition Criteria, including a summary of assurances over the last three years and completion of all but one of the CQC recommendations. The papers were shared with the Quality Board on 10 March 2025.
2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: **From the Care Groups:** **DTVF:** • Increased oversight of Baysdale continues following previous quality concerns with improvements being seen. • AMH Easington South has plans to exit BCP in March 2025. • A team of 25 staff are working closely with the broader system on variance to practice to ensure safety of a current inpatient whose baby is due next month. • Close oversight on Bransdale ward continues. **NYYS:**

		• Four incidents of sexual safety incidents involving one patient. All safeguarding procedures in place and no concerns. **Other business matters:** • The first iteration of the quality dashboard was considered, which provides much richer information across team and speciality dashboards. It was agreed there is good assurance linked to oversight on data but limited assurance in terms of managing the risks to quality. • Committee pressed for further assurance and improvement on the inconsistencies with incident review processes across teams. • Not all wards facilitating completion of the friends and family test. • Questions in the QA tool will be reviewed to smooth out any potential weaknesses, linked to asking if a patient has been "offered or given a copy" of S 17 leave and the last occasion a patient used unescorted leave, when all patients must be escorted by a member of staff.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considers that good assurance can be provided that the risks to quality are understood and are being managed appropriately. The risks narrated in the BAF about waiting times and the impact on people waiting to access services will be reviewed to ensure the current position is captured. No new risks were identified on reflection of the strategic risks at the end of the meeting.
3	**Actions to be considered by the Board**	That the Board note the report and take good assurance that there is robust oversight with regards to the management of risks to quality of care.
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

Committee Key Issues Report		
Report Date to Board of Directors – 10 April 2025		
Date of last meeting: 3 April 2025		**Report of: The Quality Assurance Committee**
		Quoracy was achieved.
1	**Agenda -** The Committee considered the following matters: • Minutes of meetings held on 6 March 2025 • Board Assurance Framework • Summary of the Executive Review of Quality Group meeting held on 25 March 2025 • Quality Dashboard • Waiting Times • DTVF- Utilising the Crisis Assessment Suite (CAS), 136 suite to support waiting for an inpatient bed. • CQC Activity and Delivery of the CQC Improvement Plan • Sexual Safety Annual Statement of Compliance • Annual Quality Account 2024/25 Timeline • Quality Impact Assessments • Compliance with Section 17 leave and time away from the ward • Clinical Outcomes • Risks to Quality: Perinatal Mental Health Service NYYS • Board Assurance Framework • Committee Workplan	
2a	**Alert**	The Committee alerts the Board on the following matters: **From the DTVF Care Group:** • There are ongoing issues linked to assurances for recording supervision, challenges with TEWVision and hence manual logs are being maintained. • Some teams are below 50% for compliance with completing quality review audits. Improvement plans are in place and the clinical triumvirate will visit non-compliant wards. • There was an unintentional prone restraint on Elm ward where the patient put themselves in the position. A review was completed. **From NYYS Care Group:** • Perinatal services have been in recovery for an extended period and there is limited assurance for the overall quality of care and patient experience, however good assurance in terms of governance by the care group board and robust oversight. Monitoring, includes the fortnightly review by Executive clinical triumvirate and Committee will receive a monthly progress report going forward. • Six teams continue to work towards recovery. Ongoing concerns about what is classed as business continuity is being discussed in the oversight meeting and whether escalation processes are being followed and adhered to. **Other business matters:** • Committee is interested in the number of patients who might be looked after away from their homes (out of area placements), across the Trust's geography, as this impacts on them and their families/carers. This will be investigated to check if we have a 'legacy performance measure' that might help understand the position.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: **From the Care Groups:** • Both care groups had no breaches in mixed sex accommodation and 72 hour target was met. **DTVF:**

		• There is good assurance following a second review of a data from November 2024 to January 2025, which has revealed that whilst some patients are being admitted to Crisis Assessment /Health Based Places of Safety when waiting for an inpatient bed, they are safe and cared for. The position is understood and recommendations are broadly the same as from the first review and relate to procedure, accuracy of reporting and quality and safety standards with an escalation process to be developed by the service Matrons. • Bed occupancy has reduced to 98%, following levels over recent months of over 100% • Patients rating services as good or very good during February was 94.81%, which is above target. All specialties above target for statutory/mandatory training. • Increased number of wards are completing audits for post rapid tranquilisation monitoring. **NYYS:** • No mechanical restraint or seclusion. • 93% of patients reported feeling safe in MHSOP, 82% in AMH. • Following the implementation of several actions to support improving **compliance with section 17 leave**, the audit results for March 2025 are consistent in areas that patients are being offered a copy of their S 17 leave and the accompanying person has been consulted prior to leave and contact numbers shared. Associate Nursing Directors are focusing weekly to improve 'informal patients' time away from the ward' and the recording of leave in liaison with the Mental Health Legislation team. **Other business matters:** • **CQC Activity and Delivery of the Trust's CQC Improvement Plan** 96% of the actions from the Improvement Plan are complete. For the actions outstanding - compliance with ILS training, this is now at 70% and embedding the harm minimisation policy and face to face training will fully complete another action once the course data is fully automated and available on IIC. Committee approved two change requests to must do actions relating to the door replacement programmes and to suspend the improvement plan for the implementation of e-roster within community services, which will be monitored via alternate governance forums. • The timeline for the annual consultation, review and approval of the **Trust's Quality Account 2024/25** (a statutory duty for all NHS Providers), demonstrates good assurance on the process for stakeholder consultation, internal review approval and publication. The Quality Account is published by 30 June each year. Committee approved the proposed timeline. • The Quality Impact Assessments and Equality Impact Assessments have been merged into a single **Quality and Equality Impact Assessment (QEIA).** There is good assurance relating to the visibility of all the assessments across the Trust. The clinical triumvirate will receive assurance on the forthcoming QEIAs. This includes assurance that consideration is being given to the clinical, quality and safety impact of the changes being proposed. 24 out of 82 QEIAs have been approved by the panel to date, which is an increase due to cash releasing efficiency savings (CRES) schemes being asked to complete the QEIAs. AuditOne will undertake a review of QEIA processes as requested by the Audit and Risk Committee. • **Board Assurance Framework:** The Committee considered that there was good assurance on the management of the strategic risks assigned to it. It was noted that the score of BAF risk 8 (Co-creation) had reduced but not to its target level as there was a need to ensure that the Co-creation Framework was embedded. In addition, confirmation was awaited that the score of BAF ref 8 (Quality Governance) had reduced. This would be provided in Q1, 2025/26. The reduction in the risk score was supported by the Committee.

2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: **From the Care Groups:** **DTVF:** • Improvements have been made with **compliance for section 17 leave** with good compliance in MHSOP and ALD, however secure inpatient services (SIS) appear to be non-compliant due to the way leave is being recorded. (leave within the perimeter being recorded as unescorted). Adult wards, particularly in Durham are also a concern and recent leadership changes have been made. Committee agreed an action for the care group to remove the figures for SIS and bring the data back to next month's meeting to understand the impact this is having on the compliance rating. • The enhanced oversight measures on Birch ward have been stepped down. • Six out of seven ALD patients at Bankfields Court are clinically ready for discharge. Discussions continue with the ICB and LA to secure placements. **NYYS:** There was one supine restraint greater than ten minutes on Esk Ward. Review is underway. **Other business matters:** • **The Quality Dashboard** continues to be developed and at the present time is not being used to provide assurance or directly inform decision making until known data quality and technical reporting issues are fully resolved. Committee therefore took reasonable assurance relating to the operational and strategic oversight of the key quality and safety measures within the Quality Dashboard. The governance route of the dashboard will be to the Executive Directors Group Quality and Performance meeting (week 4) before being reported to the Quality Assurance Committee. Care groups will be equipped as a first line defence with the tools and measures to identify emerging trends or areas of concern. • **Board IPR - Waiting Times:** There is good assurance relating to the oversight of the quality of services being delivered, however reasonable assurance linked to waiting times as the impact on quality for those patients waiting to access our services is not fully understood. The longest waiting times are for those people trying to access neurodevelopmental assessments, where discussions continue with the ICBs and an all-age neurodevelopmental steering group has been established to oversee internal and external work across respective ICB areas and to align with the Community Transformation Programme Board. The other area of long waits is for adults waiting for their second contact with Talking Therapies. • There were no breaches of **mixed sex accommodation (MSA) in 2024.** There is good assurance relating to the Trust position for MSA and reasonable assurance linked to the position for sexual safety within the Trust. New categories for recording incidents of sexual safety went live on 1 April 2025. Four moderate physical harm incidents occurred. (Two in the community with appropriate safeguarding follow up and two in inpatients, one of which was incorrectly recorded and the other being a historic event for which details could not be established) • There is reasonable assurance relating to the actions underway to improve the use of clinical outcome measures, reporting and monitoring, however there is limited assurance on CiTo related actions, due the change freeze which is still in place leaving eight actions on hold. Leadership visits are now going to include conversation and guidance about clinical outcomes. • Committee were made aware of recent changes to staffing in the CQC with new inspectors in post who are seeking more clarity and assurance on low level queries, which is impacting on time and resources.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considers that good assurance can be provided that the risks to quality are understood and are being managed appropriately.

3	**Actions to be considered by the Board**	That the Board note the report and take good assurance that there is robust oversight and management of risks to quality of care.
4	**Report compiled by**	Bev Reilly, Chair of the Quality Assurance Committee, Deputy Chair of Trust/Non-Executive Director, Kedar Kale, Executive Medical Director and Donna Keeping, Corporate Governance Manager

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Communications Dashboard

February - March 2025

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our communications objectives

We take a strategic approach to our communications which underpins Our Journey to Change and delivers the following communications objectives:

- Increase public confidence
- Support a culture of co-creation
- Strengthen partnerships
- Enhance staff engagement
- Provide accessible and timely information

Objective	Examples of how we've been doing this since our last report
Increase public confidence	• 111 news stories • Supported children's mental health week (see insights below)
Support a culture of co-creation	• Working with involvement members to co-create our upcoming prevention campaign, called 'You Matter' • Created a co-creation podcast and hosted it on YouTube
Strengthen partnerships	• Provided support for Overview and Scrutiny Committee (OSC) meetings • Responded to 70 Freedom of Information (FOI) requests
Enhance staff engagement	• Shared our staff survey results, with resources for managers • Monthly CEO webinar
Provide accessible and timely information	• Developed a communications cascade to share the publication of our CQC crisis report • Working with speech and language therapy colleagues to develop an easy read photo consent form • Set up a working group to improve our patient and carer information

Monthly review

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Some of our key pieces of work

Communications:

- Communications delivery planning for 2025-26
- Our Journey To Change strategy communications planning
- CQC crisis report
- CEO announcement
- Secretary of State meeting with families
- Campaign planning (including our prevention campaign)
- Annual staff survey results
- TEWV 5k and 10k events
- Right Care Right Person
- Cito communications
- Star awards planning
- Agreed awareness weeks/days – including children's mental health week
- Horizon scanning

Corporate affairs and stakeholder engagement:

- Planning for membership/ governor elections
- Quality account
- Quality board communications cell - monthly meetings and ongoing liaison
- Primary care communications – supporting our GP education and liaison colleagues
- Meeting with GP federation CEO (H&SH)
- Support for Overview and Scrutiny Committee (OSC) meetings
- NHSE NEY communications network meeting
- Meeting with CNTW - comms team to comms team
- NENC ICB comms directors meetings

Highlights


News › Teesside News › NHS

Learning Disability Nurses of the Year: Teesside women scoop national award

Sue Sargeant and Claire Donnelly were named Learning Disability Nurses of the Year

By Kirstie McCrum Network Content Editor
04:28, 25 MAR 2025

Bookmark Comments 2

Sue Sargeant and Claire Donnelly picked up the award at the British Journal of Nursing Awards (Image: TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST)

Get the latest Teesside Live breaking news on WhatsApp
Join us on WhatsApp
Our community members are treated to special offers, promotions and adverts from us and our partners. You can check out at any time. More info

TOP STORIES

Two Teesside nurses have received national awards for their work at a ceremony in London.

Gained regional press coverage around Sue Sargeant and Claire Donnelly winning Learning Disability Nurses of the Year

Planned and filmed with the family of Chris Irish, who sadly died in our care. His family told us more about their new campaign Chris's Voice.


NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Farewell for Brent

Thursday 10 April, 3.30-5.30pm
West Park Hospital, Darlington

I'd be delighted if you could join me for a farewell gathering for Brent Kilmurray

on Thursday 10 April, 3.30-5.30pm
at West Park Hospital, Darlington

This is a chance to say our goodbyes and extend our best wishes to Brent before he heads off to Mid Yorkshire NHS Teaching Trust.

Please RSVP by 7 April 2025.

David Jennings

Planned and delivered internal, external and partner communications around our CEO announcement

Promoted and helped organise our first ever TEWV 5k running event at HMP Kirklevington Grange

Media and online

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In the media

24
Media enquiries handled by the team

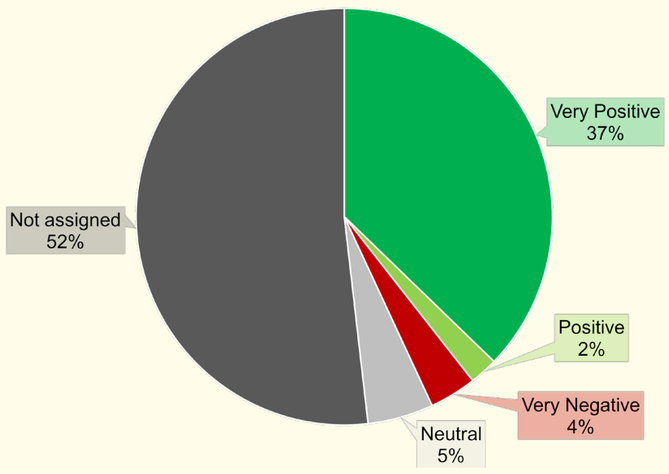
35
Media releases issued

111
Total pieces of coverage across online news, TV, and radio

Some of our news stories

- **Nursing achievements celebrated at BJN 2025 Awards** – *Independent Nurse*
- **More than 100 trees planted at Foss Park Hospital in York** – *York Press*
- **Bereaved mum speaks out after CQC inspection of TEWV** – *Northern Echo*
- **Patients' artwork to remember Covid challenges** – *BBC Online*
- **NHS Trusts to Receive Solar Panels in Government Energy Project –** *ITV Tyne Tees*
- **Boss of scandal-hit NHS foundation trust announces departure to take up new job –** *Chronicle Live*
- **Almost 150 runners take part in first Teesside NHS 5k** – *Northern Echo*
- **78-year-old Harrogate woman to take on 10km charity race** – *Your Harrogate*
- **Sue continues farm fundraising at TEWV 10k** – *Harrogate Informer*

Media sentiment



The media monitoring system doesn't always assign sentiment. We will manually add this where needed in the future

Our website

109,136
page views

Top three visited pages

1. Services
2. Careers
3. Locations

Staff intranet

117,542
page views

Top staff intranet news stories

1. New staff benefit, Serve and Protect credit union
2. Sue and Claire win at national awards
3. Mental health practitioners in GP surgeries

Social Media

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Our audience

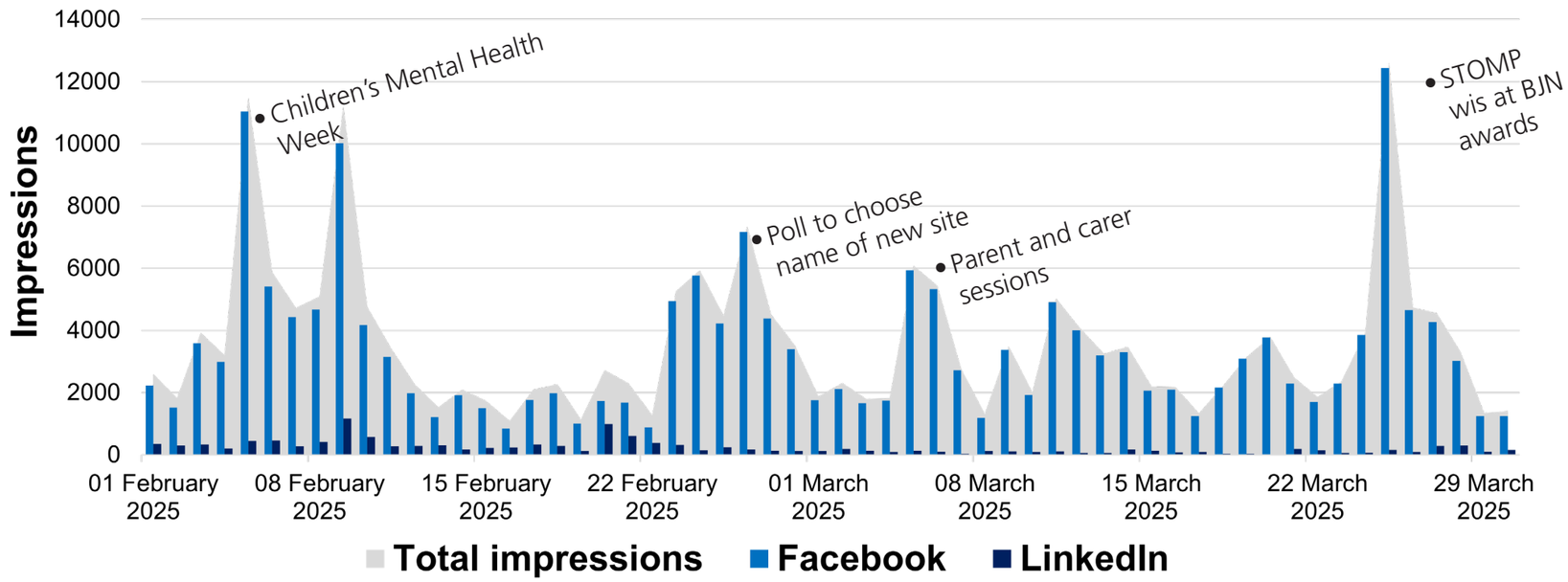
28,203
Total followers

380
New followers

173,163
People who saw our content - impressions

56
Total posts

Daily impressions



Top posts

Impressions 15,613 - Engagement 457

Impressions 2,599 - Engagement 154

Insights

Each month our team develops an 'insights' case study on a project we've worked on and evaluated. This demonstrates the impact of that project and enables us to continuously reflect, celebrate successes and improve.

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This month

Children's Mental Health Week

Children's Mental Health Week (3-9 February 2025) with Place2Be aims to empower, equip and give a voice to every child in the UK. The theme this year was 'Know Yourself, Grow Yourself'.

Campaign objectives

- To increase visits to CAMHS homepage by 10% during the campaign period.

  Outcome: *We increased visits to the CAMHS homepage by 79%*

- To raise awareness of children's mental health by reaching 1,000 Facebook viewers.

  Outcome: *We achieved 41,244 views of our content and reached 22,606 people*

How we measured success:

- 42 pieces of content generated and shared across web, intranet, internal comms channels and social media
- An engaged social media audience (including non-followers)
- CAMHS staff were onboard and enthusiastic about sharing the message of Children's Mental Health Week and strong relationship between Lynne Brown, CAMHS service development manager, and communications colleagues
- A good balance of stories captured from across the Trust's wide geographical area
- Clear focus on the theme of growth and resilience and strong call to action, with content planned for every day of the week
- Exceeded objectives to increase visitors to the CAMHS homepage and social media reach, which evidences the impact of the campaign (see below)

CAMHS homepage

In last 28 days (27 Jan – 23 Feb):

- 10th most visited page on Trust website
- 430 views
- 22 seconds average engagement time
- 79% increase in visits (compared to preceding 28-day period)

Most visited CAMHS webpages	Visits in last 28 days (27 Jan-23 Feb)	Visits in preceding 28 days (30 Dec-26 Jan)	% change
CAMHS Home	430	240	+79.17%
CAMHS Durham and Darlington neurodevelopmental assessment	334	235	+42.13%
Guide to CAMHS	191	128	+49.22%
Durham and Darlington CAMHS	81	53	+52.88%

Top Facebook posts	Views	Reach	Interactions
Anem's journey	15,383	7,444	68
Recovery College Online	5,546	3,136	39
York and Durham CAMHS seed planting	5,516	3,201	25
Meet our staff	5,193	3,113	31
Redcar CAMHS bake off	3,814	2,273	24
Miles of smiles (throwback)	3,182	1,912	8
Resilience tips from students	2,610	1,507	14

Facebook

In last 28 days (27 Jan – 23 Feb):

- There were 41,244 views of our content, our content reached 22,606 people and there were 209 interactions with our content (such as 'likes')
- The most viewed post on the Trust's Facebook page had 15,383 views (52% were non-followers), with a reach of 7,444 reach and 68 interactions
- Internally on Team TEWV, there were 11,572 views of our content, with 954 post engagements (likes etc)

Qualitative insights

"[The content] has already led to a number of emails so hopefully that's an indication that it has made people think."

"Thank you so much it means so much!! …The piece looked amazing"

"I've been in touch with Anem this morning and she is over the moon about this piece of work coming together and seeing her lived experience shared more widely."

"Thank you Stephanie (in the communications team)! You have done an amazing job!"

Anem, who shared her story about recovery and resilience for Children's Mental Health Week

Our work

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Our ongoing work

Communications:

- Campaign planning
- Monthly CEO all staff webinar
- Ongoing PR campaign/ good news stories
- Responding to media enquiries
- Patient and carer information

Corporate affairs and stakeholder engagement:

- Policies
- Freedom Of Information (FOI)
- Governor engagement
- Internal MP briefings
- Monthly partner newsletter

Intranet news
36
stories posted
~4.5 a week

Email enquires
1,393
email requests
~35 a day

Team TEWV
staff Facebook group
276
posts
576
comments
2,425
total members
63 new members

Freedom of Information requests
81
received
~10.1 a week
70
responded to
~8.8 a week

All staff emails
43
sent
~5.4 a week

Patient information
6
updated

MP briefings
4

Partner newsletter
20
stories shared

What we're working on

Star Awards 2025

Our annual awards will take place later this year in County Durham, celebrating the #TEWVstars who go above and beyond in everything they do.

We're in the early stages of planning the event, which includes:

- Reviewing our award categories and criteria and working with colleagues across our Trust to get feedback
- Acting on post-event feedback to refresh the look and feel to incorporate a star

2025 will be our fourth annual Star Awards. Last year saw a record number of over 500 nominations submitted!

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Committee Key Issues Report				
Report Date: **4 April 2025**		**Report of: Charitable Funds Committee**		
Date of last meeting:		3 March 2025 – The meeting was quorate		
1	**Agenda**	The agenda included: - Committee terms of reference - A report on the revised structure of the funds - An update on trust funds for the period April to September 2024. - A discussion on the Trust's charitable funds strategy - Feedback from the NENC region Charity Chair's and Senior Officers meeting		
2a	**Alert**	Committee approved the revised funds structure, which aim to support the Trust to maximise the benefit from Trust charitable funds, including the appropriate amalgamation of numerous low value funds. Whilst committee will monitor all aspects of charitable funds activity within the Trust and provide assurance to the board that the Trust's Charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales, the board is reminded that they are the Trustees of the Charity.		
2b	**Assurance**	Committee confirmed that the Charitable Funds would be considered by internal audit in 2025/26. Committee was assured on fund transactions and activity for the first two quarters of 2024/25, including learning taken from previous application rounds for the Capt. Sir Tom funds.		
2c	**Advise**	Committee discussed and agreed the establishment of a one-year fixed term fundraising / sponsorship post (reviewed at that point) and job description to be developed. This post holder would be required to co-create charitable funds strategy, create brand identity and web presence and establish a digital platform for donations. Committee will explore the potential to repurpose Trust laptops with the Chief Information officer. The Chair and Executive Director of Corporate Affairs and Involvement/Head of Communications will participate in a NENC region Charity Chair's and Senior Officers meeting, which although acute focused, provides an opportunity for learning and to explore areas of collaboration.		
2d	**Review of risks**	There are no BAF risks relevant to this committee.		
3	**Actions to be considered by the Board**	Committee proposes a small amendment to the terms of reference to also include reference to not placing the Trust's reputation at undue risk (paragraph 3.15).		
4	**Report compiled by**	J Preston, Chair and A Bridges, Executive Director for Corporate Affairs and Involvement	**Minutes available from**	K Christon Deputy Company Secretary

CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION

1.1 The Charitable Funds Committee is established under Standing Order 6 of the Board of Directors.

1.2 The Standing Orders of the Board of Directors, as far as they are applicable and with appropriate alterations, shall apply to meetings of the Committee.

1.3 All meetings of the Committee will be held in private unless agreed by the committee.

2 STRATEGIC PURPOSE

2.1 Provide assurance to the Board that the Trust's Charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales.

It does not remove from the Board the overall responsibility for this area but provides a forum for detailed consideration of charitable matters and allows for direct contact with the Charity Commissioners via the Trustees of the Charity when necessary.

2.2 Monitor all aspects of Charitable activity within the trust, as set out within its terms of reference; and

2.3 Maintain oversight of the appropriate use of funds.

3 FUNCTIONS

3.1 Ensure the Trust's Charitable activities comply with current legislation and review new legislation and its impact (i.e. Trustees Act 2000, SORP 2005 & The Charities Act 2006, Charities Act 2011).

3.2 Set and review an investment policy for the charity.

3.3 Appoint brokers to manage the charitable funds (if deemed appropriate).

3.4 Review the performance of the charities investments (as managed by its brokers, if appropriate).

3.5 Review individual fund balances and income and expenditure transactions within the overall charity at each meeting.

3.6 Seek expenditure plans from individual fund holders where funds are currently not being used.

3.7 Agree guidance and procedures for fund holders to apply to access fund balances (within new delegated approval limits established as up to £1k for Fund Managers, up to £10k for Director of Finance, Estates and Facilities, and over £10k the Charitable Funds Committee itself) and oversee the appropriate use of all funds including Trustee Funds.

3.8 Review relevant audit recommendations including consideration of Independent Review by external auditors.

3.9 Review the Annual Report and Accounts for the Charity prior to their submission for approval by the Trust Board and ensuring their production in accordance with the latest accountancy practice and policy as laid down by the Charity Commission for England and Wales.

3.10 Oversee the development of the strategy and objectives for the Charity (including any fundraising plans).

3.11 Ensure the funds are administered in an efficient and effective method that supports use of the funds.

3.12 Ensure the funds are utilised in accordance with the objects of the charity and where stipulated, purposes for which they are given by the donors.

3.13 Establish a process for the periodic review to rationalize funds within the powers granted by the Charity Commission where the original objectives have failed or are no longer relevant.

3.14 Encourage a culture of income generation and raise the profile of the Charity within the trust and local population to promote fundraising plans.

3.15 Approve promotional material of the Charity on behalf of the Trustees to ensure that material used will not place the Trust or Charity reputation at undue risk.

3.16 Agree the basis for allocating interest received from investments and applying management and administrative charges.

4 DELEGATED AUTHORITY

4.1 Committee is authorised by the Board to investigate any activity within its purpose and functions.

4.2 The committee is a standing committee of the Board and will continue to meet in accordance with these Terms of Reference until the Board determines otherwise.

4.3 The committee will consider arrangements for virtual approval of applications for funding where these arise unexpectedly (without advance awareness of spending plans) to ensure responsiveness to emerging requests.

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

5 MEMBERSHIP

5.1 The Committee will comprise:

- A Non-Executive Director as Committee Chair
- One other Non-Executive Director as Deputy Chair
- Executive Director for Finance, Estates and Facilities
- Executive Director for Corporate Affairs and Involvement

5.2 The Chair of the Committee shall be appointed by the Board of Directors.

5.3 Deputy or substitute members (with voting rights) may be appointed by Members of the Committee to attend particular meetings, on their behalf, where their absence is unavoidable. Notice of the appointment of a deputy/substitute member must be provided to the Chairman of the Committee and the Company Secretary, in writing, before the meeting commences.

6 ATTENDANCE AT MEETINGS

6.1 All other Board Members shall be invited to attend and participate in meetings of the Committee (but not to vote). To facilitate this, copies of all agendas and papers for meetings will be provided to them.

6.2 Officers of the Trust shall be invited to attend meetings of the Committee to deliver reports and to support the Committee's discussions on them. In particular, this will include the Head of Accounting and Governance, representatives of the Health and Wellbeing Council and Lived Experience and/or patient/carer representatives, as appropriate to agenda items.

6.3 External independent experts may be invited to attend meetings where their advice would be beneficial in the consideration of matters within the purpose and functions of the Committee.

6.4 Subject to the agreement of the Board, the committee may invite a specified number of service users or carers to attend and participate in meetings of the Committee (but not to vote) in order to gain their perspectives on matters under consideration.

7 SECRETARY

7.1 The Company Secretary, or an officer appointed by them, shall be the secretary of the Committee.

8 QUORUM

8.1 The quorum shall be not less than three Members, one of whom must be a Non-Executive Director and one Executive Director. Other attendees do not count towards quoracy.

9 FREQUENCY OF MEETINGS

The Committee shall meet at least three times a year. The arrangements for these meetings shall be set to support the timely provision of assurance to the Board.

10 REPORTING

10.1 Following every meeting the Chair of the Committee shall report to the next meeting of the Board of Directors:

- To advise of the business transacted.
- To escalate any material matters of concern which may require a response from the Board or which might impact on the functions of another Board Committee.
- To provide a commentary on the assurances it has received, drawing the Board's attention to any positive assurances and gaps in assurance (including actions being taken to address them).
- To provide assurance on the management of strategic and operational risks which relate to its purpose and functions and to advise the Board of any new risks identified and actions being taken to address them.
- To seek the Board's approval of any recommendations made by the Committee.
- Any other matters that the Committee considers important to bring to its attention.

11 REVIEW

11.1 The terms of reference of the Committee shall be reviewed at least annually.

Agreed: December 2024
Review by: December 2025

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**10 April 2025**
Title:	**Leadership Walkabouts Feedback – Feb & Mar 2025**
Executive Sponsor(s):	**Ann Bridges, Director of Corporate Affairs & Involvement**
Author(s):	**Ann 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		Visible leadership in our services 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 February and March 2025.

Overview:

1 **Background**

1.1 The Trust undertakes a monthly programme of regular leadership walkabouts to services. These visits are not inspections however offer an opportunity for teams to have 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 February and 31 March 2025 across a range of services including Adult Early Intervention in Psychosis (EIP), health and justice teams based in HMP, MHSOP and LD inpatient locations, CAMHS and MHSOP community, as well as crisis and home treatment team.

3 Key issues

- Strengths:
    - Team working, morale and wellbeing: teams demonstrated strong commitment to and support for each other and in some areas flexible working approach that benefits staff and patients, working in a more cohesive way. Staff was a priority and wellbeing was important priority, and measures had been or were being put in place to support colleagues.
    - Co-creation: some great examples innovation and of working collaboratively in co-creating new structured pathways for patients and their carer's, and staff felt able to bring forward ideas and encouraged to think outside the box to make the pathways person-centred.
    - Partnerships: teams were proud of the way they work in partnership with other key organisations for example on dual diagnosis, as well as across social care, the police eg right care, right person, and made reference to supporting newer members of the team in establishing strong relationships to ensure the best possible care was offered based on patient need.
    - Cito: some teams offered positive feedback on Cito, and whilst it had taken some time, teams were now seeing the benefit of it.

- Challenges:
    - Estates / environment: some teams reported issues with the environment they worked in not being suitable, eg locations not being accessible via public transport, not enough space / too small to accommodate teams and/or too hot / couldn't open windows, or lack of suitable meeting space eg sound proofing and privacy issues. Co-location could be a solution.
    - Staffing: vacancies particularly in recruiting nurses and medics, as well as recruitment processes being too complicated and taking too long, which caused some frustration.
    - IT / equipment / systems: some teams expressed frustration about lack of integration with Trust systems, connectivity and/or lack of access to systems eg multiple users in the bigger teams which often took more time. Telephone call waiting was also raised.
    - Discharge: from inpatients including those from HMP to the community can be problematic, example used of non-TEWV providers. Some community teams highlighted need to work better with our inpatient wards re discharge plans and 72 hour follow up.

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.