MEETING OF THE BOARD OF DIRECTORS
Thursday 30th June 2022
at 1.00 p.m.

The meeting will be held via MS Teams

Board Members:
Board Members are asked to raise any questions for clarification on matters contained within the reports with the lead Executive Director prior to the meeting.

The 'chat' function on MS Teams should not be used during the meeting.

Governor/Public Observation:
Invitations to observe the meeting have been sent to all Governors and posted on social media and the Trust's website. Those responding will be sent instructions to join the event using MS Teams.

If you are observing the meeting please keep your microphone on mute. No questions or statements are allowed.

The timings provided in the agenda are indicative only.

AGENDA

Standard Items (1.00 pm – 1.20 pm):

1	Apologies.	**Chair**	**-**
2	Chair's welcome and introduction.	**Chair**	**Verbal**
3	To approve the minutes of the last ordinary meeting held on 26th May 2022.	**-**	**Draft Minutes**
4	To receive any declarations of interest.	**-**	**Verbal**
5	Board Action Log.	**-**	**Report**
6	Chair's Report.	**Chair**	**Verbal**
7	To note any matters raised by Governors.	**Board**	**Verbal**

Strategic Items (1.20 pm – 1.50 pm):

8	Chief Executive's Report.	**CEO**	**Report**
9	Board Assurance Framework summary report.	**Co Sec**	**Report**
10	To consider the Integrated Performance Dashboard Report.	**Asst CEO**	**Report**

Goal 1: To Co-create a Great Experience for our Patients, Carers and Families (1.50 pm – 2.20 pm):

11	To consider key issues and risks arising from recent Directors' Visits.	**DoCA&I**	**Report**
12	To consider the report of the Chair of the Quality Assurance Committee.	**Committee Chair (BR)**	**Committee Key Issues Report**

13	To consider an assurance report on the delivery of the CQC Action Plan.	**DoN&G**	**Report**
14	To receive a briefing on patient safety specialists (PSS).	**DoN&G**	**Report**

Goal 2: To Co-create a Great Experience for our Colleagues (2.20 pm – 2.25 pm):

15	To consider the report of the People Culture and Diversity Committee.	**Committee Chair (SR)**	**Committee Key Issues Report**

Governance (2.25 pm – 2.35 pm):

16	To approve the Trust's Data Security and Protection Toolkit submission.	**DoFI&E/F**	**Report**

Matters for Information (2.35 pm – 2.40 pm):

17	To receive and note a report on the use of the Trust's seal.	**Co Sec**	**Report**

Exclusion of the Public (2.40 pm):

18	**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**	**Verbal**

Paul Murphy
Chair
24th June 2022

Contact: Phil Bellas, Company Secretary Tel: 01325 552312/Email: p.bellas@nhs.net

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 26TH MAY 2022 COMMENCING AT 1.00 PM

The meeting was held via MS Teams

Present:
Mr P Murphy, Chair
Mr B Kilmurray, Chief Executive
Dr C Carpenter, Non-Executive Director
Ms J Haley, Non-Executive Director
Prof P Hungin, Non-Executive Director
Mr J Maddison, Non-Executive Director
Mrs B Reilly, Non-Executive Director
Mrs S Richardson, Senior Independent Director and Deputy Chair
Mrs R Barker, Associate Non-Executive Director (Non-voting)
Mr J Preston, Associate Non-Executive Director (Non-voting)
Mrs E Moody, Director of Nursing and Governance/Deputy Chief Executive
Mrs L Romaniak, Director of Finance, Information and Estates
Mr P Scott, Managing Director, Durham, Tees Valley and Forensics Care Group
Dr S Wright, Interim Medical Director
Mrs A Bridges, Director of Corporate Affairs and Involvement (Non-voting)
Dr S Dexter-Smith, Director of People and Culture (Non-voting)
Mrs S Pickering, Assistant Chief Executive (Non-voting)

In Attendance:
Mr S Adamson, Director of Estates, Facilities & Capital
Mr P Bellas, Company Secretary
Dr J Boylan, Guardian of Safe Working (minute 22/47 refers)
Mrs. W Johnson, Team Secretary

Observers/Members of the Public
Mrs K Christon, Deputy Company Secretary (Designate)
Dr S Baxter, Public Governor for Redcar and Cleveland
Mrs J Kirkbride, Public Governor for Darlington
Mr S Double, Alders
One member of the public

22/33 WELCOME AND INTRODUCTIONS

The Chair welcomed Board Members and attendees to the meeting.

Mr Murphy also:
(1) Advised that work was continuing to enable the Board to hold hybrid meetings.
(2) Reminded Board Members of the need for an appropriate balance between introductions to reports and discussions on them following the success of the approach introduced at the last meeting.

22/34 APOLOGIES

There were no apologies for absence.

22/35 MINUTES

***Agreed** – that the minutes of the last meeting held on 28th April 2022 be approved as a correct record and signed by the Chairman.*

22/36 DECLARATIONS OF INTEREST

There were no declarations of interest.

22/37 PUBLIC BOARD ACTION LOG

The Board received and noted the Board Action Log.

It was also noted that arrangements were in hand to hold a strategic discussion on workforce issues in accordance with minutes 22/12 and 22/13 (28/4/22).

22/38 CHAIRMAN'S REPORT

Mr Murphy reported that:

(1) The frequency of meetings at a system level was increasing as the ICSs moved towards statutory establishment. Progress was also being made on appointments to the organisations and budgetary and financial matters.

(2) He and Mrs Richardson had continued to visit services including to present Living the Values Awards. Recent visits had been held to Bishop Auckland and Harrogate where they had been warmly welcomed. Staff had recognised the improvements made over the last 12 months with the successful recruitment of staff and the filling of vacancies.

(3) With Mr Maddison and Mrs Bridges he had also visited Foss Park in York. They had been very impressed with the fantastic building and fabulous staff.

(4) He had attended the inaugural lecture provided by Prof. Nick Rowe at York St John University which had been inspirational.

The Board noted that Prof Rowe was the founder of the Communitas Choir which was part of the Converge Centre; a collaboration between the University and the NHS to offer educational opportunities to adults who used mental health services.

Mr. Murphy recognised the excellent partnership between the Trust and the University.

Mr. Murphy also advised that he was intending to visit forensic services four times in June 2022 and would provide an update to the Board in his next report.

22/39 MATTERS RAISED BY GOVERNORS

It was noted that no matters had been raised by Governors for consideration at the meeting.

22/40 CHIEF EXECUTIVE'S REPORT

The Board received and noted the Chief Executive's Report.

Mr. Kilmurray drew attention to the following matters:

(1) The conversations taking place within the North East and North Cumbria (NENC) ICS on the creation of a collaborative which would take on responsibility for the strategic planning and service delivery of mental health, learning disability and autism services across the region.

He and Mr. Duncan, the Chief Executive of CNTW, were keen to ensure co-creation with partners, service users and carers in the development of the collaborative from the outset.

The Board noted that the collaborative was not expected to have commissioning powers, initially, but would create an inclusive process for setting clear clinical and social standards; provide frameworks for the consideration of investments at a place level; drive clinical networking and good practice; and bring together whole pathway strategic developments.

Mr. Kilmurray considered it to be a positive development and undertook to keep the Board updated on progress.

(2) His appointments as the Chair of the Humber and North Yorkshire Mental Health, Learning Disability and Autism provider collaborative and the Senior Responsible Officer for the mental health and learning disability programmes; both of which he was looking forward to commencing on 1st June 2022.

(3) The positive recent meeting with the Board of the Thirteen Group, in the context of the Trust's strategic goal "to be a great partner, from which it had been evident that there was a great deal of common ground between the organisations.

(4) The visit by Tom Cahill, the NHS National Director for Learning Disability and Autism on 17th and 18th May 2022 which had provided an opportunity to share the Trust's current experience of learning disability services and its perspectives on the autism agenda.

The Board noted that Mr. Cahill had met service users and staff whilst visiting a community team and Bankfields Court. He had also been introduced to Mr Paul Newton, the Managing Director of Positive Independent Proactive Support Ltd (the Trust's subsidiary providing complex care) which he had recognised as a good solution to the challenges being faced in the provider market.

Whilst appreciative of the way the ICS was developing Prof Hungin highlighted a recent meeting, which he had attended with Mr Preston, where discussions on health inequalities and deprivation had focussed exclusively on acute physical problems. He considered that the system needed to be reminded that mental health issues also impacted significantly on mortality and morbidity.

Board Members echoed Prof Hungin's views and expressed their disappointed that it remained the case that mental health issues were afforded less emphasis.

The Chair reassured the Board that he sought to be a strong advocate for the importance of mental health services through his regular attendance at meetings at a system level.

It was also noted that:

(1) The high incidence of acute physical problems affecting people with mental health conditions needed to be promoted in the context of the ICS's statutory duty to tackle health inequalities.

(2) Mental Health and learning disabilities services had equal status to acute providers on the Boards of both ICSs and were well represented by Michelle Moran and Dr Rajesh Nadkarni on the Humber and North Yorkshire (HNY) ICB and NENC ICB respectively.

(3) Tackling health inequalities would remain challenging unless resources were made available. There were difficulties in lobbying for this, at present, as discussions on the funding formula had been paused.

In addition, the Board noted that the Trust continued to make progress on the delivery of the CQC action plan.

Ms. Haley considered that, given its importance and for assurance and transparency, the Board should receive a full update before July 2022 (as referenced in the report).

Whilst noting that the delivery of the action plan was being monitored by the Quality Assurance Committee it was considered appropriate to receive an interim report at the Board meeting to be held on 30th June 2022.

Action: Mrs. Moody

22/41 AUDIT AND RISK COMMITTEE

The Board received and noted the key issues report on the business transacted and matters arising from the meeting of the Audit and Risk Committee held on 20th May 2022.

It was noted that there were no issues or risks for escalation to the Board.

Mr. Maddison, the Chair of the Committee, highlighted the following matters:

(1) The good progress being made on the preparation of the Head of Internal Audit's Annual Report and Opinion and the Annual Governance Statement.

(2) Excellent work had been undertaken by the Director of Finance and Information and the Finance Team on the annual accounts. The Committee had reviewed a report on significant movements since the previous year and there had been limited questions.

The Board expressed their appreciation to the Company Secretary's and Finance Departments for drafting the Annual Governance Statement and the annual accounts particularly, in the latter case, as the extended process for producing the financial plan had impacted on capacity.

The Chair thanked the Committee for their work and for the assurances provided to the Board.

22/42 BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

The Board Assurance Framework (BAF) Summary Report, which provided information on the alignment between the strategic risks and the matters due for consideration during the meeting, was received and noted.

22/43 DIRECTORS' VISITS

The Board received and noted a report on the Directors' visits held on 9th May 2022 to:

- NE Community York
- Durham and Chester-le-Street MHSOP CMHT
- Easington MHSOP CMHT
- Hartlepool MHSOP CMHT
- Harrogate CMHT
- Ryedale CMHT

Mrs Bridges, in her introduction to the report, advised that the feedback from the visits provided assurance that teams were fully committed to patient care; had shown cohesion, positive team dynamics and innovation (particularly through the pandemic); and had responded positively to the recent changes to the Trust's organisational and governance arrangements.

Some challenges relating to recruitment had been highlighted; however, processes had now been streamlined.

Mrs. Romaniak advised that a visit had also been undertaken to MHSOP in Stockton and similar themes had been noted.

Board members:

(1) Observed that staff were impressed that their views were considered at Executive Directors' meetings and directly by the Board.

(2) Considered that there should be greater emphasis on, and visibility of, MHSOP within community transformation.

Mr Kilmurray undertook to raise this matter with Dr. Wright and the Managing Directors.

(3) Questioned how learning from the Directors' visits was shared particularly with peers.

In response Dr. Dexter-Smith undertook to raise the matter with Mr Bartley, the Associate Director of Improvement and Redesign.

It was also noted that the clinical networks had a key role to play in this area and conversations were being held within the Care Group Boards focusing on learning.

The Chair asked Mr. Scott to liaise with Dr. Dexter-Smith and Mr. Bartley to ensure that a virtuous cycle of learning was developed.

22/44 QUALITY ASSURANCE COMMITTEE

The Board received and noted the key issues report on the business transacted and matters arising from the meeting of the Quality Assurance Committee held on 5th May 2022.

It was noted that there were no issues or risks for escalation to the Board.

Mrs. Reilly, the Chair of the Committee, reported that:

(1) There were no new matters to bring to the Board's attention from the perspective of the Care Quality Commission or from the reports from the Localities as similar themes had been evident for some time.

(2) Future reporting to the Committee from the Care Groups had been the subject of recent discussions with Mr. Scott including the benefits of holding a "time out" to develop the approach.

(3) The safe staffing report presented to the Committee had highlighted an increase in staff working shifts in excess of 13 hours.

It was considered that the Board needed to keep this matter under review.

(4) The data in the Trust Level Quality and Learning Report and the Positive and Safe Annual Report had highlighted an increase in incidents relating to self-harm and, whilst in the latter report all the Trust set metrics were within normal variations, there was an upward trend for rapid tranquilisation, seclusion and self-harm. Mrs. Moody had agreed to undertake a detailed piece of work on these matters.

(5) The Committee would continue to maintain oversight of the delivery of the ligature reduction programme and would escalate any risks to the Board.

Mrs Reilly also advised that, at the request of Mr Kilmurray, the Committee had listened to Viktor's story.

The Board noted that Viktor had taken his own life, at home, at the age of 23 whilst under the care of the Trust. His parents had unresolved concerns about the care and treatment offered to their son and were dissatisfied with the process and outcome of the associated serious incident review. In view of this the Trust had commissioned an independent review which had highlighted many areas of learning throughout Viktor's care and had concluded that he had not received an evidenced based, multi-disciplinary care and treatment programme in line with his needs and there had been some weaknesses in the Trust's investigatory process.

The Trust had accepted the recommendations of the independent review and had developed an improvement plan to address key areas of learning.

The Committee, whilst recognising that oversight of the delivery of the improvement plan would be the responsibility of the Care Group Boards, had requested, as a commitment to Viktor and his family, that an update on progress be provided in six months' time.

Mrs. Reilly paid tribute to Viktor's parents for their courage and determination in advocating for him in his life and ensuring that the Trust learnt from his death. They had wanted the Committee and the Board to be aware of his story.

Mr. Kilmurray advised that Viktor's parents had spent time with the Trust supporting the review of investigation processes and it was important for the issues to be kept in sight and for the improvement plan to be delivered.

Mr Preston observed that, since his appointment to the Board, it was evident that serious incident processes had improved in terms of the quality of feedback and learning; however, he considered that the Trust needed to focus on ensuring that the learning was retained and taken forward rather than being a one-off exercise.

Mrs Moody advised that retaining learning was challenging for all organisations. The Trust's approach was to have all learning in one place based on themes; to consolidate learning and improvements to date; and to have a set a range of measures, both qualitative and quantitative, to seek to measure its impact in terms of patient experience and on the incidence of serious incidents. This would enable the factors which made the greatest difference to be understood and assurances to be provided to the Board that learning was effective and being retained.

The Chair thanked Mrs Reilly and members of the Committee for their work on behalf of the Board.

22/45 MENTAL HEALTH LEGISLATION COMMITTEE

The Board received and noted the key issues report on the business transacted and matters arising from the meeting of the Mental Health Legislation Committee held on 17th May 2022.

It was noted that there were no issues or risks for escalation to the Board.

Prof. Hungin, the Chair of the Committee, reported that:

(1) Traditionally the Committee had received a lot of data; however, more recently, it had started to consider the factors and circumstances which impacted on it in the context of the provisions of the Mental Health Act.

He complimented the MHL team on the improvements to reporting which had allowed the Committee to do this.

(2) The Committee had derived significant benefits from the discussions at its recent development session and urged colleagues to take a similar approach for the other Board Committees.
(3) The new Mental Health Act would not only impact on the collection of information but also on which part of the care system was responsible for care. Further information would be presented to the Board as clarity was gained on its implications.

Prof Hungin advised that the Committee had also received a case study concerning the provision of care to patients with very complex needs. This had brought home to its members the very real and challenging issues in providing care to these individuals and had given greater insight than could be achieved solely by the data.

The Chair commended the Committee for holding the development session and advised that he would be attending one of its future meetings to see the progress being made.

22/46 PEOPLE CULTURE AND DIVERSITY COMMITTEE

The Board received and noted the key issues report on the business transacted and matters arising from the meeting of the People Culture and Diversity Committee held on 10th May 2022.

It was noted that there were no issues or risks for escalation to the Board.

Mrs. Richardson drew attention to the following matters:
(1) The colleague story and the discussions arising from it which had focussed on how staff with long-term conditions could be supported, through reasonable adaptations, to continue in employment.
(2) The identification of an additional risk for inclusion in the Corporate Risk Register (CRR) in relation to 'missing data'.

The Committee had noted the work being undertaken by the Director of People and Culture and her staff to ensure the information was visible and mainstreamed.
(3) The evolution of the information available on compliance with the public sector duty under the Equality Act.

It was noted that data from the patient record system and Meridien now enabled an in-depth analysis to be undertaken to identify any statistically significant differences within protected characteristic groups across a number of measures. On the suggestion of Ms Haley, the Committee had agreed that the next version of the report should include additional detail of the key areas of significant difference and the actions which it was proposed to take from an assurance perspective.
(4) The work being undertaken on rewards and recognition which would bring the Trust's well-being offer together.
(5) The improvements made through the work undertaken by the People and Culture Directorate as evidenced in the metrics presented to the Quality Board (previously circulated to Board members in accordance with minute 22/12 – 28/4/22).

Dr. Dexter-Smith highlighted the position on a range of key workforce metrics which demonstrated significant improvements in the time taken for recruitment, particularly the completion of pre-employment checks, and increases in the number of staff commencing work; a high response rate to the last pulse survey compared to other Trusts; improvements to compliance with mandatory training requirements; and stability in the sickness absence rate.

The Board noted that the integrated performance report and data held within the Directorate provided clarity on areas of focus going forward. The data collated under the Equality Act enabled the protected characteristics to be considered at each part of the clinical pathway.

Mr Maddison, the Chair of the Audit and Risk Committee, advised that counter fraud referrals had been received about staff working whilst on sick leave and asked whether a report could be provided on the outcome of those cases.

Dr. Dexter-Smith undertook to provide a joint report on this matter to the Audit and Risk and People, Culture and Diversity Committees which would also reference the work being undertaken on embedding the Trust's values.

Action: Dr Dexter-Smith

22/47 GUARDIAN OF SAFE WORKING

The Board received and noted the annual report of the Guardian of Safe Working which provided assurance that junior doctors were safely rostered with working hours that were safe and in compliance with their terms and conditions of service.

Dr. Boylan was satisfied that the Trust continued to fulfil the spirit and terms of the contract and recognised that the Board has been attentive and supportive of concerns and the wellbeing of junior doctors over the past year.

He highlighted two areas for continued monitoring:

(1) The pressures on services particularly in Teesside and Scarborough where a significant proportion of the fines for breaching the contract had been levied.
(2) The challenges with recruiting senior medical staff which raised concerns about the maintenance of appropriate levels of supervision for junior doctors.

The Board considered the impact of the challenges faced by the Trust on its attractiveness to trainee doctors.

Dr. Boylan considered that the position was mixed. On the one hand the Trust had a strong reputation, evidenced through the annual surveys, for training and education. On the other, trainees were mindful of the workloads and working conditions of senior medical staff. Recent experience suggested that trainees remained interested in working for the Trust but retention and supervision were key issues for them.

Mrs. Reilly, referencing the significant increase of shifts worked that exceeded 13 hours (minute 22/44 refers) and noting the processes in place to safeguard the working hours of junior doctors, questioned the arrangements in place to support other professional groups.

On this matter:

(1) Dr. Wright considered all staff needed to feel valued and invested in and the Board should be challenging itself on how team working was developed and maximised.
(2) Mr. Kilmurray highlighted the importance of multi-disciplinary training, staff wellbeing and retention.
(3) Mrs. Moody highlighted the nursing workforce standards which were monitored through the PCDC; the oversight of excess working hours by nurses by the QuAC; and the work being undertaken on 12-hour shift patterns, missed breaks and supervision.

22/48 COMPOSITION OF THE BOARD OF DIRECTORS

Consideration was given to amending the provisions in the Constitution in regard to the composition of the Board of Directors.

It was noted that the proposed changes had been approved by the Council of Governors at its meeting held on 12th May 2022 in accordance with the requirements of the NHS Act 2006 (as amended).

Agreed *– that paragraph 22.2 be amended to state:*
"22.2 The Board of Directors is to comprise:
22.2.1 a non-executive Chairman;
22.2.2 a non-executive Deputy Chairman;
22.2.3 5-9 other non-executive Directors; and
22.2.4 5-9 executive Directors."

22/49 REGISTER OF SEALINGS

The Board received and noted the report on the use of the Trust's seal in accordance with Standing Order 15.6.

22/50 CONFIDENTIAL MOTION

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

Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.

Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.

Any documents relating to the Trust's forward plans prepared in accordance with paragraph 27 of schedule 7 of the National Health Service Act 2006.

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.

Information which is held by the Trust with a view to its publication, by the Trust or any other person, at some future date (whether determined or not), and it is considered reasonable, in all the circumstances, to withhold the information from disclosure until that date.

Following the transaction of the confidential business the meeting concluded at 4.37 pm.

Board of Directors

Public Action Log

RAG Ratings:

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

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
31/03/22	22/03/14/226/14.2	Outcome of the Establishment Reviews	Further updates to be presented to the People, Culture and Diversity Committee; and the Strategy and Resource Committee	DoN&G	Jun-~~22~~ Aug-22		
28/04/22	22/15	Ockenden Report	Arrangments to be made for further assurance to be provided to the Board on the Trust's approach and the impact of changes following the Organisational Learning Group's review of the Ockenden Report	DoN&G/Co Sec	-		
28/04/22	22/16	Learning from Deaths	Arrangements to be made for the Board to gain assurance that the revised investigation procedure and patient safety strategy will have the desired impact	DoN&G/Co Sec	-		
26/05/22	22/40	Chief Executive's Report	Interim report on the delivery of the CQC action plan to be provided to the Board	DoN&G	30/06/22		See agenda item 13
26/05/22	22/46	People Culture and Diversity Committee	Joint report to be provided to the Audit and Risk and People Culture and Diversity Committees on the outcome of counter fraud cases relating to staff working whilst on sick leave	DoP&C	Sep-22		

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO 8

PUBLIC

BOARD OF DIRECTORS

DATE:	**Thursday 30 June 2021**
TITLE:	**Chief Executive's Report**
REPORT OF:	**Brent Kilmurray, Chief Executive**
REPORT FOR:	**Information**

This report supports the achievement of the Strategic Goals:	
To co-create a great experience for our patients, carers and families	✓
To co-create a great experience for our colleagues	✓
To be a great partner	✓

Executive Summary:

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

Recommendations:

To receive and note the contents of this report.

New Board Members

I am pleased to confirm that Zoe Campbell started with the Trust on 13th June as Managing Director for the North Yorkshire, York and Selby Care Group. Dr Kedar Kale starts on 27th June. Mike Brierley will pick up his new role as Assistant Chief Executive on 11th July. Following a recent meeting of the Remuneration and Nominations Committee it was agreed that the role of Director of Therapies be made a board level role. Therefore from this month Dr Hannah Crawford joins the Board.

I am sure you will join me in welcoming our new colleagues to the Board. All of the new members of the Board are doing their business chemistry assessments to facilitate future board and executive team development work.

Sharon Pickering, current Assistant Chief Executive will retire on 14th July. Sharon is keen to leave quietly, however we thank Sharon for all she has done and wish her well.

Care Quality Commission

The CQC has been inspecting our Adult Learning Disability (ALD) inpatient services at both Lanchester Road and Bankfields Court (there are currently no patients at Oak Rise). As a consequence of the inspection the team has put an action plan in place to seclusion and safeguarding, reducing restrictive practices, developing our positive behaviour support plans, reviewing CCTV to identify learning, staff training, strengthening multi-disciplinary team leadership.

We have also invited the expert team from Merseycare to undertake a External Supportive Review of our ALD inpatient services.

More broadly with regard to the CQC we expect the inspection team to return to Secure Inpatient Services and to Children and Young Peoples services before the end of June. This timing is in line with their requirement to reinspect following the completion of the S29A action plan implementation. Quality Assurance Committee and the Executive Group has been taking a regular (weekly for the Executive) overview of the completion of the embedding of key actions.

Integrated Care Boards

Integrated Care Boards (ICBs) go live on 1st July. I attached a document that sets out the detail of the operating model and detail of the Board members and senior officers of each of the ICBs in the North East and Yorkshire region.

North East North Cumbria (NENC) Mental Health and Learning Disability Collaborative development

Sam Allen, Chief Executive of NENC ICB has written to senior leaders across mental health, learning disability and autism organisations to ask that discussions and development work be undertaken to develop options for creating a multi-sector collaborative partnership to oversee the development of an ICB wide strategy, prioritisation of investment, the development of a small number of at scale initiatives, the setting of standards and creating opportunities for sharing best practice and learning.

Several sessions have now taken place and ideas are coming together. It is expected that a proposal will be co-created over the summer and put to Sam and ICB colleagues, with a view to getting the new partnership up and running as soon as possible.

There is a strong consensus that we build on the positive experiences we have had in both place and, especially within the Durham and Tees Valley MHLDA partnership over the past several years.

Business Plan Update

The Strategy and Resources Committee have considered the 2021/22 Quarter 4 Business Plan Update report virtually. They noted that as of the end of March 2022 of the 188 actions contained within the Business Plan 59 actions were due for completion during Q4. 53% (31 of 59) of these were achieved successfully which is an improvement on previous quarters. The most common reasons for the non-delivery of actions at the end of 2021/22 was the diversion of scarce managerial and clinical resources into managing Covid, and the requirement to prioritise addressing of safety issues raised by regulators. In addition, the organisational restructure has impacted the delivery and prioritisation of some actions and the increasing maturity of the Programme Boards has increased scrutiny of the existing business plan actions aligned to them which has driven requests to change milestones.

Having considered the report the Strategy and Resources Committee agreed:

- to the transfer of 18 of the actions into the new 2022/23 - 2024/25 business plan.
- that the remaining 10 actions that were not deliver will not be included in the 2022/23 Business Plan as they are now either Business As Usual or they have already been completed prior to the publication of the new business plan.

The Committee recognised the challenges that had faced the organisation in 2021/22 and the significant work that had been undertaken across the Trust during that period.

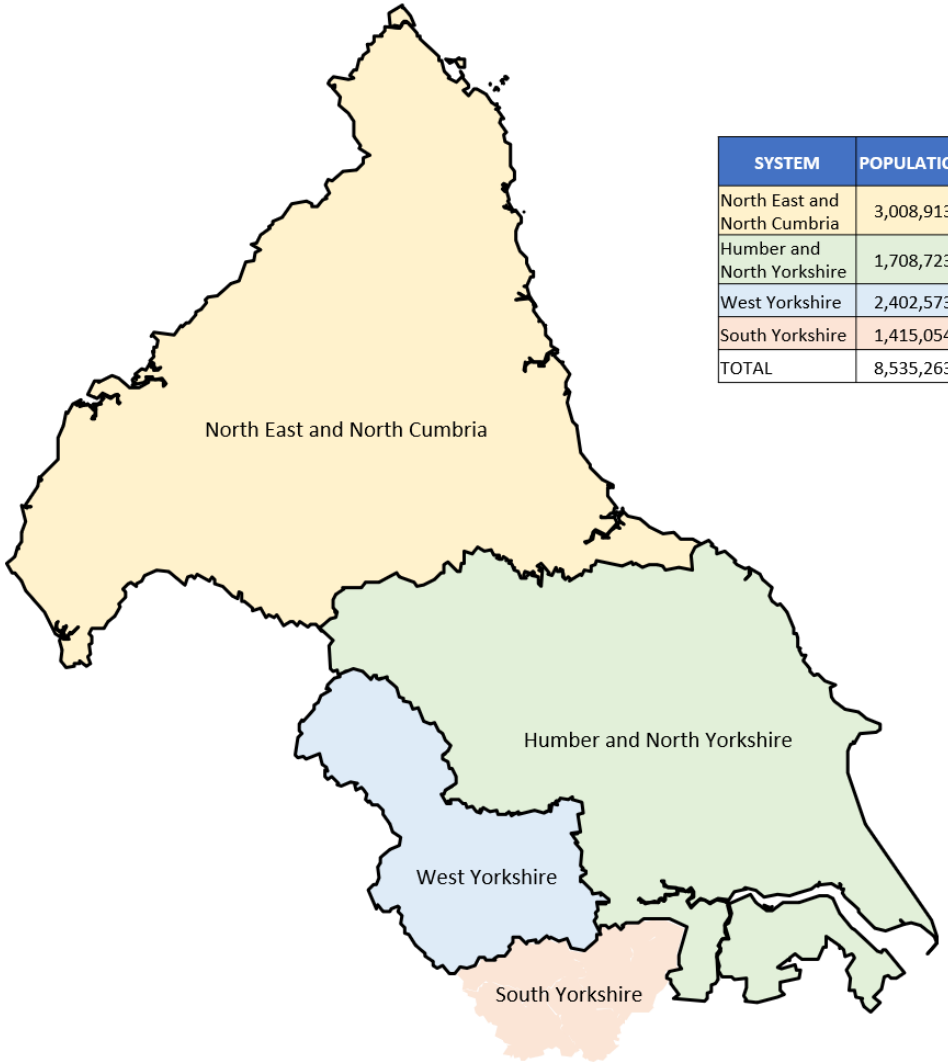
North East and Yorkshire Integrated Care Boards

June 2022

Contents

Regional Overview

North East and Yorkshire ICSs at a glance



SYSTEM	POPULATION	LOCAL AUTHORITIES	NHS TRUSTS†	ACUTE TRUSTS	COMMUNITY/ MH TRUSTS	AMBULANCE TRUSTS	PCNs	GENERAL PRACTICES
North East and North Cumbria	3,008,913	13	11	8	2	1	67	374
Humber and North Yorkshire	1,708,723	6	9	5	3	1	46	228
West Yorkshire	2,402,573	6	10	5	4	1	52	309
South Yorkshire	1,415,054	4	9	5	3	1	27	186
TOTAL	8,535,263	27	33	22	9	2	192	1097

† Region hosted Trusts only. Includes Ambulance Trusts.
Local Authorities and Trusts which operate across more than one ICS are included as part of the total for each ICS.

Population figures source: 2020-21 ONS mid-year population estimates

ICB Executives List

Role	NENC	HNY	WY	SY
Chief Executive	Samantha Allen	Stephen Eames	Rob Webster	Gavin Boyle
Chair	Professor Sir Liam Donaldson	Sue Symington	Cathy Elliot	Pearse Butler
Director of Finance	Jon Connolly	Jane Hazelgrave	Jonathan Webb	Lee Outhwaite
Medical Director	Dr Neil O'Brien	See below Dir Clinical and Professional	Dr James Thomas	Dr David Crichton
Director of Nursing/Chief Nurse	David Purdue	Teresa Fenech	Beverley Geary	Cathy Winfield
Director of Clinical/Professional		Dr Nigel Wells		
Director of People	Annie Laverty	Jayne Adamson	Kate Simms	Christine Joy
Director of Strategy/Partnerships	Jacqueline Myers	Mainly part of Dir Corp Affairs	Ian Holmes	Will Cleary-Gray
Place Based Leads/Directors	Dave Gallagher (Central and Tees Valley) Mark Adams (North and North Cumbria)	Alex Seale (N Lincs) Helen Kenyon (N E Lincs) Wendy Balmain (N Yorks)	Jo Webster (Wakefield) Tim Ryley (Leeds) Carol McKenna (Kirklees) Robin Tuddenham (Calderdale) Mel Pickup (Bradford)	Christopher Edwards (Rotherham) Wendy Lowder (Barnsley) Anthony Fitzgerald (Doncaster) Emma Latimer (Sheffield)
Chief Operating Officer		Amanda Bloor		
Chief Digital and Information Officer	Professor Graham Evans	Interim – Andy Williams	Shared role within the Clinical and Professional Directorate, currently Paul Jones	Kieran Baker
Director of Corporate Affairs/Governance and Corporate Secretary	Claire Riley	Karina Ellis	Laura Ellis (Non-Exec)	Mark Janvier

Director of Communications	Mainly part of Dir Corporate Affairs	Anja Hazebroek		Andrew Ashcroft
Director of Innovation	Aejaz Zahid	Part of Dir Clinical and Prof		
Non-Executive Directors	2 appointed: Jon Rush Professor Eileen Kaner	2 appointed: Mark Chamberlain *(Remuneration Committee Chair)* Stuart Watson *(Audit Committee Chair)*	2 appointed: Jane Madeley: *Non-executive Integrated Care Board - Audit, Finance, and Innovation* Becky Malby: *Non-executive Integrated Care Board - Citizens and Future Generations* *Non-executive development placement with the ICB;* Haris Sultan	3 appointed: Moira Wilson Kevin Turner Lesley Dabell

North East and North Cumbria

Local Authority Areas

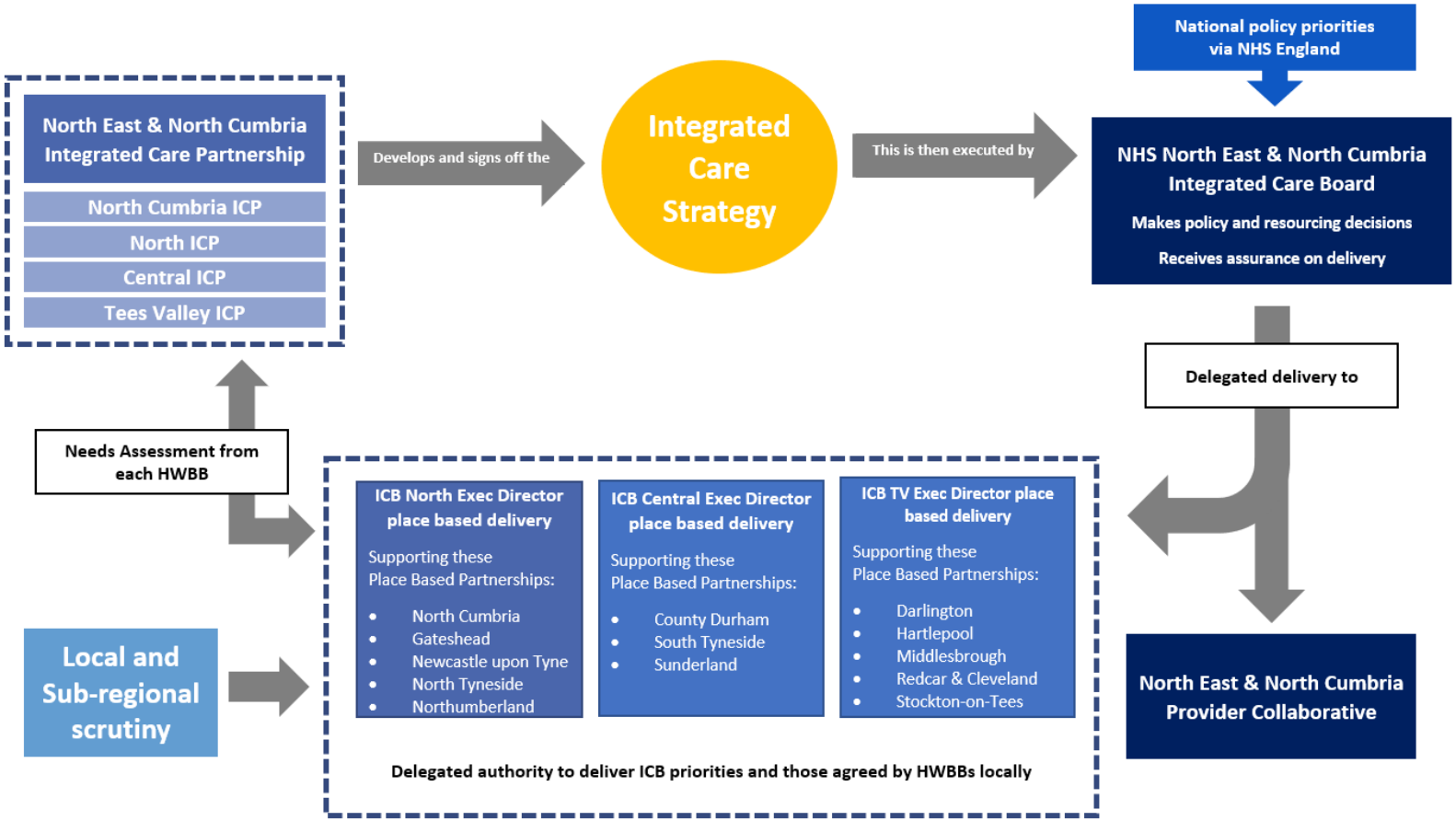
POPULATION	LOCAL AUTHORITIES	NHS TRUSTS†	ACUTE TRUSTS	COMMUNITY/ MH TRUSTS	AMBULANCE TRUSTS	PCNs	GENERAL PRACTICES
3,008,913	13	11	8	2	1	67	374

Population figures source: 2020-21 ONS mid-year population estimates

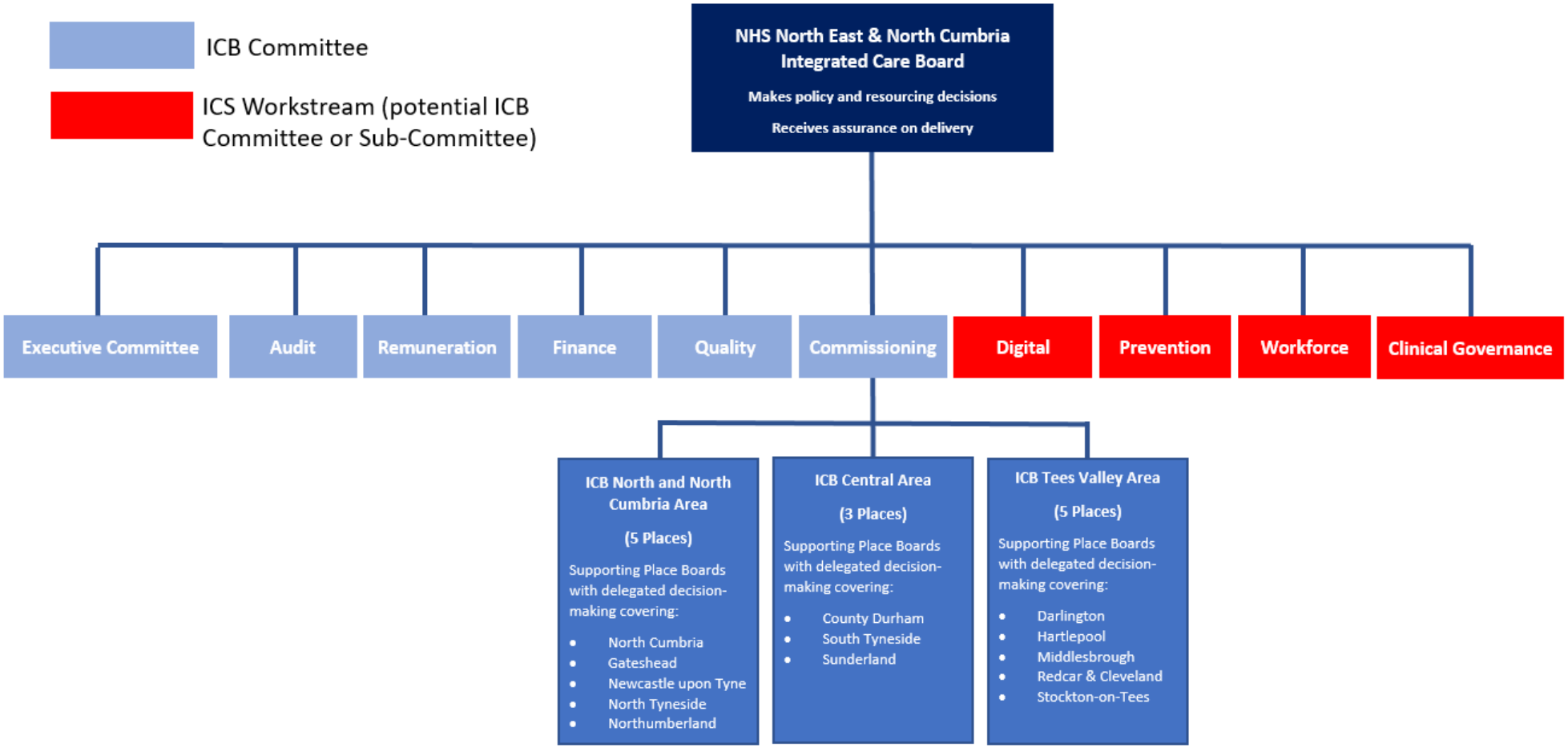
† Region hosted Trusts only. Includes Ambulance Trusts.

System Structure

ICS OPERATING MODEL – SYSTEM FLOW CHART



ICB OPERATING MODEL – ACCOUNTABILITY TO THE ICB

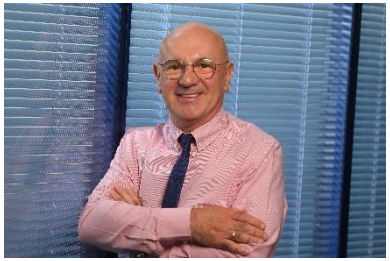


Executive Profiles

Role	Appointee	Biography
Chief Executive	Samantha Allen 	Samantha joined from the South East where she was Chief Executive of an NHS Mental Health and Learning Disability Trust for the last five years. Prior to this Samantha has worked in a range of operational management and leadership roles across healthcare. She is also Chair of the Health and Care Women Leaders Network at the NHS Confederation, a member of The Kings Fund General Advisory Council, St. George's House Leadership Fellow, and a member of the Chartered Management Institute Board of Companions.
Chair	Professor Sir Liam Donaldson 	Professor Sir Liam Donaldson is recognised as an international champion of public health and patient safety. He is the World Health Organisation's Envoy for Patient Safety and Chairman of the Independent Monitoring Board for the Global Polio Eradication Programme. In the UK, he is Chair of the Integrated Care Board (ICB) for the North East and North Cumbria, Professor of Public Health at the London School of Hygiene and Tropical Medicine, Honorary Distinguished Professor at Cardiff University, Associate Fellow in the Centre on Global Health Security at Chatham House and was Chancellor of Newcastle University for 10 years until 2019. Prior to this Sir Liam was the 15th Chief Medical Officer for England, and the United Kingdom's Chief Medical Adviser, from 1998-2010. In this role, he produced landmark reports which set health policy and legislation in fields such as stem cell research, clinical governance, quality and safety of health care, health protection, patient empowerment, poor clinical performance, smoke-free public places, medical regulation, and organ and tissue retention. He led the government's response to the H1N1 influenza pandemic.
Executive Director of Finance	Jon Connolly	Jon joins the ICB Executive Team from North Tyneside and Northumberland Clinical Commissioning Group where he is Chief Finance Officer. He began his career with the Audit Commission, joining the NHS in 2007 and has held senior finance positions in a range of NHS organisations across the North East and Cumbria.

		
Executive Medical Director	Dr Neil O'Brien 	Dr O'Brien has been a local GP in Chester-le-Street for over 20 years. He has developed a special interest in cardiology and has previously worked as a GP with special interest in this area. Neil is a practicing clinician, which strengthens his influence with local practices and other clinicians. Dr O'Brien joins the ICB from NHS Sunderland CCG and NHS South Tyneside CCG where he is the Clinical Accountable Officer. Neil is a member of the Integrated Care System (ICS) Management Group representing the needs of local populations at the North East and North Cumbria ICS. During the last year Neil has chaired the ICS vaccination board overseeing the roll out of the flu vaccination programme and the Covid-19 vaccination programme, Neil is also a member of the national clinical advisory group advising the national roll out of the Covid-19 vaccination. Neil has recently been appointed as the North East and North Cumbria Integrated Care System (ICS) Executive Medical Director designate. He is very excited about this new role and the opportunities and improvements that integrated care will provide across the regional crucial role in leading our successful Covid-19 and flu vaccinations programmes. Neil has been a GP for 20 years

Executive Chief Nurse	David Purdue 	David qualified as a registered general nurse from Nottingham University in 1990 and specialised in cardiac nursing in Nottingham where he set up a number of cardiac nurse-led services, an innovation that won him an award from the National Modernisation Agency. After four years working on the implementation of the National Service Framework for coronary heart disease and then improving access to heart services in the East Midlands, David returned to hospital life in 2004 as clinical nurse manager for cardiothoracics at City Hospital in Nottingham. He joined Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust in October 2008 as Divisional Nurse Manager for Medicine. David was Associate Director of Performance from 2010 and became Acting Chief Operating Officer from June 2013 until his substantive appointment to the role in July 2013 which he held for six years until June 2019. David joins the ICB in July and is currently Deputy Chief Executive and Chief Nurse at the Trust and also Director of Nursing for Leadership and Quality (North East and Yorkshire) at NHS England and NHS Improvement.
Director of Clinical/ Professional		
Executive Director of People	Annie Laverty 	Annie joins the ICB from Northumbria Healthcare where she was the Chief Experience Officer leading an award-winning patient and staff experience programme. She is a qualified speech and language therapist with clinical expertise in stroke care and care of older people and has specialist skills in improvement and learning systems.
Executive Director of Strategy & System Oversight	Jacqueline Myers	Prior to taking up post in NENC, Jacqueline was most recently undertaking the role of Director of the Collaborative of Acute Providers in Humber and North Yorkshire ICS. She has worked within the NHS since 1993 and has previously held a range of senior operational and strategic roles in Hull, Leeds and London, including most recently, 6 years as Director of Strategy and Planning and Exec Lead for Improvement at Hull University Teaching Hospitals NHS Trust.

Executive Director of Place Based Partnerships (Central and Tees Valley)	Dave Gallagher 	Dave Gallagher is the accountable officer for the Tees Valley CCGs. He has extensive management experience across the NHS including in hospitals, at a strategic health authority and in commissioning, including 12 years in senior manager roles at South Tees Hospitals and as a director at Co Durham PCT. Prior to his current post, he was the accountable officer at Sunderland CCG for seven years.
Executive Director of Place Based Partnerships (North and North Cumbria)	Mark Adams 	Mark is the Chief Officer of the Newcastle, Gateshead, North Tyneside, Northumberland and North Cumbria CCGs. Starting his career in private sector as a Management Consultant he joined the NHS in 1990 working within the NHS Provider Sector before moving into the Strategic Health Authority in the North East in 2003 and then on to Director of Commissioning for North of Tyne Primary Care Trusts.
Chief Operating Officer		
Executive Chief Digital and Information Officer	Professor Graham Evans 	Graham joins the ICB from North Tees and Hartlepool NHS Foundation Trust where he was the Chief Information and Technology Officer (CITO). Graham has held a number of national and regional leadership roles in the NHS relating to health informatics.

Executive Director of Corporate Affairs	Claire Riley 	Claire joins the ICB from Northumbria Healthcare where she was Executive Director of Communications and Corporate Affairs and led a multi award-winning team for 12 years. Prior to this she was Director of Communications for the North East Strategic Health Authority where she joined in 2007 with over 20 years private sector experience gained within the region.
Director of Communications		
Executive Director of Innovation	Aejaz Zahid 	Aejaz has joined the ICB from the South Yorkshire system where he was Director of the South Yorkshire & Bassetlaw ICS Innovation Hub, a joint partnership between the Integrated Care System and the Yorkshire & Humber Academic Health Science Network. Prior to his current role, Aejaz's career has spanned academia, the NHS, non-profits and digital health start-ups developing innovative and award-winning healthcare technologies and services globally. Originally trained in the NHS as a Clinical Scientist, he has been a Sloan Fellow at the Massachusetts Institute
Non-Executive Director	Eileen Kaner	Eileen Kaner is Professor of Public Health and Primary Care Research at the University of Newcastle upon Tyne, and an applied behavioural scientist. Her interdisciplinary research focuses on illness prevention in high-risk, vulnerable groups with complex physical and mental health needs. Addressing inequity and social exclusion is at the heart of her work. To date, she has produced 365 publications and won £80 million in grants. She is an Honorary Fellow of the Royal College of Physicians, an Honorary Member of the Faculty of Public Health and a Trustee of Adfam a national charity supporting families affected by Addiction. She has a leadership role in two NIHR Schools (Public Health Research and Primary Care Research), the NIHR Innovation Observatory, the NIHR Policy Research Unit in

		Behavioural Sciences and is Director of an Applied Research Collaboration for the North East and North Cumbria. She is currently chair of the NIHR Academy Advanced Fellowship panel and deputy chair of the Population Health Career Scientist panel. She is also an NIHR Senior Investigator.
Non-Executive Director	Jon Rush	Jon Rush retired from the police in 2013 after spending 6 years as a Chief Superintendent with Greater Manchester Police and 24 years working for Cumbria Constabulary. He joined NHS Cumbria CCG at its inception in 2013, initially the Lay Member for Patient and Public Engagement. In 2017 he became the Chair of the newly formed NHS North Cumbria CCG. Apart from his role as Chair of the CCG he has also chaired North Cumbria Integrated Care Leaders Board and the North East and North Cumbria CCG Joint Committee. He is a strong advocate of effective partnership working and community involvement, with a particular emphasis on ensuring that the NHS engages and recognises the valuable role of the Voluntary, Community, Faith, and Social Enterprise Sector (VCFSE). In his spare time, he likes to swim in the Cumbrian lakes and is a keen supporter of Manchester City.

Humber and North Yorkshire

Local Authority Areas

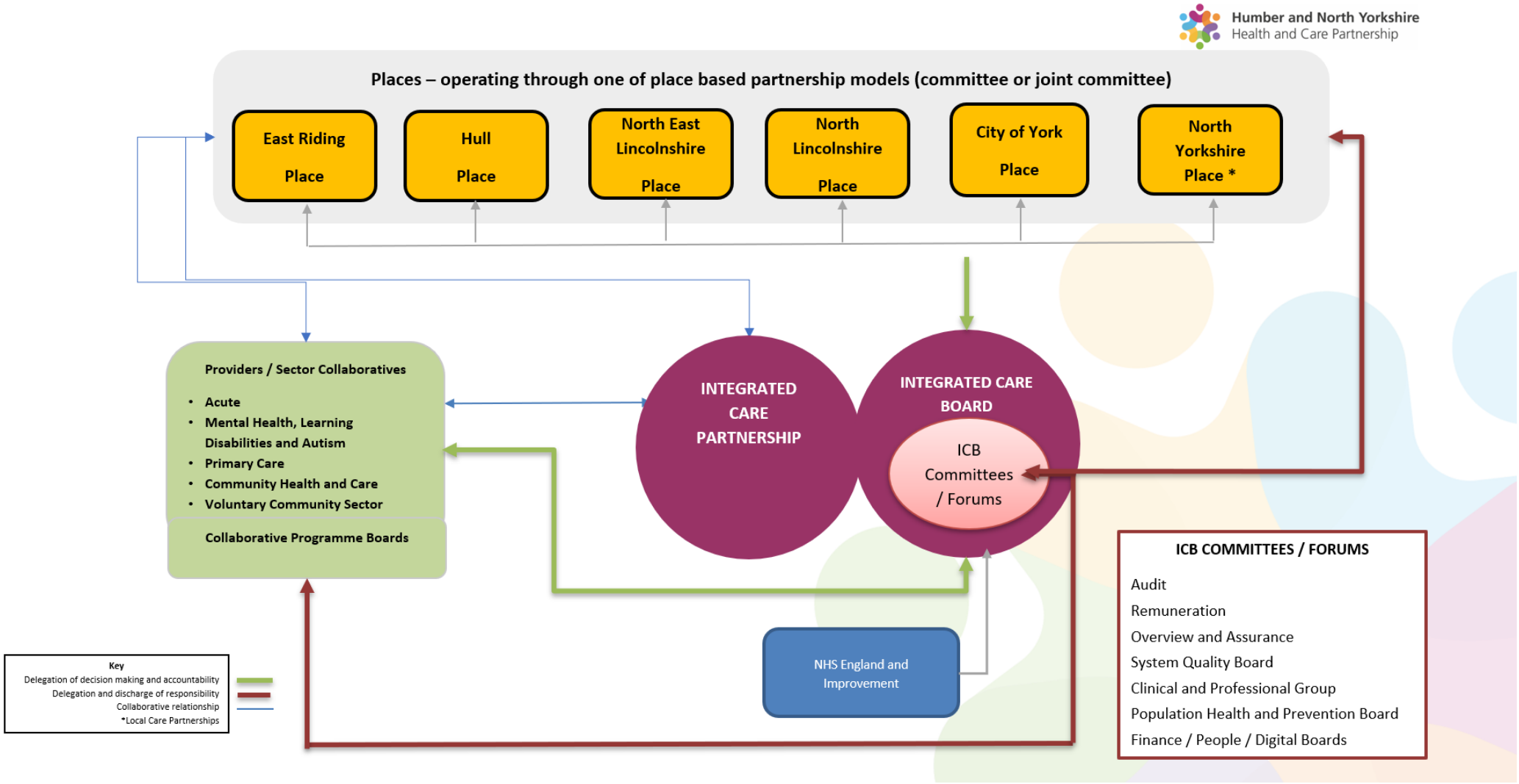
POPULATION	LOCAL AUTHORITIES	NHS TRUSTS†	ACUTE TRUSTS	COMMUNITY/ MH TRUSTS	AMBULANCE TRUSTS	PCNs	GENERAL PRACTICES
1,708,723	6	9	5	3	1	46	228

Map created with SHAPE Place Atlas: https://shapeatlas.net
Population figures source: 2020-21 ONS mid-year population estimates

† Region hosted Trusts only. Includes Ambulance Trusts.

System Structure

Our Governance Structure



Relationship between ICB and ICP

Humber and North Yorkshire
Health and Care Partnership

Executive Profiles

Role	Appointee	Biography
Chief Executive	Stephen Eames 	Stephen has served the Humber and North Yorkshire region since June 2019 when held the post of System Lead and Independent Chair of the Humber, Coast and Vale Health and Care Partnership. Prior to this Stephen has held roles as System Lead for North Cumbria Integrated Health and Care System, Chief Executive of North Cumbria University Hospitals NHS Trust and Chief Executive of the Cumbria Partnership NHS Foundation Trust.
Chair	Sue Symington 	Sue began her non-executive career in the NHS at Harrogate and District NHS Foundation Trust in 2008, becoming Chair of York Teaching Hospital NHS Foundation Trust (now York and Scarborough Teaching Hospitals NHS Foundation Trust) in 2015. Her career has spanned the public, private and voluntary sectors, and the hallmark of her leadership has been her focus on patients and staff.
Executive Director of Finance and Investment	Jane Hazelgrave	Jane will join Humber and North Yorkshire Health and Care Partnership from Mid Yorkshire Hospitals NHS Trust in May 2022. Jane has a wealth of experience of financial management within public and private sectors, including roles at Bradford

		Districts and Bradford City Clinical Commissioning Groups, Bradford and Airedale PCT, Yorkshire and Humber SHA and NHS Leeds Teaching Hospitals Trust.
Medical Director	See below Dir Clinical and Professional	
Executive Director of Nursing and Quality	Teresa Fenech 	Teresa joins Humber and North Yorkshire Health and Care Partnership from NHS England and NHS Improvement. Her previous roles include Deputy Director of Quality Assurance, Director of Nursing and Taskforce Director, and Director of Nursing and Specialised Commissioning.
Executive Director of Clinical and Professional	Dr Nigel Wells 	Nigel qualified as a GP in 2003 and began working as a locum GP in Yorkshire before becoming a GP partner in Durham, and then in 2008 a GP partner at Beech Tree Surgery in Selby. Prior to being appointed as the designate Executive Director of Clinical and Professional for Humber and North Yorkshire ICB, Nigel held roles as Clinical Lead for the Health and Care Partnership alongside the role of Clinical Chair for Vale of York CCG.
Executive Director of People	Jayne Adamson	Jayne has been the People Director at Humber Coast and Vale Integrated care System since June 2020, and prior to that has held executive positions in Health for the last 12 years. Jayne previously worked in the Private Sector at companies such as Smith and Nephew, Swift, Ideal Standard and Nestle.

		
Director of Strategy/Partnerships	Mainly part of Dir Corp Affairs	
Place Based Lead/Director (North Lincolnshire)	Alex Seale	Alex is currently the Chief Operating Officer for North Lincolnshire CCG, a role which she has held since 2018. Prior to this Alex was Director for Commissioning and Integration at East Riding of Yorkshire CCG.
Place Based Lead/Director (North East Lincolnshire)	Helen Kenyon	Helen is currently the Chief Operating Officer for North East Lincolnshire CCG. She is a qualified accountant and has worked in the NHS for over 25 years and in North East Lincolnshire since 1999.
Place Based Lead/Director (North Yorkshire)	Wendy Balmain	Wendy is currently the Director of Strategy and Integration for North Yorkshire CCG, a role she has held since 2019. Prior to this she served as Director of Transformation and Delivery for NHS Harrogate and Rural District CCG where she was responsible for delivering health care commissioning for the CCG and led work to integrate community and adult social care services.
Chief Operating Officer	Amanda Bloor	Amanda trained as a diagnostic radiographer and worked in hospitals across Newcastle upon Tyne and York. After becoming involved in clinical redesign and service improvement, Amanda decided to pursue a career in management and has held senior management roles within the acute sector, strategic health authority and Primary Care Trusts. More recently Amanda has been a CCG Accountable Officer, firstly for Harrogate and Rural District CCG and then North Yorkshire CCG.

		
Chief Digital and Information Officer	Interim – Andy Williams	Not a member of the Executive Team
Executive Director of Corporate Affairs	Karina Ellis 	Karina has been a member of the Humber and North Yorkshire (formally Humber, Coast and Vale) Health and Care Partnership Team since April 2017 and prior to that she held a number of corporate roles at NHS England having joined the organisation on its first day in April 2013. Karina previously worked for North East Lincolnshire Council where she held a variety of roles in business planning, strategy, performance management, governance, organisation change and was responsible for delivering a number of major transformational change programmes across Council services with a wide range of partners.
Executive Director of Communications, Marketing and Media Relations	Anja Hazebroek	Anja will be joining Humber and North Yorkshire Health and Care Partnership from her current role as Director of Marketing and Student Recruitment at the University of Hull. She has a wealth of experience in developing and implementing highly effective brand, communications, marketing and PR strategies across a range of industries.

		
Director of Innovation	Part Dir Clinical and Prof	
Non-Executive Director	Mark Chamberlain (Remuneration Committee Chair) 	Prior to joining Humber and North Yorkshire Health and Care Partnership, Mark has held the roles of Chair at Harrogate Integrated Facilities Ltd, and Deputy Chair and Non-Executive Director of Leeds Teaching Hospitals NHS Trust. The bulk of Mark's earlier career was with BT, where he held a variety of senior roles in HR, marketing, operations, strategy, business transformation and business development. He was a member of the BT Yorkshire & The Humber Regional Board from 2000 to 2014 and a Non-Executive director of the Learning and Skills Council Regional Board until 2010.

Non-Executive Director	Stuart Watson (Audit Committee Chair) 	A chartered accountant, Stuart was the Managing Partner at Ernst & Young for Yorkshire and the North East until his retirement in 2017. Stuart continues to share his vast experience through a number of positions. In addition to his role with Humber and North Yorkshire Health and Care Partnership, he is a non-executive director at a logistics company, advisor to an investment bank, a school chair of governors, and regional chair for a children's charity.

West Yorkshire

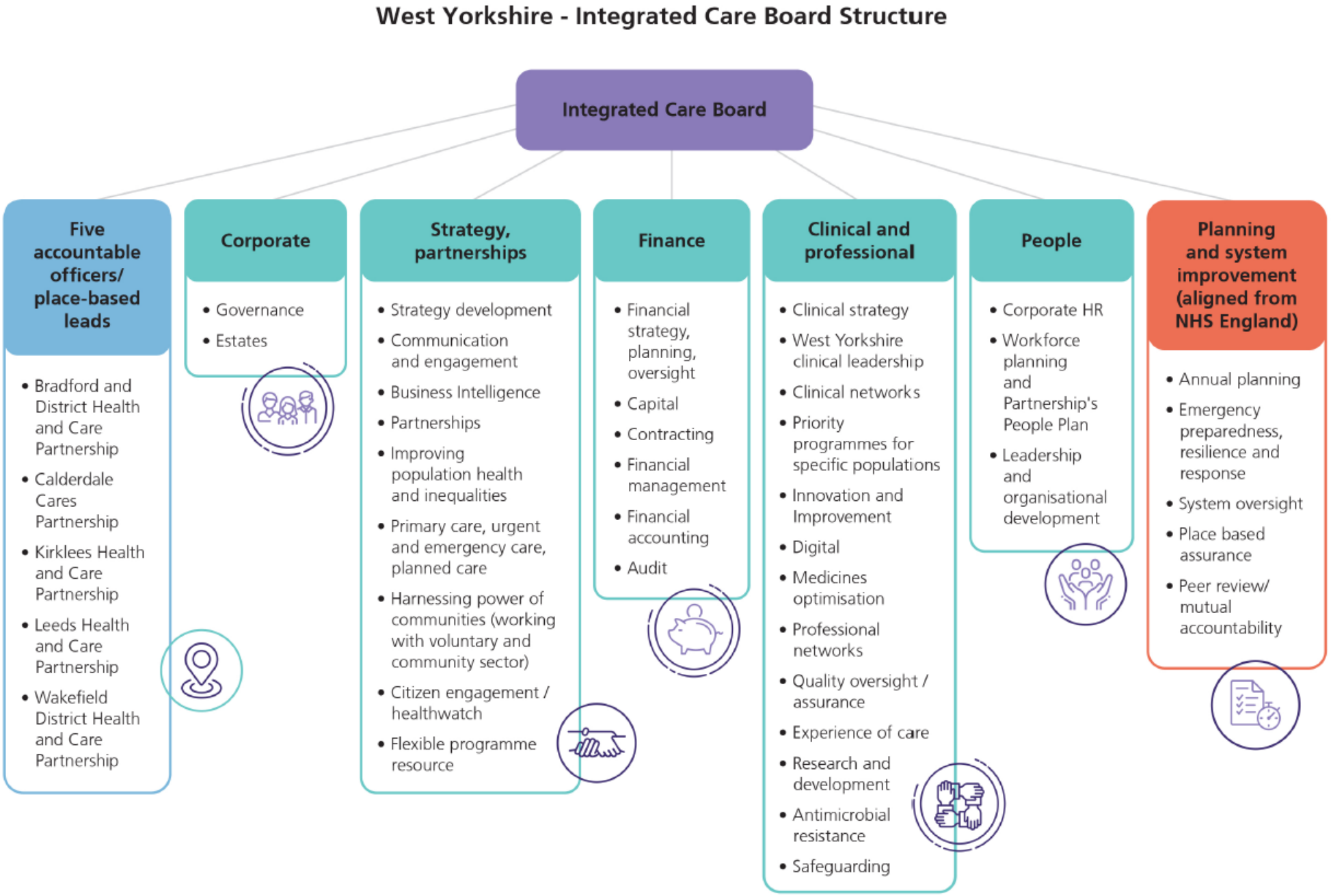
Local Authority Areas

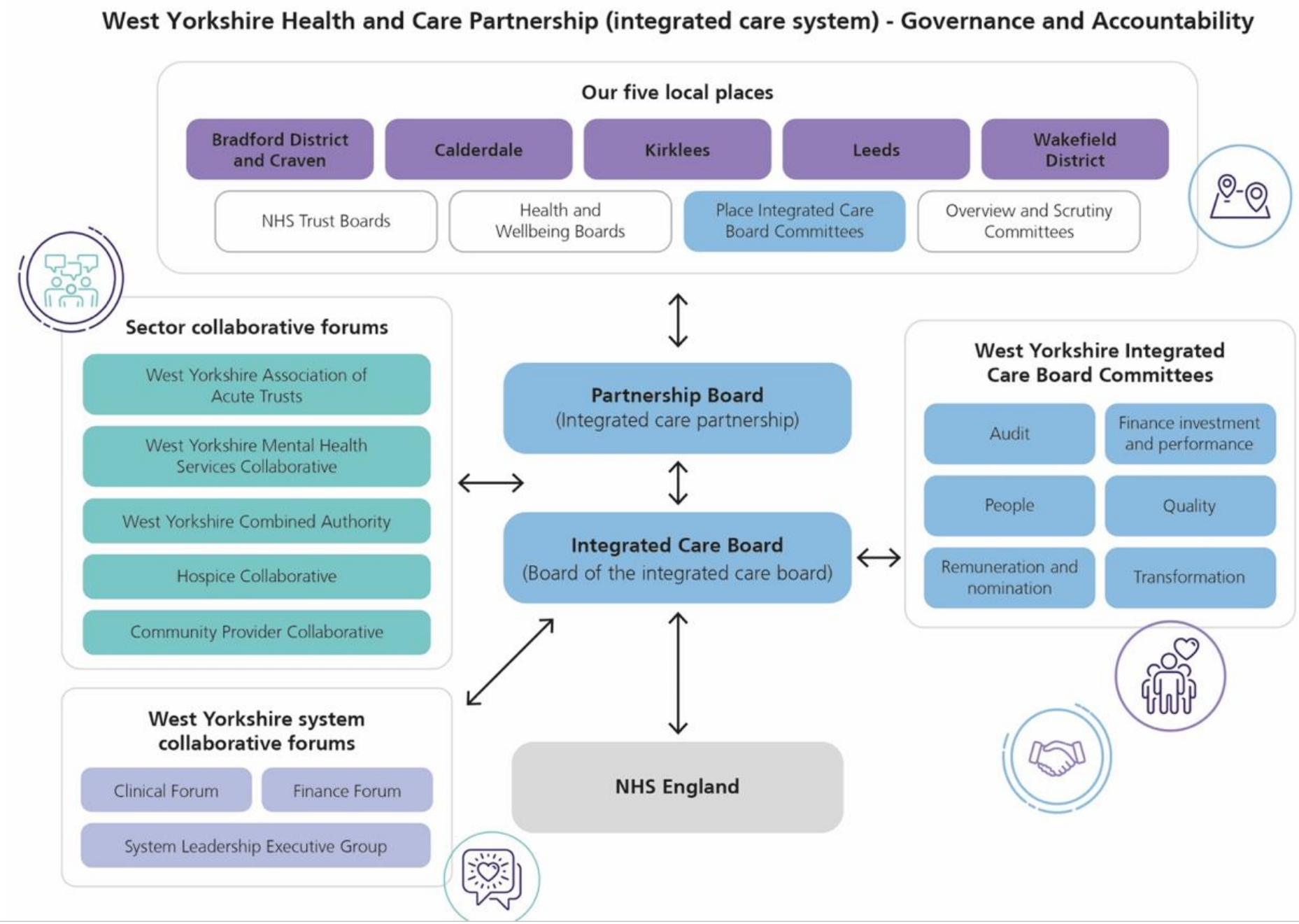
POPULATION	LOCAL AUTHORITIES	NHS TRUSTS†	ACUTE TRUSTS	COMMUNITY/ MH TRUSTS	AMBULANCE TRUSTS	PCNs	GENERAL PRACTICES
2,402,573	6	10	5	4	1	52	309

Map created with SHAPE Place Atlas: https://shapeatlas.net
Population figures source: 2020-21 ONS mid-year population estimates

† Region hosted Trusts only. Includes Ambulance Trusts.

System Structure




West Yorkshire Health and Care Partnership (integrated care system) - Governance and Accountability
Our five local places
Bradford District and Craven
Calderdale
Kirklees
Leeds
Wakefield District
NHS Trust Boards
Health and Wellbeing Boards
Place Integrated Care Board Committees
Overview and Scrutiny Committees
Sector collaborative forums
West Yorkshire Association of Acute Trusts
West Yorkshire Mental Health Services Collaborative
West Yorkshire Combined Authority
Hospice Collaborative
Community Provider Collaborative
Partnership Board
(Integrated care partnership)
Integrated Care Board
(Board of the integrated care board)
West Yorkshire Integrated Care Board Committees
Audit
Finance investment and performance
People
Quality
Remuneration and nomination
Transformation
West Yorkshire system collaborative forums
Clinical Forum
Finance Forum
System Leadership Executive Group
NHS England

Executive Profiles

Role	Appointee	Biography
Chief Executive	Rob Webster 	Rob is defined by a values-based approach to leadership and comes with a wealth of knowledge and experience nationally and locally. He has been the lead CEO for the West Yorkshire Health and Care Partnership, an integrated care system (ICS), since March 2016 and has carried this role out alongside his previous role as Chief Executive for South West Yorkshire Partnership NHS Foundation Trust. Rob's role is to build on the success of the Partnership to date, working together with health and care leaders, organisations, and communities to deliver ambitious plans for improved health, care, and wellbeing, including those set out in the Partnership's existing Five-Year Plan. Rob has worked in healthcare since 1990. He was CEO of the NHS Confederation between 2014 and 2016, he is an active member of the NHS Assembly, NHS National People Board and National Centre for Creative Health Advisory Group. Rob contributes to several national programmes including the New Hospital Programme Board and Health Devolution Commission. Rob was awarded HSJ's Chief Executive of the Year in March 2021.
Chair	Cathy Elliot	In December 2021, Cathy became the Designate Chair of West Yorkshire's Integrated Care Board. She works closely with Chair of the West Yorkshire Integrated Care Partnership Board, Cllr Tim Swift who is the Leader for Calderdale Council. Previously Cathy has been Non-Executive Director (NED) for Tameside and Glossop Integrated Care NHS Foundation Trust in the Greater Manchester Integrated Care System, Chief Executive of Community Foundations for Lancashire, and Merseyside, alongside a trustee of the national UK Community Foundations.

		Before joining West Yorkshire Health and Care Partnership in December 2021, she was the Chair of Bradford District Care NHS Foundation Trust.
Director of Finance	Jonathan Webb 	Jonathan is the Integrated Care Board Director of Finance, following his role as Chief Finance Officer and Deputy Chief Officer for NHS Wakefield CCG since May 2018. During this time Jonathan was also the West Yorkshire Partnership Lead Director of Finance. Under his leadership, the Directors of Finance and Chief Finance Officers have worked together as part of the West Yorkshire Finance Forum to manage our collective resources. This has led to many successes, including the securing of over £300m of additional capital resources for West Yorkshire as part of a collective bidding process and delivering a balanced financial position across the NHS in 2019/20 for the first time in many years. Key to this success has been the development of a collaborative and partnership culture amongst a range of colleagues. In his new role, Jonathan will be leading our finance directorate, working closely with partner organisations and with the support of the independent non-executive director finance role for our integrated care board. As a member of the board, he will hold collective responsibility with directors for our financial performance.
Medical Director	Dr James Thomas	Dr James Thomas is our Integrated Care Board Medical Director. Originally from London, James moved to Yorkshire in 1995 to train as a GP and has most recently been the

		Clinical Chair for Bradford District and Craven's Clinical Commissioning Group. He is also the Chair of the Partnership's Clinical Forum and Co-Chair of our Improving Population Health Board. With his support, the Clinical Forum has led on the development of an ethical standard clinical framework. James also implemented the Partnership's Health Inequality Academy, which involved working together with partners to reduce health inequalities due to social and geographical barriers and addressing some of the preventable differences. This was recognised as an example of good practice nationally. As a member of the integrated care board, alongside the director of nursing, James provides leadership to the clinical and professional directorate and across the Partnership.
Director of Nursing	Beverley Geary 	Beverley Geary is the Integrated Care Board (ICB) Director of Nursing-Designate. Before joining the Partnership, Beverley was the Executive Director of Nursing at Hull University Teaching Hospitals NHS Trust, where she worked since March 2019. She has been a Registered Nurse for over 30 years; and is dual trained in general and mental health nursing. Beverley has worked in several acute providers across the region and was previously Director of Nursing at York and Scarborough Teaching Hospital NHS Foundation Trust. Beverley was Humber Coast and Vale Health and Care Partnership regional nursing workforce lead, Chair for the Local Maternity System, and lead provider senior responsible officer for the COVID-19 vaccination programme for this partnership.
Director of Clinical/Professional Leadership		
Director of People	Kate Simms	Kate Sims is the NHS West Yorkshire Integrated Care Board (ICB) Director of People. Kate's previous role was as People Director for West Yorkshire Police where she worked from 2017 to 2022. During this time, she brought about substantial and tangible change in the way that West Yorkshire Police delivers for its people. This has included radical action

		on diversity and a focus on transforming the experiences of staff and citizens by bringing together all the people functions, developing a supporting structure and using her strong leadership and relationship building skills. Her work and that of her teams with local communities, colleges and universities has been excellent. Before joining the police, Kate worked in several senior people roles in several NHS organisations, including NHS Digital, Yorkshire Ambulance Service NHS Trust, Chesterfield Royal Hospital NHS Foundation Trust and Wirral University Teaching Hospital NHS Foundation Trust.
Director of Strategy and Partnerships	Ian Holmes 	Ian began his career in healthcare in 1998 as a government economist, providing advice to the Department of Health on workforce, primary care, and finance. Ian joined West Yorkshire Health and Care Partnership as Director in August 2016. He leads the strategy and partnership directorate, which provides support and infrastructure to our leadership across West Yorkshire. Since November 2019, Ian has worked one day per week as a National Systems Advisor for NHS England / Improvement on national integrated care system policy design, working with other systems to support their development.
Place Based Lead (Wakefield)	Jo Webster	Jo Webster is proud to be the place-based lead for Wakefield District Health & Care Partnership. She is also Chief Officer of NHS Wakefield Clinical Commissioning Group, Corporate Director for Adults and Health at Wakefield Council and has responsibility for community services at The Mid Yorkshire Hospitals NHS Trust. This gives her overall responsibility for integrating health and care for the whole of the area. She is one of the

		first leaders in England to have three executive roles across one local health and care system. Wakefield Clinical Commissioning Group was rated outstanding in 2021 under her leadership.
Place Based Lead (Leeds)	Tim Ryley 	Tim joined the NHS 19 years ago as a primary care service improvement manager, looking at older people and medicines management. Before coming to Leeds, he was the Director for Strategy, Planning, and Corporate at Stockport Clinical Commissioning Group and acted as the Programme Director for the Stockport Together partnership – a national Vanguard site.
Place Based Lead (Kirklees)	Carol McKenna	Carol was the Accountable Officer for Kirklees Clinical Commissioning Group. She is the West Yorkshire Health and Care Partnership Chair of the Primary and Community Care Programme, and the Partnership's lead for the West Yorkshire Vaccine Programme. Carol joined the NHS 30 years ago and is proud to have spent the last 22 years in senior roles in Kirklees.

		
Place Based Lead (Calderdale)	Robin Tuddenham 	Robin has been Chief Executive at Calderdale Council since June 2017 and the Accountable Officer for NHS Calderdale Clinical Commissioning Group since October 2020. He is responsible for supporting system leadership across Calderdale with public, private, and voluntary sector leaders in support of Calderdale Vision 2024 and overseeing a major capital programme of infrastructure investment across the borough. Robin is lead Chief Executive for Migration and Cohesion and Workforce Development for Yorkshire and Humber. Robin is one of the sector leaders for West Yorkshire Health and Care Partnership, where he is also Co-Chair of the Improving Population Health Programme.
Place Based Lead (Bradford District and Craven)	Mel Pickup	As well as the place-based lead for Bradford District and Craven Health and Care Partnership, Mel has been Chief Executive of Bradford Teaching Hospitals NHS Foundation Trust since 2019. She started her career as a registered general nurse in 1990 and is a member of the West Yorkshire Association of Acute Trusts. For West Yorkshire, Mel leads on critical care and trauma, and is the lead CEO for the local maternity services network. You can watch a film from Mel here about the work across the area.

		
Chief Operating Officer		
Chief Digital and Information Officer	Shared role within the Clinical and Professional Directorate, currently Paul Jones	
Director of Corporate Affairs (Non-Exec)	Laura Ellis 	Laura's role involves working alongside our ICB directors, local place-based governance colleagues, and wider partners to provide strategic leadership on all aspects of corporate governance. This includes establishing robust Board arrangements to ensure we are compliant and properly recorded in accordance with good governance. Laura's previous roles include leading the governance and corporate affairs portfolios for Greater Huddersfield and North Kirklees CCGs. Prior to joining the NHS in 2013, Laura worked in several roles within local authorities' governance and democratic services including at Kirklees and Wakefield Councils. Laura is a member of the Chartered Governance Institute and comes with the right expertise, skills, behaviours, and values to help us move forward with our legal and corporate affairs requirements. "I'm delighted to be taking up the role of Director of Corporate Affairs for the Integrated Care Board and very much looking forward to working with colleagues across the Partnership".

Director of Communications		
Director of Innovation		
Non-Executive Director	Jane Madeley: Non-executive Integrated Care Board - Audit, Finance, and Innovation	Jane comes with a wealth of experience and knowledge for this role, including in her current role as the Chief Financial Officer at The University of Leeds. She has recently completed two terms as a member of the UK Research and Innovation 'UKRI' Audit Committee and was recently appointed Chair of the Confederation of British Industry Yorkshire and the Humber Regional Council. Jane was previously a Non-Executive Director for Leeds Community Healthcare NHS Trust Board, where she was Chair of the Audit Committee. Jane also brings her experience of being a steering group member of the Yorkshire 2% Club, which supported mid-career level women to develop and plan how they might move into board level roles. She is currently a Trustee of the Hepworth Wakefield and lives with her family in West Yorkshire.
Non-Executive Director	Becky Malby: Non-executive Integrated Care Board - Citizens and Future Generations	Whilst living in West Yorkshire, Becky currently holds a role at London South Bank University with 17,000 students and 1,700 staff, leading on primary care, the health district and citizen participation strategy. Becky has worked in every part of the NHS and has over 30 years' experience of setting strategy and leading change with health and local government colleagues, citizens, community and voluntary sectors and academics, primarily from a base in universities, especially working with young people. Becky has an impressive background in volunteering with local organisations and leading on work committed to social justice and community building. This ranges from offering temporary accommodation to homeless young people with Bradford Nightstop; leading the local Jo Cox Foundation's Great Get together and free school meals provision; leading a national coalition movement to mobilise action for clean rivers; to supporting local people to connect through the isolation of the pandemic.
Non-Executive Directors	2 further appointments still to be made	
Non-executive development	Haris Sultan	Haris' work in health and social care started within West Yorkshire as Co-Founder of the Youth Board at Leeds Community Healthcare Trust. Locally he has worked as youth representative on Leeds Clinical Commissioning Group Governing Body leading on the

placement with the ICB		Leeds Youth Health and Social Care Charter. He also sits on the Board of Trustees of Leeds Hospitals Charity and is a member of the Partnership's People's Board. Nationally Haris is Founder and Chair of the National Network of Youth Forums, working with over 60 NHS Trusts across England. He is also board member of the Children and Young People Transformation Programme at NHS England. He has led national initiatives looking into the teaching of health inequalities resulting in changes to the undergraduate curriculum. He has also worked with the Department of Health and Social Care and Public Health England on young people's vaccines throughout the COVID-19 pandemic.

South Yorkshire

Local Authority Areas

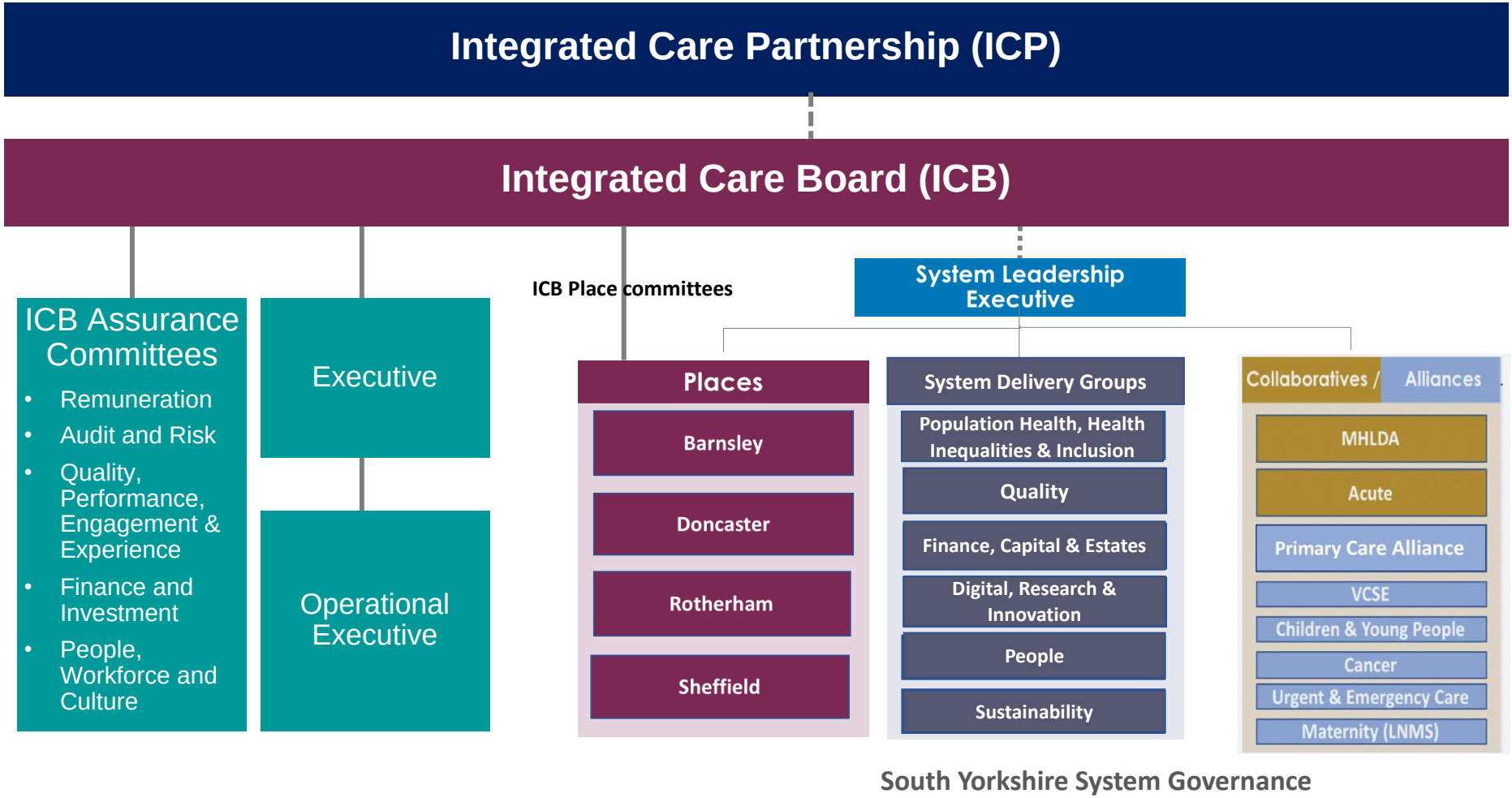
POPULATION	LOCAL AUTHORITIES	NHS TRUSTS†	ACUTE TRUSTS	COMMUNITY/ MH TRUSTS	AMBULANCE TRUSTS	PCNs	GENERAL PRACTICES
1,415,054	4	9	5	3	1	27	186

Map created with SHAPE Place Atlas: https://shapeatlas.net

Population figures source: 2020-21 ONS mid-year population estimates

† Region hosted Trusts only. Includes Ambulance Trusts.

System Structure



South Yorkshire System Governance

Executive Profiles

Role	Appointee	Biography
Chief Executive	Gavin Boyle 	Gavin, who has over 30 years' experience of working within NHS organisations, will lead the designate organisation within South Yorkshire and will take on his new duties in the new year. Gavin has held Board-level posts as Director of Operations at Oxford University Hospitals NHS Foundation Trust, The Queens Medical Centre, Nottingham, and Leeds Teaching Hospitals. Since 2007, Gavin who lives in Sheffield, has been a Chief Executive Officer (CEO) at Yeovil Hospital, Chesterfield Royal Hospital and most recently at University Hospitals of Derby and Burton. South Yorkshire and Bassetlaw ICS is one of the original 'first-wave' health and care systems first launched in 2018, having initially started out as a Sustainability and Transformation Partnership (January 2016) before becoming an Accountable Care System (in April 2017). Commenting on his appointment, Gavin said: "It's an enormous privilege to be appointed as the first Chief Executive of the South Yorkshire Integrated Care Board. There's a long track record in South Yorkshire of partner organisations working together. I'm excited to be part of a new approach which seeks to address health inequalities, improve clinical outcomes, make services more effective and contribute to the wider social and economic development of the Region. "There are undoubtedly many challenges ahead as the NHS recovers from the effects of Covid-19 and seeks to address the health inequalities that the pandemic has thrown into sharp relief. "I particularly welcome the opportunity to work closely with local leaders in Barnsley, Doncaster, Rotherham and Sheffield. My priority will be to work with them to help support our communities to be healthy but able to access good quality joined-up services when they need to."

Chair	Pearse Butler 	Pearse Butler, who was most recently chair at Blackpool Teaching Hospitals NHS Foundation Trust, has now been approved by the Secretary of State as the Independent Chair of the current SYB ICS and future Designate Chair of the SY ICB. “I am very pleased to be joining as the Independent Chair of the South Yorkshire and Bassetlaw Integrated Care System and Chair Designate of the future South Yorkshire Integrated Care Board. I recently moved to the area and am very much looking forward to working with colleagues from across the NHS, local authorities and voluntary and community organisations to improve the health and healthcare of South Yorkshire’s population by shaping the future of integrated care. “I look forward to continuing the work of the partnership which has an excellent reputation as one of the first ICSs in the country, for its innovative approach and strong leadership.”
Chief Finance Officer	Lee Outhwaite 	Lee joined Chesterfield Royal Hospital NHS Foundation Trust in August 2017 and his post covers Finance, Procurement and Estates. In addition, Lee is Chief Finance and Strategy Officer of Derbyshire Community Healthcare Services, which he joined in November 2021. Prior to joining DCHS he was the ICS finance lead for Derbyshire. Lee has worked in the NHS, since 1993, (in Devon, Hampshire, London and Derbyshire). He was appointed to his first Finance Director role in 2007 and has spent three years working as a Regional Director of Finance, for first the TDA, and then NHSI. He sits on the Council of the Chartered Institute of Public Finance and Accountancy and is Vice Chair of their Public Policy and Reform Faculty Board. He is also a Trustee of the Healthcare Financial Management Association (HFMA) and sits on their Policy and Research and System Finance Committees. In addition, he is trying to complete a Professional Doctorate at Keele University, in their Public Policy and Management faculty.

Chief Medical Officer	Dr David Crichton 	Dr David Crichton was born in a British Military Hospital in Germany, to Scottish parents. David spent his childhood travelling around the world with his soldier father. Studying at Leeds University school of medicine, David qualified as a doctor in 1994 before undertaking a number of junior doctor jobs across Yorkshire, then serving as an Army doctor for 7 years in many continents of the world. David is proud to have passed military parachute selection and achieved the rank of Major. David then returned to his adopted county where he has worked as a local GP since, alongside being Clinical Chair of NHS Doncaster CCG since 2016. David is passionate about improving Cancer survival and has led on Inequalities and Early Diagnosis for the South Yorkshire and Bassetlaw Cancer Alliance. On his appointment, David comments: *"It is a great honour to have been appointed Chief Medical Officer for South Yorkshire Integrated Care Board. I want the people of South Yorkshire to have access to the best Health and Care possible and for our staff to be happy and supported in their work.* *"I acknowledge there are many challenges ahead, however I am committed to tackling them and to improving health outcomes for our local population."*
Chief Nursing Officer	Cathy Winfield 	Cathy started her career as a Registered General Nurse and moved on to be the first in her family to get a university education and complete her Masters in Healthcare Governance with Distinction at Loughborough University in her late 30's and was awarded an MBE in 2020 for services to Nursing. Cathy became the Director of Patient Experience and Director of Nursing at Derby Teaching Hospitals in May 2013, having joined the Trust as Deputy Director of Patient Experience and Director of Nursing in August 2009. Cathy qualified as a Registered General Nurse in 1993 from Bloomsbury and Islington School of Nursing and Midwifery in London, before going on to specialise as a Haemato-oncology nurse, working at the Middlesex Hospital on the first Teenage Cancer Trust Unit in the UK. Cathy held several nurse leadership roles at Nottingham City Hospital, then at Nottingham University Hospital as Clinical Lead and Head of Nursing for Cardiac Surgery, Diabetes, Renal and Vascular Services. Cathy is passionate about Staff & Patient Experience, Safety, supporting vulnerable individuals and equality for all. She is an advocate for arts in hospital to create a therapeutic space and she is a coach and mentor. Cathy has more recently been appointed to one of the first CNO Executive Nurse Fellows working to NHSE/I.

		On her appointment, Cathy comments: *"It is an honour to be appointed as Chief Nursing Officer of the new South Yorkshire Integrated Care Board. I am excited at the opportunity to really support and enable, through leaders in health and social care, a reduction in the enormous inequalities between communities, to support improved access to services and empowering patients to live a 'well life'.* *"I'm excited to be working across all sectors in South Yorkshire, where it is clear there is already a passion and drive from all across the system. It is a huge privilege to have the opportunity to work with so many committed leaders and organisations at a time when the NHS and Social Care face such huge challenges, which we will only overcome by working collectively together."*
Director of Clinical/Professional		
Chief People Officer	Christine Joy 	Christine is an HR and Organisation Development professional with over 20 years' experience in the NHS and has worked in a variety of sectors including ambulance service, PCTs, Mental Health, Commissioning Support Units as well as in national roles in NHS England and NHS Improvement, such as Director of HR and OD Operations and most recently in the national ICS Development Programme as operational lead for Change, HR and OD. Christine worked in South Yorkshire for a large part of her career and feels very connected to this area and for the past year Christine has been working two days a week with South Yorkshire and Bassetlaw ICS supporting the HR and OD aspects of transition. On her appointment, Christine comments: *"I see the role of Chief People Officer as a huge opportunity to put our people at the heart of our ambition. I am excited to work with people leaders and trade unions across the system, to work together to tackle key workforce issues and make a difference to the health outcomes of our population."*
Director of Strategy and Partnerships	Will Cleary-Gray	Will has been the Chief Operating Officer of the South Yorkshire and Bassetlaw Integrated Care System since 2016 and is committed to developing integrated care for the people of South Yorkshire. Will has senior experience across a range of health, care and academic sectors, including system partnerships, commissioning, provision, the voluntary sector, the Department of Health, the University of York and the Royal College of Nursing. He brings a breadth of experience working across health and care in highly complex and emergent environments. Will is a critical care nurse by background and is passionate about improving population health and wellbeing.

		On his appointment, Will Comments: *"I'm really excited about the opportunity to continue to support the journey towards and delivery of integrated care for the people of South Yorkshire.* *"I genuinely see the benefits of integrated care for our population, and I'm delighted that my appointment gives me the opportunity to continue to work with all of the committed partners in South Yorkshire, with the ultimate goal of our integrated health and care aspirations becoming reality."*
Deputy Chief Executive and Place Director for Rotherham	Christopher Edwards 	Chris is a graduate of the NHS Management training scheme and has over 25 years NHS experience in a range of organisations including Clinical Commissioning Groups, Primary Care Trusts, Hospital Trusts, Mental Health Trusts and the Department of Health. He has spent over 20 years working in the South Yorkshire system, most recently taking on a joint role across Rotherham and Barnsley in 2020, after being appointed Chief Officer at NHS Rotherham in 2011. Chris has also been seconded, part-time, into the South Yorkshire ICS since 2016, leading on the development of commissioning, Children's and Maternity services, and on the Capital and Estates agenda. On his appointment, Chris comments: *"I am excited by the opportunity of working in the new South Yorkshire Integrated Care Board. The new organisation will allow us to further develop our strong partnership working across health and care in our four places, where we can also enjoy the benefits of working at scale across South Yorkshire.* *"Our key aim will be to work as a health and care system to improve our population's health and to really start to tackle long standing health inequalities. We will also be better placed to develop joined up, seamless services across South Yorkshire to allow us to improve outcomes, to utilise taxpayers money efficiently, and to provide our patients with a joined up approach when they are accessing services."*

Place Director (Barnsley)	Wendy Lowder 	Having started as a volunteer, Wendy qualified as a Learning Disability Nurse and then spent a number of years in the voluntary sector with responsibility for a range of services from employment to care and support. Since 2003 she has worked in Local Government in a range of leadership roles including personalisation, digital, social care and commissioning. She is currently the Executive Director of Adult Social Care and Communities in Barnsley Council. Wendy will continue to be responsible for Adult Social Care in Barnsley, with her title as Executive Director of Place Health and Adult Social Care. On her appointment Wendy comments *"I am really honoured and excited to have been confirmed as Executive Place Director for Barnsley.* *"Barnsley people should have the best possible chance of enjoying life in good physical and mental health. I will strive to make a difference for them, their families and communities and the working lives of those teams that we depend on every day.* *"I truly believe that by building on what is strong across South Yorkshire and harnessing all of our collective skills, knowledge and energies we can co-create a great future and deliver sustainable improvements."*
Place Director (Doncaster)	Anthony Fitzgerald 	Anthony joins the Integrated Care Board after 20 years of working to deliver transformation and continuous improvement across a range of health and social care services. Most recently he has worked as Director of Strategy at Doncaster CCG driving the agenda of integrated care across place partners to improve the health outcomes and experience of Doncaster residents. He is passionate about investing significantly in staff and public relationships to ensure service design and transformation are informed by local intelligence and targeted at addressing the health inequalities across our region. On his appointment, Anthony comments *"As a proud Doncaster and South Yorkshireman, I feel privileged to have this opportunity to work with our fantastic staff across the region to deliver our vision of "wanting everyone in South Yorkshire to have a great start in life, supporting them to stay healthy and live longer". More than ever, we need to ensure the support we give to our public is coordinated and compassionate – and I am excited by the opportunity the ICS gives all of us to ensure this."*

Place Director (Sheffield)	Emma Latimer 	Emma Latimer hails from the North West of England, and her NHS experience spans 32 years, including ambulance, acute and Strategic Health Authority, with over ten years' experience leading commissioning organisations. She has led NHS Hull Clinical Commissioning Group (CCG) since its establishment in 2013 and is also currently the Interim Accountable Officer for NHS East Riding of Yorkshire and NHS North Lincolnshire CCGs. Emma is Geographic Partnership Director for the Humber, within the Humber and North Yorkshire Integrated Care Board. She has led the Humber Acute Services programme for two years - designing the future of hospital services for 900,000 people living in the Humber area. Emma is a successful collaborator who believes in values-based and inclusive leadership. She enjoys working within a complex environment, supporting teams to be transformational. She is also very much a people person and has a particular interest in social mobility and inspiring the next generation to ensure that children and young people realise their full potential. One of her proudest career achievements was the establishment of Hull's Jean Bishop Integrated Care Centre that provides a community frailty service with GPs, community geriatricians, advanced nurse practitioners, social workers, pharmacists and other specialists all working together around the needs of the population. On her appointment Emma says: *"I am delighted to have been appointed into this new role. Sheffield is a vibrant and forward-looking city - that is rightly proud of its heritage - and I want to build on all the great partnership working that is happening.* *"I already know some members of the NHS South Yorkshire through wider system work across Yorkshire, and I'm really looking forward to meeting and getting to know the rest of the team as we transition into the new place-based arrangements."*
Chief Operating Officer		
Chief Digital and Information Officer	Kieran Baker	Kieran, brings a wealth of experience and working with a variety of NHS provider organisations in our region, and most recently at NHS Digital as Head of Service for Analytical Insights, where he led delivery of national data programmes and he and his teams supported population health management initiatives, specifically related to our national response to the COVID-19 pandemic. Kieran has significant experience of leadership of digital transformation and leveraging healthcare data to support population health management initiatives and realising the full potential of strong, system-wide alliance in digital and data.

Director of Governance and Corporate Secretary	Mark Janvier	Mark joins the ICB from NHS England and Improvement and has held the role of deputy director in South Yorkshires locality team. Mark has worked alongside the ICS over the past 6 years and contributed significantly to its success today. Mark brings extensive experience in NHS performance, assurance and regulation working across provision, commissioning and system leadership. Mark stared his career in community mental health in Liverpool before moving to then, South Humber leading on performance and information. In addition, Mark has 20 years of governance leadership experience in the education sector and has contributed significantly in this area.
Director of Communications	Andrew Ashcroft	Andy worked as a Journalist in his 20s before moving into NHS Comms in 2008. First at Pennine Acute in Manchester, then nearly a decade in Stoke before just under four years at Derby/Burton. The decade in Stoke included leading Comms on a new PFI hospital and then merging Mid Staffs into the Trust following its dissolution, and then four years leading the post-merger Comms of the Derby and Burton trusts. The last two years were spent leading the operational response to Covid. Andy's focus in these roles has been building resilient and effective Comms/Engagement teams, combined with creating strong and responsive systems and process for communications and engagement. Both of which then support senior leadership teams and others to communicate and engage with different audiences to achieve their aims and embed values, behaviours and wider narrative. Away from work, Andy holds two BA degrees and a PGC in Healthcare Communications. He is Chair of a local primary school in Macclesfield and sits on the advisory panel for NHS Communicate Conference/Awards.
Director of Innovation		
Non-Executive Director	Moira Wilson	Moira has been the Rotherham Safeguarding Adults Board Independent Chair since 2019 and is also a Local Government Association Care and Health Improvement Advisor. Her previous roles include Strategic Director Adult and Community Services with Bradford Council, Interim Director of Care and Support at Sheffield City Council and North Lincolnshire Safeguarding Adults Board Independent Chair. Moira is committed to working together, being prepared to understand different perspectives and to negotiate successful outcomes based on evidence of what works well and how it can be applied to specific situations. Moira is also passionate about

		communication, and has experience in working with senior leaders, managers, front line practitioners and people who use services on a wide-ranging agenda. On her appointment Moira comments *"I am delighted to have the opportunity to contribute to how we can really join up health and care services, listen to people and local communities, and improve the way we offer care and support to our residents across South Yorkshire."*
Non-Executive Director	Kevin Turner 	Kevin worked in the NHS for the whole of his career, prior to his retirement in 2019 from his Deputy Chief Executive post at United Lincolnshire Hospitals NHS Trust. Kevin is a qualified accountant with 18 years' experience as a Director of Finance at United Lincolnshire Hospitals NHS Trust, Doncaster and Bassetlaw NHS Foundation Trust, Northern Lincolnshire and Goole Hospitals NHS Foundation Trust and Lincolnshire Health Authority. Kevin is an advocate for Place being the foundation upon which integrated health and care services can best serve the needs of patients, carers and users with and across neighbourhoods. Kevin, who hails from South Yorkshire, is keen to help to build upon the excellent partnership working across South Yorkshire and Bassetlaw to improve our offer to those patients, carers and users. On his appointment Kevin comments *"The new way of working across NHS and Care presents a great opportunity to make a really positive difference for patients, carers and users. I am excited to be working as part of a new team, all committed to improving health and care services for the people of South Yorkshire, building upon some great foundations of the past. As one of the Independent Non-Executive members of the team, my role is to help shape the future of local services, provide support and different perspectives and challenge."*

Non-Executive Director	Lesley Dabell 	Lesley has lived in South Yorkshire her whole life and has a strong affiliation and understanding of the South Yorkshire area, its people and communities. She has worked in Rotherham since 1995 in a variety of roles in the Public, Voluntary and Community Sectors (VCS) and is currently the Chief Executive Officer (CEO) at Age UK Rotherham. Lesley is also a carer for members of her own family. In this Non-Executive Member role she aims to use her local knowledge, knowledge about community engagement and over 20 years' experience of working within the voluntary and community sector in South Yorkshire to make a contribution to the development and transformation of health services for the people of South Yorkshire. On her appointment, Lesley said: *"As a South Yorkshire person I am passionate about ensuring that all local people have access to high quality health services, and that we achieve the best possible health outcomes for all – preventing ill health wherever possible, promoting well-being and reducing health inequalities. I hope through this role to play my part in achieving this."*

ITEM NO. 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th June 2022**
TITLE:	**Board Assurance Framework – Summary Report**
REPORT OF:	**Phil Bellas, Company Secretary**
REPORT FOR:	**Information & Assurance**

This report supports the achievement of the following Strategic Goals:	
To co create a great experience for our patients, carers and families	✓
To co create a great experience for our colleagues	✓
To be a great partner	✓

Report:

The Board Assurance Framework (BAF) is a key means of providing assurance to the Board that the Trust's strategic risks are being managed effectively across the organisation.

A summary of the BAF, highlighting relevant reports included on the agenda, is provided in Annex 1 to this report.

This summary is intended to act as an aide memoire to support the Board to focus on the strategic risks in its discussions. It also provides assurance on the alignment of the BAF with the matters due for consideration at the meeting.

Recommendations:

The Board is asked to receive and note this report.

BAF Summary

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Present Risk Grade	Indicative Controls Assurance Rating	Risk Management Approach	Related Agenda Items
	1	2	3						
1	✓	✓		**Recruitment and Retention** Inability to recruit and retain sufficient qualified and skilled staff might jeopardise our ability to provide high quality/safe services	**DoP&C**	**Very High**	**Good**	Risk significantly above tolerance Strengthening of controls required, at pace, to reduce exposure to tolerable levels	▪ Public Agenda Item 10 – Board Integrated Performance Dashboard ▪ Public Agenda Item 11 – Directors' Visits Feedback ▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 15 – People Culture and Diversity Committee Key Issues Report
2	✓			**Demand** Demand for our services, particularly as a result of the post-Covid surge, might result in us not being able to meet patient/carer expectations or commissioner requirements	**COO (CEO)**	**High**	**Reasonable**	Opportunities to improve controls; however, new controls (if available) are required to reduce exposure to tolerable levels	▪ Public Agenda Item 10 – Board Integrated Performance Dashboard ▪ Public Agenda Item 11 – Directors' Visits Feedback ▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report
3	✓			**Involvement and Engagement** A fragmented approach to service user and carer engagement and involvement might prevent us from co-creating a great experience	**DoC&I**	**High**	**Good**	Present controls are, generally, considered to be operating effectively; however, achievement of the target risk score is dependent on the implementation of identified new controls.	
4	✓			**Experience** We might not always provide a good enough experience for those who use our services, their carers and their families, in all places and all of the time (see also BAF refs 1 (recruitment and retention) and 6 (Learning))	**DoN&G**	**High**	**Reasonable**	Controls are, generally, considered to be operating effectively; however, further strengthening is required, at pace, to reduce exposure to tolerable levels	▪ Public Agenda Item 8 – Chief Executive's Report ▪ Public Agenda Item 10 – Board Integrated Performance Dashboard ▪ Public Agenda Item 11 – Directors' Visits Feedback ▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 13 – Assurance Report on the delivery of the CQC Action Plan ▪ Confidential Agenda Item 3 – Reportable

									Issues Log ▪ Confidential Agenda Item 4 – Chief Executive's Report ▪ Confidential Agenda Item 5 – CQC Update
5	✓	✓		**Culture & Wellbeing** Pockets of poor culture or low staff wellbeing could undermine our ability to provide a safe and sustainable service as well as putting individual staff and patients at risk of harm	**DoP&C**	**High**	**Good** ↑	Controls need to be strengthened. This is required at pace, through the delivery of mitigations, to reduce the risk to tolerable levels.	▪ Public Agenda Item 10 – Board Integrated Performance Dashboard ▪ Public Agenda Item 11 – Directors' Visits Feedback ▪ Public Agenda Item 15 – People Culture and Diversity Committee Key Issues Report
6	✓			**Safety** Failure to effectively undertake and embed learning could result in repeated serious incidents	**DoN&G**	**High**	**Good**	Controls are, generally, considered to be operating effectively; however, further strengthening, through the delivery of mitigations, is required at pace to reduce the risk to tolerable levels.	▪ Public Agenda Item 8 – Chief Executive's Report ▪ Public Agenda Item 10 – Board Integrated Performance Dashboard ▪ Public Agenda Item 11 – Directors' Visits Feedback ▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 13 – Assurance Report on the delivery of the CQC Action Plan ▪ Public Agenda Item 14 – Briefing on Patient Safety Specialists ▪ Confidential Agenda Item 3 – Reportable Issues Log ▪ Confidential Agenda Item 4 – Chief Executive's Report ▪ Confidential Agenda Item 5 – CQC Update
7	✓	✓	✓	**Infrastructure** Poor quality physical or digital infrastructure could impede our ability to co-create a great experience both for staff and for patients [excludes CITO (see risk 12), Cyber security (see risk 8) and RPH (see risk 14)].	**DoF&I**	**Medium**	**Good**	The risk is within tolerance and controls are operating effectively. Continued delivery of mitigations is required to achieve target score.	▪ Public Agenda Item 10 – Board Integrated Performance Dashboard
8	✓	✓	✓	**Cyber Security** A successful cyber-attack could compromise patient safety, business continuity, systems and information integrity and cause reputational damage	**DoF&I**	**Very High**	**Reasonable**	Ongoing strengthening of controls required due to the constantly evolving nature of the risk	▪ Public Agenda Item 16 – Data Security and Protection Toolkit submission

9	✓	✓	✓	**Regulatory Action** Further regulatory action could result in loss of confidence and affect our reputation among service users, staff, and other key stakeholders (see also BAF ref. 11 – Governance and Assurance)	**CEO**	**High**	**Good**	Controls considered to be operating effectively and scope for improvements limited. Higher degree of exposure than acceptable will need to be tolerated. Regular monitoring of the risk advisable.	▪ Public Agenda Item 8 – Chief Executive's Report ▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 13 – Assurance Report on the delivery of the CQC Action Plan ▪ Confidential Agenda Item 3 – Reportable Issues Log ▪ Confidential Agenda Item 4 – Chief Executive's Report ▪ Confidential Agenda Item 5 – CQC Update
10			✓	**Influence** Changes in the external environment, and insufficient capacity to respond or to align our objectives with those of partners, might lead to loss of strategic influence and reputation	**Asst CEO**	**High**	**Good**	The risk is within tolerance. Further strengthening of controls required through the delivery of mitigations to achieve target score.	
11	✓			**Governance & Assurance** The absence of a clear line of sight from ward to Board, due to ineffective governance and assurance processes, could result in the inconsistent quality of services and increased risks to patients	**CEO**	**High**	**Good**	Urgent action to be taken to strengthen controls but a higher degree of exposure than acceptable will need to be tolerated. Regular monitoring of the risk advisable.	▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 10 – Board Integrated Performance Dashboard ▪ Public Agenda Item 13 – Assurance Report on the delivery of the CQC Action Plan ▪ Public Agenda Item 16 – Data Security and Protection Toolkit submission ▪ Confidential Agenda Item 4 – Chief Executive's Report ▪ Confidential Agenda Item 5 – CQC Update
12	✓	✓	✓	**Roseberry Park** The necessary Programme of rectification works at Roseberry Park and associated legal case could adversely affect our service quality/safety and financial, reputational and regulatory standing	**DoF&I**	**Very High**	**Good**	The risk is significantly in excess of tolerance. Urgent action is required to reduce exposure.	
13	✓	✓	✓	**West Lane** The outcome of the independent enquiry, coroners' investigations, and civil legal actions could affect our reputational and	**CEO**	**Very High**	**Good**	Opportunities to strengthen controls but this will have a limited impact due to third	

				regulatory standing if the Trust is not able to demonstrate the necessary improvements and approach				party decision-making. Exposure above tolerance will need to be accepted.	
14	✓	✓	✓	**CITO** Failure to deliver the CITO project to its revised timescale will delay its benefits for patients and staff	**DoFI**	**High**	**Good**	Whilst controls are, generally, considered to be operating effectively further strengthening is required at pace, through the delivery of identified mitigations, to reduce exposure to tolerable levels	
15	✓	✓	✓	**Financial Sustainability** Failure to gain a fair share of resources for the Trust and mental health could impact on the delivery of Our Journey to Change and the sustainability of services	**DoFI**	**Very High**	**Reasonable**	Urgent action is required to strengthen controls, where practicable due to national/regional constraints, to reduce the risk score to target (within tolerance) through the delivery of mitigations	▪ Public Agenda Item 10 – Board Integrated Performance Dashboard

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Board Integrated Performance Dashboard (IPD)

As 30th April 2022

journey to change

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

CONTENTS

Introduction

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Background and Context

As part of the continuous improvement of the Trust's Performance Management Framework, we have been developing a more integrated approach to quality and performance assurance and improvement across the Trust during 21/22. This is to enable us to have oversight, monitor and report key measures that demonstrate the delivery of the quality of services we provide and provide assurance to the Board through its sub-committee structure.

The measures for the new Integrated Performance Dashboard (IPD) were identified by the relevant Board Sub Committees and agreed by the Board of Directors. All the measures have been aligned to one of our three strategic goal(s) and where appropriate, support the monitoring of the Board Assurance Framework risks. (See final slides on Strategic Context). Each month we will provide the IPD which will give oversight and assurance against the agreed key measures through the agreed assurance processes. On a quarterly basis this will be expanded into wider Integrated Performance Report (IPR) which will incorporate reports from the Board Sub Committees which will include other key information issues and risks (not already included in the IPD) but which the sub committees (Quality Assurance, Mental Health Legislation, People, Culture & Diversity and Strategy & Resources) wishes to escalate to the Board. The IPR will also provide progress against the System Oversight Framework and any other key National Standards.

Further work is planned to develop relevant dashboard for each of the Board Sub Committees within the Integrated Approach this financial year. This will provide additional oversight and assurance of the key measures identified by each Board Committee.

First Board Integrated Performance Dashboard

It is important to note that this is the first Board Integrated Performance Dashboard for our Trust and due to the significant development required for this new approach and the organisational restructure on 1st April 2022, we have been unable to test this through the agreed assurance framework prior to publication. We also have not identified any "standards" at this point in the development work; however work will be undertaken during quarter 1 with each of the Board Sub Committees to propose standards, where appropriate, for each of the measures. These will be brought to the Board of Directors for discussion and approval in August 2022.

During May we have provided the Care Group Boards and the Corporate Directorates with their performance information for the first time and asked that focus is given on:

- Understanding the measures (some of which are new)
- Understanding what the data is showing for the Care Group/Corporate Directorate as a whole and at the next level (i.e. speciality)
- Start to think how they will use information this to improve the quality of services being provided.

At this stage we are unable to provide assurance; however we expect this, and the triangulation of information, to increase and improve in the coming months as this new approach is embedded.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

The key areas of concern identified from the Integrated Performance Dashboard (IPD), with triangulation of any other relevant information

It is important to note that this is the first Integrated Performance Dashboard and with implementation of the organisational change and revised governance framework on 1st April 2022; this report has not been through the full information and assurance flow. However, we have identified the following areas of concern which require improvement.

Our quality

- Outcomes: *05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported; 06) Percentage of CYP showing measurable improvement following treatment - clinician reported and 07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported* – These are all new measures we have developed in collaboration with the clinical services which were shared with the Care Boards in May. Work is underway to understand the data including the variances between Care Groups and what further training staff will require. The Associate Director of Performance will also discuss the future direction for the Outcomes Steering Group with the new Medical Director once in post.
- Bed Pressures: *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* – There are a range of actions ongoing in relation to addressing inpatient bed pressures which includes the re-opening up of beds on Esk Ward (now fully reopened) and Danby Ward (currently 8 beds open with plans to reopen remaining 5 by September 2022) in North Yorkshire and detailed analysis of current inpatients including identifying whether they are in their "local hospital", their length of stay and whether there are any delayed discharges.
- Safety:*12) The number of Restrictive Intervention Incidents* had already been identified as a concern and there are a number of actions underway which are closely monitored by the Positive & Safe Group. We know this relates to a small number of highly complex patients and significant support continues to be provided to Learning Disabilities Services at this time.

Our People

- *19) Percentage Sickness Absence Rate* - Our sickness levels continue to be high across the Trust and whilst all sickness is managed in line with Trust Policy it is closely monitored. There are a number of pieces of work underway in the respective areas to identify the key issues and improvement actions required.
- *20) Percentage compliance with ALL mandatory and statutory training and 21) Percentage of staff in post with a current appraisal* remain a concern. Latest performance is a reflection on the ongoing pressures on staff which has meant staff have not been able to complete their training or appraisal. We are working with our colleagues in the People and Culture Directorate to look at what possible improvement actions will be required.
- To co-create a great experience for our staff, we are continuing to focus on recruitment and have reduced the time to recruit.
- We also have high use of flexible staff including agency, (with some reliance on high cost/off framework arrangements including to support a small number of specialist packages of care). We have agreed a targeted approach to incentives and to reduce reliance on premium rate agencies in order to ensure they are appropriately focused, targeting volume and rate reductions.

Our Activity and Finance

- *23) Unique Caseload (snapshot)* This is a new measure we have developed in collaboration with Digital and Data Colleagues. We shared this data with our Care Boards in May and work is underway to analyse this information in order to facilitate future discussions
- *24) Financial Plan: SOCI - Final Accounts - Surplus/Deficit* – whilst the end of April position is broadly on plan, the underlying run rate is of concern. Work is ongoing as part of finalising the ICB financial plan and we are developing a number of down-side scenario plans in order to identify appropriate mitigation. Development of CRES schemes, including for plans that commence in July, during Q1 is ongoing.

The areas of positive assurance identified within the IPD

There are no areas of positive assurance identified within the IPD at this point.

Other key information, issues, and risks (not already included in the IPD) that the Executives wishes to highlight and/or escalate to the Board

Areas of positive assurance to highlight to the Board

- As part of the Commissioning for Quality and Innovation (CQUIN) initiative, in 2022/23, there are a number of outcome based clinical quality indicators which will support our internal outcome measures around measurable improvement.
- The organisational restructure and revised governance arrangements continued to be embedded. We now have in post the new Managing Director for the North Yorkshire and an interim Director of Operations for the York & Selby Care Group; and a new permanent Director of Secure Inpatient Services. We have appointed to all Executive Director posts and to all Board vacances except for the chair which is underway.
- The Trust continues to make good progress against the delivery of the CQC Core Services and Well Led Action Plan.
- The Audit and Risk Committee received a preliminary external audit update on the 2021/22 Annual Accounts at its 10th June meeting. There were no changes identified or proposed, and whilst not final, the majority of field work is now complete.
- Analysis of the letters received in relation to the Quality Account 2021/2022 showed widespread support and no opposition to the 3 proposed improvement priorities. There are also some positive comments about the clarity / transparency of the Quality Account, Our Journey to Change, our commitment to working in partnership, progress made in addressing CQC recommendations, and local service developments such as the mental health support teams that work with schools.

Issues to highlight to the Board

- On 29th May 2022, we received a unannounced CQC Responsive Inspection of Adult Learning Disability Wards at Lanchester Road Hospital, followed by inspections of the remaining Adult Learning Wards in the Trust. A number of concerns were raised and we have taken immediate action to address them and to ensure the quality and safety of patient care within Adult Learning Disability services. We continue to implement extensive and a detailed action plan in collaboration with system partners .
- Within the letters received in relation to the Quality Account 2021/2022, some of our stakeholders were concerned about the continued worse than target rate of restraints per occupied bed day. There were also concerns about waiting times for CYP services, and the lack of progress in implementing improved care planning arrangements.

Other key information, issues, and risks (not already included in the IPD) that the Executives wishes to highlight and/or escalate to the Board

Risks to highlight to the Board

As part of the System Oversight Framework, we monitor the Long Term Plan ambitions that have been agreed in partnership with our Commissioners. Whilst we are assessed on a quarterly basis, we monitor progress through the Care Boards on a monthly basis and report this to our Commissioners. For the period ending April 2022, we are at risk of delivering the agreed ambitions for the following measures by the CCGs described:

IAPT Services

1) Total access to IAPT services - Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy: County Durham CCG; Vale of York CCG and North Yorkshire CCG
2) The proportion of people who are moving to recovery - Vale of York CCG
3) Percentage of people who have waited more than 90 days between first and second appointments (IAPT) - County Durham CCG; Tees Valley CCG and Vale of York CCG

CYP Eating Disorders

4) The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment - County Durham CCG; Tees Valley CCG; Vale of York CCG and North Yorkshire CCG
5) The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment – Vale of York CCG and North Yorkshire CCG

EIP Services

6) Percentage of people experiencing a FEP treated with a NICE approved care package within 2 weeks of referral - County Durham CCG; Vale of York CCG and North Yorkshire CCG

Out of Aare Placements

7) Inappropriate adult acute mental health Out of Area Placement (OAP) bed days – North East and North Cumbria Integrated Care System and Humber Coast & Vale Integrated Care System

For measures 1-6, key issues and actions have been identified by each of the Care Groups and are being monitored by the Executive Meeting. For measure 7, please see *09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider* within the report for further details.

Please note a more detailed update will be provided against the full SOF at quarter end.

Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

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

 Special Cause Improvement Low is good	We're aiming to have low performance and we're moving in the right direction.
 Special Cause Improvement High is good	We're aiming to have high performance and we're moving in the right direction.
 Common Cause – no significant change	There is no significant change in our performance. – it is within the expected levels.
 Special Cause Concern Low is good	We're aiming to have low performance and we're moving in the wrong direction.
 Special Cause Concern High is good	We're aiming to have high performance and we're moving in the wrong direction.

Assurance: is the standard achievable?

 Target Pass	We will consistently achieve the target/standard
 Target Pass / Fail	Our performance is not consistent and we regularly achieve or miss the target/standard
 Target Fail	We will consistently fail the target/standard

Please note assurance on whether the standard is achievable is currently not in this report as this is pending the work around standards that is referenced in the Introduction section.

Our Approach to Data Quality and Action

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Data Quality
We regularly undertake a data quality assessment on Board level measures. Our current assessment focusses on 4 key elements: data source, data reliability, construct/definition of the measures, and when it was last amended/tested. Liaising with Trust leads for each measure, we assess and score against each element to calculate an overall Data Quality Assessment (DQA) status.

A development is underway to review our current assessment tool and work will be undertaken to complete the assessment for all measures using the new tool, by the 30th September 2022.

Action Status
Our action status is informed by a combination of current performance, performance over time (including trends) and general intelligence. When we interpret an SPC chart we look at how our performance is compared to what we are trying to achieve, whether we have assurance that we will achieve the standard and whether our performance over time is improving.

Data Quality Assessment status

DQ ★	Data Quality Assessment Score **100%**	No action required
DQ ✓	Data Quality Assessment Score **85% to 99%**	Some work is required
DQ ✗	Data Quality Assessment Score **less than 80%**	Significant work is required

Please note the Data Quality Assessment status has only been included for those measures that we reported in the 21/22 Trust Performance Dashboard. Work will be undertaken to complete this assessment for all measures by the 30th September 2022.

Action status

Positive Assurance	We are doing well in this area and therefore no action is required
No Concerns	No further action is neededat this point in time
Continuous Improvement	Whilst there are no specific concerns at present, we wantto continuously improve in this area
An Area of Concern	We need to investigate this to understand what's happened and/or take action

Please note as this is the first Dashboard; the action status has been determined upon the current variation depicted within the Statistical Process Chart or other relevant information.

Board Integrated Performance Dashboard Summary as at 30th April 2022

Tees, Esk and Wear Valleys NHS
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				93.43%	
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				70.70%	
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC				56.96%	
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L			46.69%	
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC				44.87%	
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC				21.80%	
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC	H			100.24%	
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	H			877	
10)	The number of Serious Incidents reported on STEIS	QAC				15	
11)	The number of Service Reviews relating to incidents of moderate harm and near misses	QAC				49	
12)	The number of Restrictive Intervention Incidents	QAC	H			546	
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				1	
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				0	
15)	The number of uses of the Mental Health Act	MHLC				341	

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
16)	Percentage of staff recommending the Trust as a place to work	PC&D				55.01%	
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				58.76%	
18)	Staff Leaver Rate	PC&D				12.81%	
19)	Percentage Sickness Absence Rate (month behind)	PC&D	H			6.60%	
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	L			86.23%	
21)	Percentage of staff in post with a current appraisal	PC&D	L			79.57%	

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				7,497	
23)	Unique Caseload (snapshot)	S&RC	H			59,419	

Rep Ref	Our Financial measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - Surplus/Deficit	S&RC	913,000	903,330
26)	Use of Resources Rating - overall score	S&RC	3	3
27)	CRES Performance - Recurrent	S&RC	609,667	609,667
28)	CRES Performance - Non-Recurrent	S&RC	5,133	5,1333
29)	Capital Expenditure (CDEL)	S&RC	1,043,000	486,000
30)	Cash against plan	S&RC	76,924,000	78,041,926

Please Note:

Measure 04) Percentage of CYP showing measurable improvement following treatment - patient reported – is under development.

Measure 25) Underlying Performance - run rate movement - the Oversight Framework is still in consultation and this indicator is yet to be defined.

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

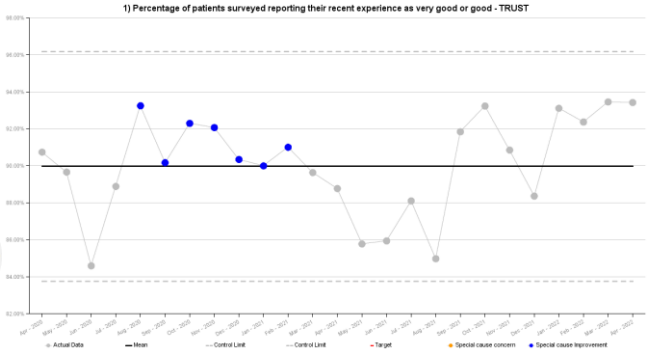
We are all committed to co creating a great experience for patients, and carers and families by ensuring we are providing outstanding and compassionate care and that people tell us this is the case from their experience.

During April, **654** 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, **611 (93.43%)** scored "very good" or "good"

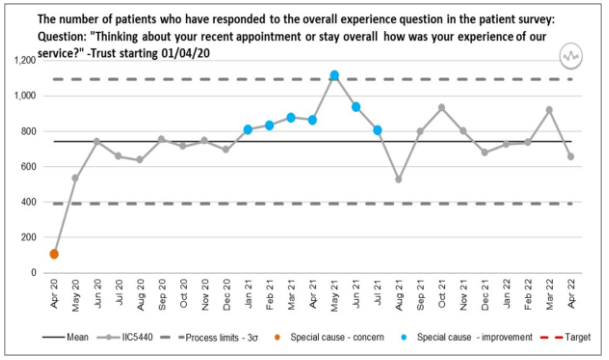
Nothing to note. Our activity is within the expected levels of performance

DQ ✓ 85%

Whilst there are no specific concerns at present, we want to continuously improve in this area



Care Group\Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	



Key Issue(s)	Action(s)	Progress Update	Impact
Whilst our patients have continuously rated our care as very good or good, we are concerned that the number of responses we receive to our surveys are not as high as we would like. This has been impacted by operational pressures and a reduction in face to face contact, as remote clinical contacts have increased in response to pandemic pressures.	Head of Patient Experience to review the outstanding actions in line with the organisational changes, to identify what needs to be taken forward in terms of a new plan for 2022/23. This work will commence in May 2022.	**Not started.** This work did not commence in May 2022 due to the focus on embedding the new governance structure. This will be discussed at the Care Group Quality Assurance & Improvement Sub Groups early June to agree how this will be taken forward.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
A comparison exercise was undertaken with Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust on the 'Feeling Safe' theme during December 2021, which identified similarities in feedback from inpatients in relation to feeling safe, witnessing violence and aggression and the number of activities available.	Head of Patient Experience to hold focus groups initially within secure services during April 2022 to explore these themes further and identify areas of improvement.	**Ongoing.** Secure Services focus groups have been running during April and May 2022 and there are some further focus groups planned for June 2022 for the remaining wards. Areas of improvement have been identified from the initial focus groups and these will be consolidated with the output from the remaining focus groups.	
A data quality issue has been identified as a number of survey responses have not been aligned to Trust cost centres and are, therefore, incorrectly excluded from the measure.	The IIC Team Manager and Corporate Systems Manager to work with Meridian, the survey provider, during April 2022 to investigate and identify appropriate actions to correct the measure.	**Ongoing**. We have received the refreshed data for January 2022 and this will be included in the next dashboard (for the period ending May 2022). There were some other discrepancies identified and we are contacting the system supplier to provide the missing data which we hope to have by the end of June 2022.	

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

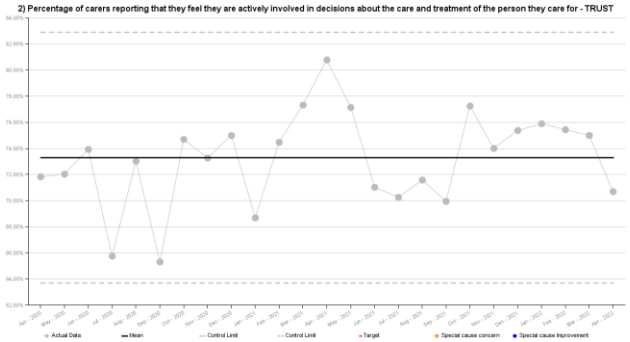
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, carers and families by including carers in any decisions about the person they care for and working with them to provide quality care, and that carers will tell us this is the case from their experience.

During April**, 215** 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, **152 (70.70%)** scored “yes, always”.

Nothing to note. Our activity is within the expected levels of performance

Whilst there are no specific concerns at present, we want to continuously improve in this area



Care Group\Directorate	Variation
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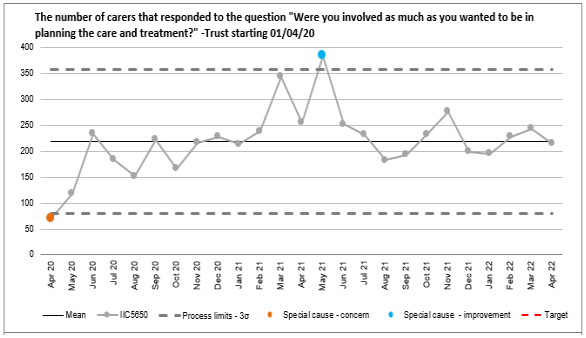
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	



Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that carers of patients within our North Yorkshire, York & Selby Mental Health Services for Older People do not feel they are actively involved in decisions regarding those they care for.	Head of Performance/Senior Performance Manager to engage with the Head of Patient Experience to understand the key work undertaken to date, lessons learned and ongoing actions to support the discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group.	**Ongoing.** The Associate Director of Performance met with the Head of Patient Experience on 10th June 2022. We are aware that Rowan Lea and Springwood currently have carer groups providing support to carers; discussions are ongoing to roll these out to other wards. York Carers Centre is working from Foss Park hospital supporting carer through discharge process and there are now carer workers in Scarborough and York who provide support to carers. This will be discussed further at the Care Group Quality Assurance & Improvement Sub Groups early June 2022.	

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

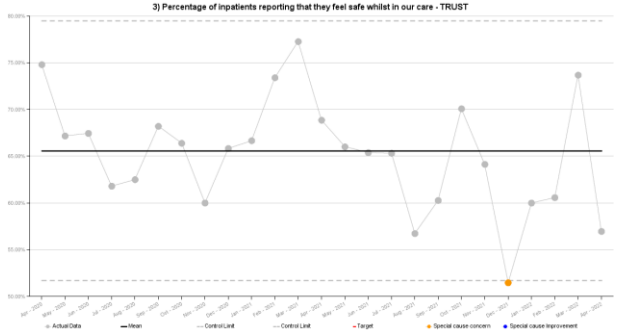
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co-creating safe and personalised care, preventing people from receiving unsafe care and treatment and preventing avoidable harm or risk of harm to inpatients within our services, and that patients will tell us this is the case from their experience.

During April, **79** patients responded to the overall experience question in the patient survey: Question: “During your stay, did you feel safe?”. Of those, **45 (56.96%)** scored “yes, always"

Nothing to note. Our activity is within the expected levels of performance

Whilst there are no specific concerns at present, we want to continuously improve in this area



Care Group\Directorate	Variation
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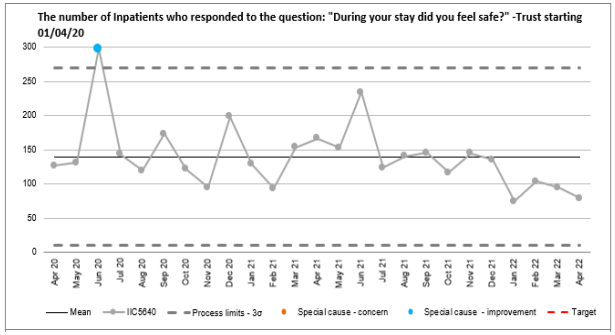
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	



Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that inpatients within our Durham and Tees Valley Adult Mental Heath Services do not feel safe during their stay with us.	Senior Performance Manager to engage with the Head of Patient Experience to understand the key work undertaken to date, lessons learned and ongoing actions to support the discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group.	**Not yet started.**	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, and carers and families by ensuring they experience outstanding care. Knowing that the work we do with patients, families and carers is improving the outcomes for each service user, from a patient perspective, is one way we will know our care is outstanding

This measure is currently under development

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

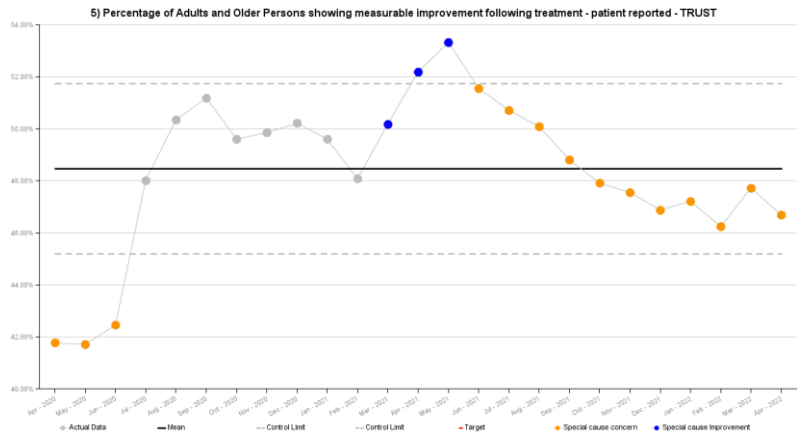
We are all committed to co creating a great experience for patients, and carers and families by ensuring they experience outstanding care. Knowing that the work we do with patients, families and carers is improving the outcomes for each service user, from a patient perspective, is one way we will know our care is outstanding

For the 3 month rolling period ending April, **1912** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 892 (46.65%)** made a measurable improvement.

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

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

We need to investigate this to understand what's happened and/or take action



Care Group\Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that fewer of our patients within our North Yorkshire, York & Selby Adult and Older People Services are showing an improvement in their patient-rated outcome measures than we would like.	Care Group Director of Nursing & Quality to facilitate a discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group to identify the actions that are required to address this. Contact will be made with all General Managers before the meeting to ensure that the discussion will be meaningful.	**Not yet started**	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that fewer of our patients within our North Yorkshire, York & Selby Adult and Older People Services are showing an improvement in their patient-rated outcome measures than we would like.	Head of Performance to engage the Adult Mental Health and Mental Health Services for Older People Service Development Managers in undertaking a team-level deep dive into the data to support the discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group. Work will start the week commencing 23rd May 2022.	**Ongoing.** Work is underway to analyse the data at team level. The Performance Lead has linked in with the Service Development Managers and confirmed that a Trust-wide introduction to outcome measures has been developed and is to be published on the Intranet.	
As above	The Adult Mental Health and Mental Health Services for Older People Service Development Managers to develop a clinical network work plan, which will include actions on training and the support required to improve outcomes from a network point of view. This will be completed in July 2022.	**Not yet started**.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

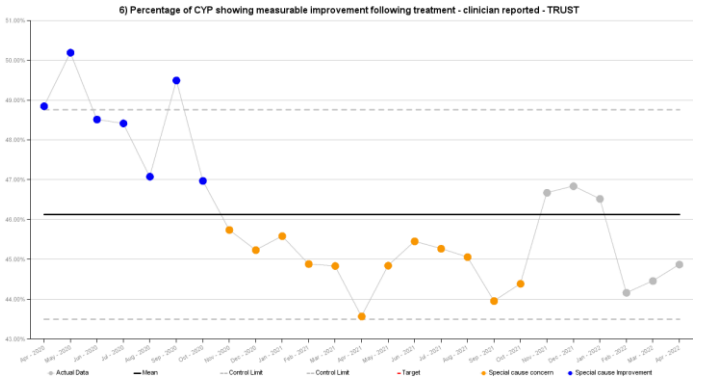
We are all committed to co creating a great experience for patients, and carers and families by ensuring they experience outstanding care. Knowing that the work we do with patients, families and carers is improving the outcomes for each service user, from a clinical perspective, is one way we will know our care is outstanding

For the 3 month rolling period ending April, **780** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 350 (44.87%)** made a measurable improvement.

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

Nothing to note. Our activity is within the expected levels of performance

We need to investigate this to understand what's happened and/or take action



Care Group\Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	L

NB. This is due to the key issues outlined below

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that fewer of our patients within our North Yorkshire, Children & Young People Services are showing an improvement in their clinician-rated outcome measures than we would like.	Care Group Director of Nursing & Quality to facilitate a discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group to identify the actions that are required to address this. Contact will be made with all General Managers before the meeting to ensure that the discussion will be meaningful.	**Not yet started**	
As above	Head of Performance to engage the Service Development Manager in undertaking a team-level deep dive into the data to support the discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group. Work will start the week commencing 23rd May 2022.	**Ongoing.** Work is underway to analyse the data at team level.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, and carers and families by ensuring they experience outstanding care. Knowing that the work we do with patients, families and carers is improving the outcomes for each service user, from a clinical perspective, is one way we will know our care is outstanding

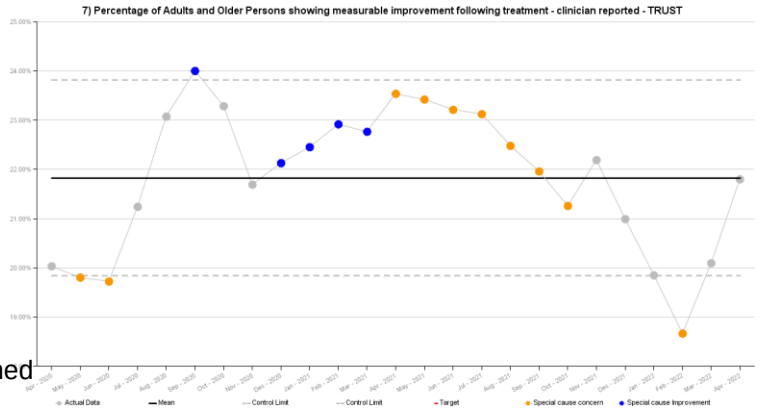
For the 3 month rolling period ending April**, 3188** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 695 (21.80%)** made a measurable improvement.

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

Nothing to note. Our activity is within the expected levels of performance

We need to investigate this to understand what's happened and/or take action

NB. This is due to the key issues outlined below



Care Group\Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	H
NORTH YORKSHIRE, YORK AND SELBY	L

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that fewer of our patients within our North Yorkshire, York & Selby Adult and Older People Services are showing an improvement in their clinician-rated outcome measures than we would like.	Care Group Director of Nursing & Quality to facilitate a discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group to identify the actions that are required to address this. Contact will be made with all General Managers before the meeting to ensure that the discussion will be meaningful.	**Not yet started**	
In addition to above, we are also concerned that fewer of our patients within our Durham & Tees Valley, Adult Services are showing an improvement in their clinician-rated outcome measures than we would like.	Head of Performance/Senior Performance Manager to engage the Service Development Managers in undertaking a team-level deep dive into the data to support the discussions at the June 2022 Care Group Quality Assurance & Improvement Sub Groups. Work will start the week commencing 23rd May 2022.	**Ongoing.** Work is underway to analyse the data at team level.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

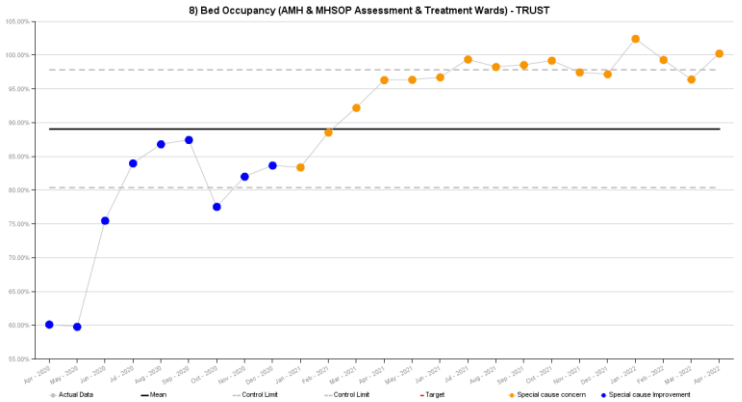
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community. It is important that our patients do not stay in hospital longer than they clinically need to and are discharged appropriately, as we know this can affect their recovery.

During April **10,428** daily beds were available for patients; of those, **10,453 (100.24%)** were occupied.

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

! — We need to investigate this to understand what's happened and/or take action

DQ ★ — 100%



Care Group/Directorate	Variation
TRUST	H
DURHAM, TEES VALLEY AND FORENSIC	H
NORTH YORKSHIRE, YORK AND SELBY	H

Key Issue(s)	Action(s)	Progress Update	Impact
Bed Pressures including increased length of stay and out of area placements are impacting on our service; however further work is required to understand any additional underlying issues and consolidate actions	The Associate Director of Strategic Planning and Programmes to lead a procurement for external support to help us to understand if there is anything further we can do to manage inpatient pressures and out of area placements to be commissioned.	**Ongoing.** The Trust sought external support to help us to understand anything further we could do to manage inpatient pressures and out of area placements to be commissioned. Unfortunately no suppliers were able to respond during 2021/22. Consequently we are now discussing other options to progress this work as a business planning priority for 2022/23, including with the North of England Commissioning Support Unit.	
As above	During June 2022, Associate Director of Strategic Planning and Programmes to form a Trust-wide working group, with executive oversight of our inpatient bed pressures. This group will be led by the Trust Medical Director once in post.	**Ongoing.** A working group has been established and the first meeting is scheduled for the 9th June 2022.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
Our Adult beds have been impacted by the bed reductions at our Cross Lane site. Whilst Esk is now fully opened, Danby remains at reduced number to ensure there are enough staff to safely support the ward.	General Manager Adult Mental Health to support the increase of beds on Danby Ward (13 beds) to full capacity by September 2022.	**Ongoing.** The ward is currently operating with 8 beds and a Notification of Service Change is being progressed.	
Bed Pressures within our Durham and Tees Valley beds, including increased length of stay and out of area placements, are impacting on our service; however further work is required to understand any additional underlying issues and consolidate actions	Senior Performance Manager to engage the Bed Services Manager in undertaking a ward-level deep dive to support the General Managers in a discussion on this measure and the key areas of concern at the June 2022 Care Group Quality & Improvement Sub Group. Work will start the week commencing 23rd May 2022.	**Not yet started**	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

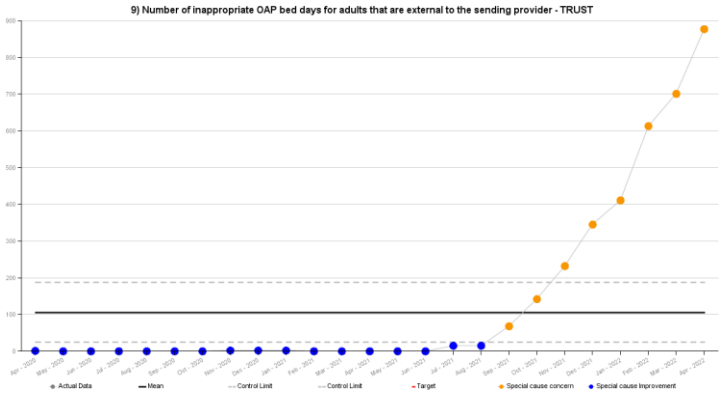
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community.

For the 3 month rolling period ending April, **877** days were spent by patients in beds away from their closest hospital.

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

! — We need to investigate this to understand what's happened and/or take action

DQ ★ — 100%



Care Group\Directorate	Variation
TRUST	H
DURHAM, TEES VALLEY AND FORENSIC	H
NORTH YORKSHIRE, YORK AND SELBY	H

Key Issue(s)	Action(s)	Progress Update	Impact
Bed Pressures as outlined in measure *08) Bed Occupancy,* are impacting on our service; however further work is required to understand any additional underlying issues and consolidate actions	The Associate Director of Strategic Planning and Programmes to lead a procurement for external support to help us to understand if there is anything further we can do to manage inpatient pressures and out of area placements to be commissioned.	**Ongoing.** The Trust sought external support to help us to understand anything further we could do to manage inpatient pressures and out of area placements to be commissioned. Unfortunately no suppliers were able to respond during 2021/22. Consequently we are now discussing other options to progress this work as a business planning priority for 2022/23, including with the North of England Commissioning Support Unit.	
As above	During June 2022, Associate Director of Strategic Planning and Programmes to form a Trust-wide working group, with executive oversight of our inpatient bed pressures. This group will be led by the Trust Medical Director once in post.	**Ongoing.** A working group has been established and the first meeting is scheduled for the 9th June 2022.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
Bed Pressures trust-wide including increased length of stay are impacting on our service	General Manager Adult Mental Health to open 2 beds on Rowan Lea on 4th April 22 which would create an additional 52 available bed days in April then proportionate amount thereafter	**Complete** – 2 beds were opened on Rowan Lea on the 4th April 2022.	
As above	General Manager Adult Mental Health to open 13 beds on Esk Ward by the end of June 22 which would create an additional 403 available bed days in July within the North Yorkshire, York & Selby Care Group, then proportionate amount thereafter	**Ongoing.** Esk has opened 13 beds on 26th April 2022 (earlier than planned). However, Danby Ward had to reduce its beds from 13 to 4 on 26th April 2022 to support safe staffing so is currently operating with 8 beds. As at the end of April we had 4 additional beds (overall) which has created 20 available bed days .	
As above	Director of Partnerships and Case Management to review the contract for the Priory for 5 beds which are due to cease at the end of June 22, during May 2022.	**Complete.** Gold Command agreed an extension to the end of September 2022, on the 20th May 2022.	
There is concern that a high number of beds within the Care Groups are being occupied by patients outside of the Care Group.	Head of Performance and Senior Performance Manager to investigate whether we can identify the current patient base (e.g. the use of total bed capacity by the different populations and how long their LOS is) to support discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Groups. Work will start the week commencing 23rd May 2022.	**Ongoing.** The Performance Lead for North Yorkshire, York & Selby Care Group has submitted a request for the data.	

10) The number of Serious Incidents reported on STEIS

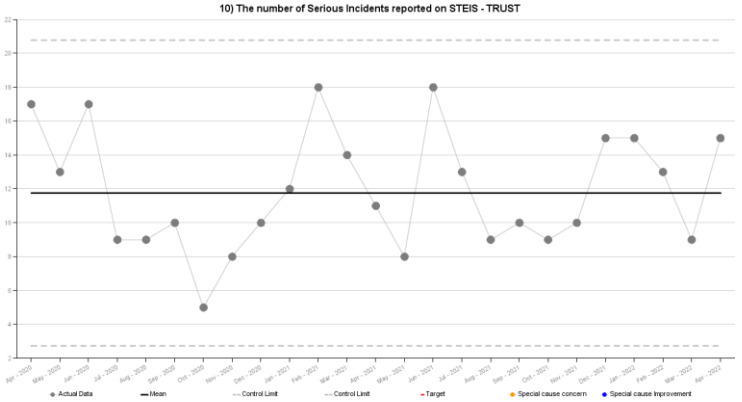
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety of our patients and to minimise the risk of any harm to them and distress to their families and carers.

15 serious incidents were reported on the Strategic Executive Information System (STEIS) during April.

Nothing to note. Our activity is within the expected levels of performance

Whilst there are no specific concerns at present, we want to continuously improve in this area



Care Group\Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

Key Issue(s)	Action(s)	Progress Update	Impact
Whilst there are no specific trends in the number of Serious Incidents reported on STEIS, we review every Serious Incident and optimise the opportunities for learning and improvement to prevent similar incidents occurring.	Associate Director of Performance to engage with the Director of Quality Governance to understand the key work undertaken to date, lessons learned and ongoing actions to support the discussions at the Quality Assurance & Improvement Groups.	**Complete.** Meeting held 10th June 2022. Where new or consistent themes are identified from the review of Serious Incidents these will be discussed through the appropriate governance route and highlighted to the Board including the actions we are taking to make improvements.	We would expect to see a reduction in number/themes once actions are completed and reported via the Organisational Learning Group.

11) The number of Service Reviews relating to incidents of moderate harm and near misses

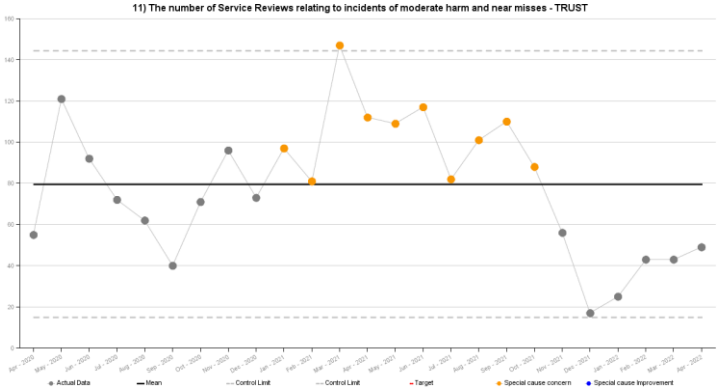
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety of our patients and to minimise the risk of any harm to them and distress to their families and carers.

49 number of service reviews were undertaken in relation to incidents of moderate harm or 'near misses' during April.

Nothing to note. Our activity is within the expected levels of performance

Whilst there are no specific concerns at present, we want to continuously improve in this area



Care Group\Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

Key Issue(s)	Action(s)	Progress Update	Impact
Whilst there are no specific trends in the number of Service Reviews relating to incidents of moderate harm and near misses, we review every Incident and optimise the opportunities for learning and improvement to prevent similar incidents occurring.	Associate Director of Performance to engage with the Director of Quality Governance to understand the key work undertaken to date, lessons learned and ongoing actions to support the discussion at the Quality Assurance & Improvement Groups.	**Complete.** Meeting held 10th June 2022. Where new or consistent themes are identified from the review of Incidents these will be discussed through the appropriate governance route and highlighted to the Board including the actions we are taking to make improvements.	We would expect to see a reduction in number/themes once actions are completed and reported via the Organisational Learning Group.

12) The number of Restrictive Intervention Incidents

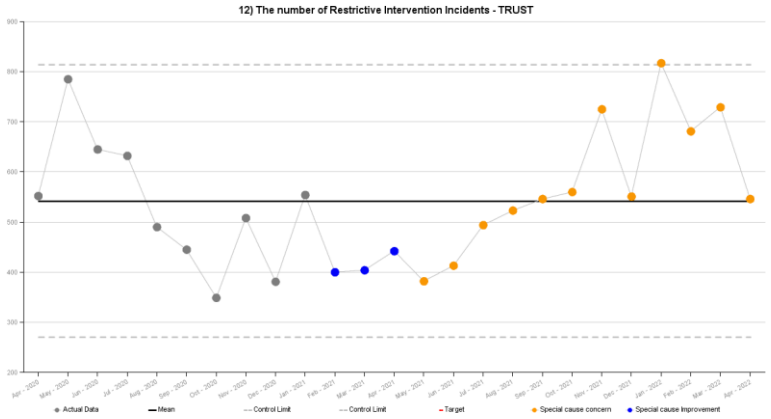
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are committed to ensuring that all our patients are cared for in a safe and secure environment. When restrictive intervention incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety of our patients and to minimise the risk of any harm to them and distress to their families and carers.

546 number of Restrictive Intervention Incidents took place during April.

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

We need to investigate this to understand what's happened and/or take action



Care Group/Directorate	Variation
TRUST	H
DURHAM, TEES VALLEY AND FORENSIC	H
NORTH YORKSHIRE, YORK AND SELBY	

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that there have been a higher number of restrictive intervention incidents within our Learning Disability Services in Durham, Tees Valley & Forensics Care Group than we would like.	Associate Director of Performance to engage with the Director of Quality Governance to understand and share the learning on the work undertaken, in order to support the discussions around the measure and the key areas of concern at the Quality Assurance & Improvement Groups.	**Ongoing.** Meeting held 10th June 2022. This issue has already been identified in the Quality & Learning Report and there are a number of actions underway which are closely monitored by the Positive & Safe Group. We know this relates to a small number of highly complex patients and significant support continues to be provided to Learning Disabilities Services at this time.	We would expect to see a reduction in the number of restrictive intervention incidents once improvements are embedded.

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

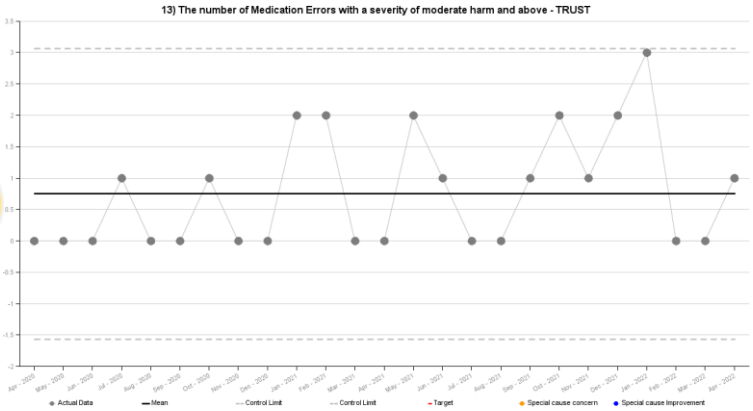
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are committed to ensuring that all our patients are cared for in a safe and secure environment. When medication errors occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety of our patients and to minimise the risk of any harm to them and distress to their families and carers.

1 medication error has been recorded with a severity of moderate harm, severe or death during April.

Nothing to note. Our activity is within the expected levels of performance

Whilst there are no specific concerns at present, we want to continuously improve in this area



Care Group/Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

Key Issue(s)	Action(s)	Progress Update	Impact
Whilst there are no specific trends in the number of Medication Errors with a severity of moderate harm and above, we review every medication error of moderate harm and above and optimise the opportunities for learning and improvement to prevent similar errors occurring.	Associate Director of Performance to engage with the Director of Quality Governance and Chief Pharmacist during June 2022 to understand the key work undertaken to date, lessons learned and ongoing actions to support the discussions at the Quality Assurance & Improvement Groups.	**Not yet started.**	

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

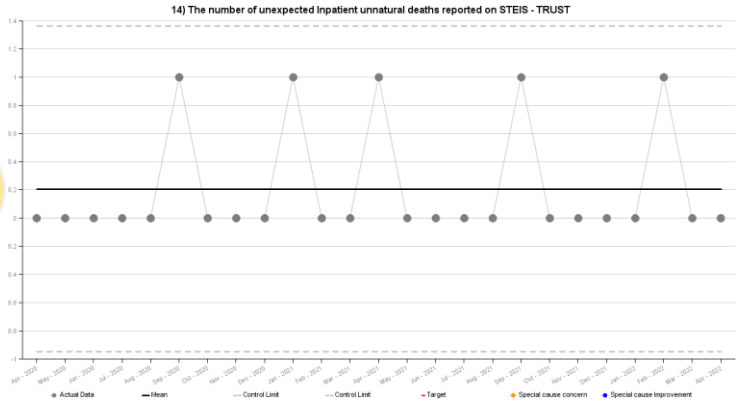
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are committed to ensuring that all our patients are cared for in a safe and secure environment. When any deaths occur within our services that are not attributable to natural causes, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety of our patients and to minimise the risk of any harm to them and distress to their carers and families.

0 unexpected Inpatient unnatural deaths reported on the Strategic Executive Information System (STEIS) during April.

Nothing to note. Our activity is within the expected levels of performance

Whilst there are no specific concerns at present, we want to continuously improve in this area



Care Group/Directorate	Variation
TRUST	
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

Key Issue(s)	Action(s)	Progress Update	Impact
Whilst there are no specific trends in the number of unexpected inpatient unnatural deaths reported on STEIS, every unexpected Inpatient unnatural death is a concern to us We review these through a Rapid Patient Safety Review to identify any immediate learning which is then followed by full Serious Incident Review.	Associate Director of Performance to engage with the Director of Quality Governance to understand the key work undertaken to date, lessons learned and ongoing actions to support the discussions at the Quality Assurance & Improvement Groups.	**Complete.** Meeting held 10th June 2022. We adhere to the Learning from Deaths policy which is based on the National Guidance on Learning from Deaths which includes a report to the Board. Where new or consistent themes are identified from the review these will be discussed through the appropriate governance route as per the Learning from Deaths policy.	We would expect to see a reduction in number/themes once actions are completed and reported via the Organisational Learning Group.

15) The number of uses of the Mental Health Act

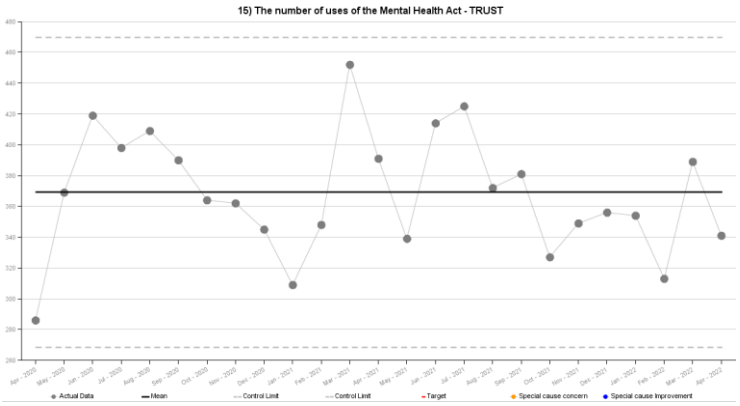
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are committed to co creating a great experience by ensuring all patients that are admitted to our beds feel secure, supported and safe within our services. It is important that we support all patients that are treated within our hospitals equally and support them to retain contact with family, carers, friends and their community.

There were **341** uses of the Mental Health Act during April.

Nothing to note. Our activity is within the expected levels of performance

No further action is needed at this point in time



Care Group\Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

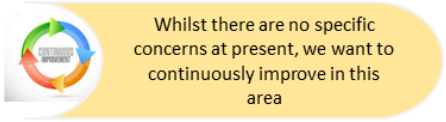
Key Issue(s)	Action(s)	Progress Update	Impact
There are currently no specific trends or areas of concern identified in the number of uses of the Mental Act.	N/A		

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work, as we recognise staff recommending the Trust as a place to work is an indication of a high level of job satisfaction within our workforce which will support the provision of high quality care.

2196 staff responded to the April 2022 National Quarterly Pulse Survey question "I would recommend my organisation as a place to work" Of those, **1208 (55.01%)** responded either "Strongly Agree" or "Agree"



	Apr - 2022
TRUST	55.01%
ASSISTANT CHIEF EXEC	61.29%
DIGITAL AND DATA SERVICES	68.00%
DURHAM, TEES VALLEY AND FORENSIC	54.63%
ESTATES AND FACILITIES MANAGEMENT	50.38%
FINANCE	57.58%
MEDICAL	64.10%
NORTH YORKSHIRE, YORK AND SELBY	52.85%
NURSING AND GOVERNANCE	51.95%
PEOPLE AND CULTURE	56.99%
THERAPIES	54.17%

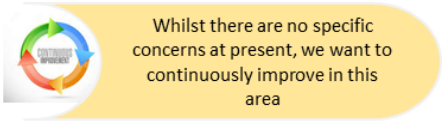
Key Issue(s)	Action(s)	Progress Update	Impact
We currently have limited data on the percentage of staff recommending the Trust as a place to work.	Associate Director of Performance to engage with the Director of People & Culture and Head of Business Intelligence to explore options to routinely collect staff experience during May 2022.	**Completed:** Meeting held on 11th May. It was agreed that we would explore technical solutions to the routine collection of staff experience and trial this in a small number of areas.	
As above	The Head of Business Intelligence to discuss technical solutions within Digital and Data Services by 30th June 22.	**Not yet started.**	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work, as we recognise that having the ability to suggest improvements and a high level of job satisfaction within our workforce which will support the provision of high quality care.

2221 staff responded to the April 2022 National Quarterly Pulse Survey question "I am able to make improvements happen in my area of work" Of those, **1305 (58.76%)** responded either "Strongly Agree" or "Agree"



	Apr - 2022
TRUST	58.76%
ASSISTANT CHIEF EXEC	74.19%
DIGITAL AND DATA SERVICES	72.00%
DURHAM, TEES VALLEY AND FORENSIC	57.98%
ESTATES AND FACILITIES MANAGEMENT	52.67%
FINANCE	69.70%
MEDICAL	79.49%
NORTH YORKSHIRE, YORK AND SELBY	56.45%
NURSING AND GOVERNANCE	63.64%
PEOPLE AND CULTURE	73.12%
THERAPIES	70.83%

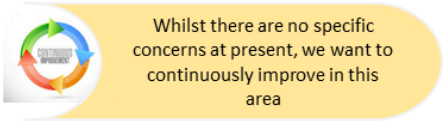
Key Issue(s)	Action(s)	Progress Update	Impact
We currently have limited data on the percentage of staff feeling they are able to make improvements happen in their area of work.	Associate Director of Performance to engage with the Director of People & Culture and Head of Business Intelligence to explore options to routinely collect staff experience during May 2022.	**Completed:** Meeting held on 11th May. It was agreed that we would explore technical solutions to the routine collection of staff experience and trial this in a small number of areas.	
As above	The Head of Business Intelligence to discuss technical solutions within Digital and Data Services by 30th June 22.	**Not yet started.**	

18) Staff Leaver Rate

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for our colleagues so that they will feel they can continue to develop their careers within the organisation. By ensuring that we do not have an excessively high staff leaver rate, we will be retaining experienced staff helping us to ensure continuity of care and the provision of high quality services.

6899.28 staff were in post at the beginning of May 2021. Of those, **883.81 (12.81%)** had left the Trust as at the end of April 2022



	Apr - 2022
TRUST	12.81%
ASSISTANT CHIEF EXEC	8.97%
COMPANY SECRETARY	17.83%
CORPORATE AFFAIRS AND INVOLVEMENT	13.57%
DIGITAL AND DATA SERVICES	8.92%
DURHAM, TEES VALLEY AND FORENSIC	12.22%
ESTATES AND FACILITIES MANAGEMENT	14.61%
FINANCE	27.65%
MEDICAL	16.60%
NORTH YORKSHIRE, YORK AND SELBY	14.38%
NURSING AND GOVERNANCE	14.99%
PEOPLE AND CULTURE	6.92%
THERAPIES	38.00%

Key Issue(s)	Action(s)	Progress Update	Impact
We currently have limited data on Staff Leaver Rate within this report so we are unable to identify if there are any specific trends or areas of concern	Head of Business Intelligence to engage with the Workforce Information Manager by the 31st May 22, to progress a plan of work for the inclusion of historic data for this measure.	**Ongoing:** Data has been provided for the period January 21 to March 22. This will be included in the performance dashboard for the period ending May 21. Data will be provided for the period April-Dec 20 for the performance dashboard for the period ending June 21.	

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

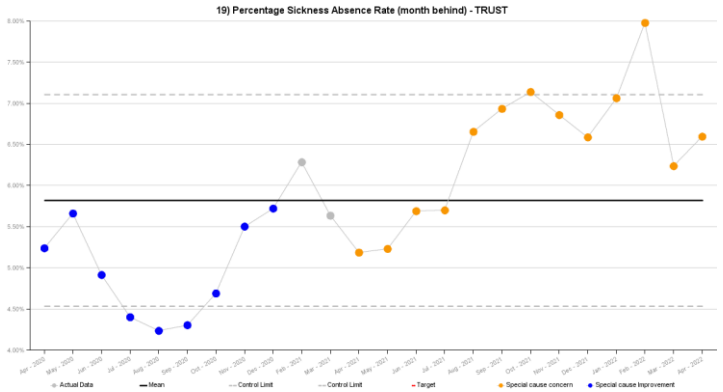
We are all committed to co creating a great experience our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work as we know this also impacts on the quality of care we provide to our patients.

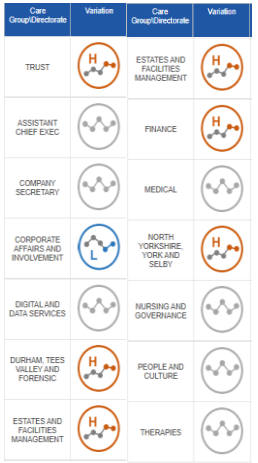
There were **217,242.96** working days available for all staff during March (reported month behind); of those, **14,328.07 (6.60%)** days were lost due to sickness.

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

We need to investigate this to understand what's happened and/or take action

DQ ★ 100%





Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that staff within our North Yorkshire, York & Selby services are under increasing pressures due to current recruitment challenges.	Care Group Director of Therapies to facilitate a discussion at the June 2022 Care Group People, Culture & Diversity Sub Group to identify the key areas of concern.	**Not yet started**.	
We are concerned that more members of staff within our Durham and Tees Valley services have been absent from work due to sickness than we would like.	Senior Performance Manager to engage the relevant People Partner in undertaking a team level deep dive and discussion with General Managers across CYPS, Learning Disabilities and Mental health services for older people to understand the areas of concern and document key actions in place. These will be shared for discussion in the June 2022 Care Group People, & Culture & Diversity Sub Group. Work will start the week commencing 23rd May 2022.	**Ongoing.** The Senior Performance Manager has met with the Durham, Tees Valley & Forensics People Partner to discuss the process. The People Partners for both Care Groups are leading a piece of analysis work supported by the Human Resources leads for each speciality and linking with the General Mangers. Findings will be shared for discussion in the June 2022 Care Group People, & Culture & Diversity Sub Groups.	

19) Percentage Sickness Absence Rate continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that more members of staff within our Secure Inpatient Services have been absent from work due to sickness than we would like.	SIS General Manager and relevant People Partner to ensure completion of the current action plan by end of June 22.	**Ongoing.** Of the 17 actions14 have been completed. All remaining actions are on track for completion.	
We have a high number of Health & Justice staff absent from work due to sickness within the Oakwood Locked Rehabilitation centre.	By March 2022, relevant People Partner to meet with the team managers to obtain a background and intelligence on any staff concerns.	**Ongoing.** The People Partner has met with the current team manager but further discussion with the previous manager have been delayed and is rescheduled for then end of May 2022.	
We are concerned that more members of staff within our Corporate services have been absent from work due to sickness than we would like.	Head of Performance and Senior Performance Manager to escalate with Heads of Service during May 2022, to identify areas of concern.	**Ongoing.** Data shared with all corporate Directors 30th May 2022.	

20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

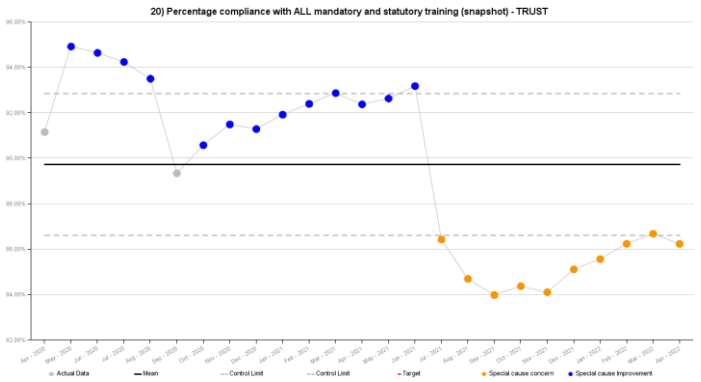
We are all committed to co creating a great experience for patients, carers families and our colleagues by ensuring colleagues feel engaged in the organisation and appraisals offer one opportunity for staff to get and give feedback on their experience of working for the Trust. We also ensure that our staff having the appropriate levels of training to maintain their skills, which is vital if we are to provide high quality and safe services.

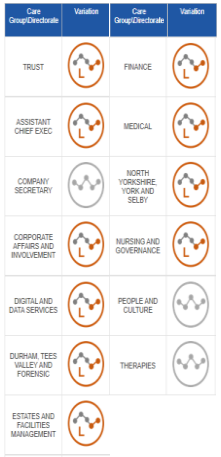
112,976 training courses were due to be completed for all staff in post by the end of April. Of those, **97,419** (**86.23%**) courses were actually completed

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

We need to investigate this to understand what's happened and/or take action

DQ ★ 100%





Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that staff capacity and demand for our services are impacting on the ability of staff within our North Yorkshire, York & Selby services to undertake their training by the 30th June 2022 as planned.	Care Group Director of Therapies and Quality Improvement Manager to meet with the North Yorkshire, York & Selby Business Manager by the end of June 2022 to discuss potential actions that can be taken forward.	**Not yet started**	
We are concerned that staff capacity and demand for our services are impacting on the ability of staff within our Durham ,Tees Valley & Forensic services to undertake their training by the 30th June 2022 as planned.	Senior Performance Manager to engage the relevant People Partner in undertaking a team level deep dive and to meet with the General Managers to understand the areas of concern and document key actions in place. These will be shared for discussion in the June 2022 Care Group People, Culture & Diversity Sub Group. Work will start the week commencing 23rd May 2022.	**Ongoing.** The Senior Performance Manager has met with the Durham, Tees Valley & Forensics People Partner to discuss the process. The People Partners for both Care Groups are leading a piece of analysis work supported by the Human Resources leads for each speciality and linking with the General Mangers. Findings will be shared for discussion in the June 2022 Care Group People, & Culture & Diversity Sub Groups.	

20) Percentage compliance with ALL mandatory and statutory training continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that staff within a number of our corporate teams do not have up to date mandatory and statutory training.	Head of Performance and Senior Performance Manager to escalate with Heads of Service during May 2022, to identify areas of concern.	**Ongoing.** Data shared with all corporate Directors 30th May 2022	

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, carers families and our colleagues by ensuring colleagues feel engaged in the organisation and appraisals offer one opportunity for staff to get and give feedback on their experience of working for the Trust. We also ensure that our staff having the appropriate levels of training to maintain their skills, which is vital if we are to provide high quality and safe services.

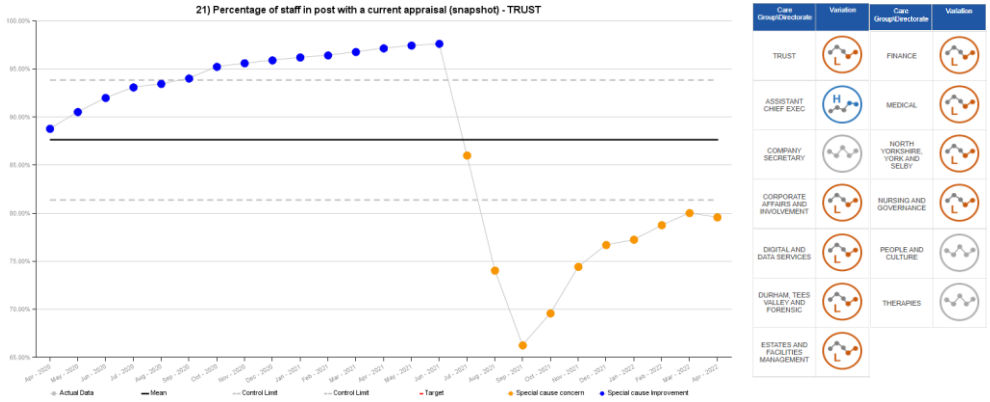
Of the **6251** eligible staff in post at the end of April; **4974** (**79.57%**) had an up to date appraisal

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

We need to investigate this to understand what's happened and/or take action

DQ

100%



Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that a high number of staff within our Care Groups have not received a timely appraisals and that the services are not on track to deliver the trajectories agreed during 2021/23.	Head of Performance/Senior Performance Manager to engage the Care Groups' People Partners in undertaking a deep dive into the service data to support a detailed discussion at the June 2022 Care Group People, Culture & Diversity Sub Group. Work will start the week commencing 23rd May 2022.	**Ongoing.** The Senior Performance Manager has met with the Durham, Tees Valley & Forensics People Partner to discuss the process. The People Partners for both Care Groups are leading a piece of analysis work supported by the Human Resources leads for each speciality and linking with the General Mangers. Findings will be shared for discussion in the June 2022 Care Group People, & Culture & Diversity Sub Groups.	
We are concerned that staff within a number of our corporate teams have not received a timely appraisal.	Head of Performance and Senior Performance Manager to escalate with Heads of Service during May 2022, to identify areas of concern.	**Ongoing.** Data shared with all corporate Directors 30th May 2022	

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

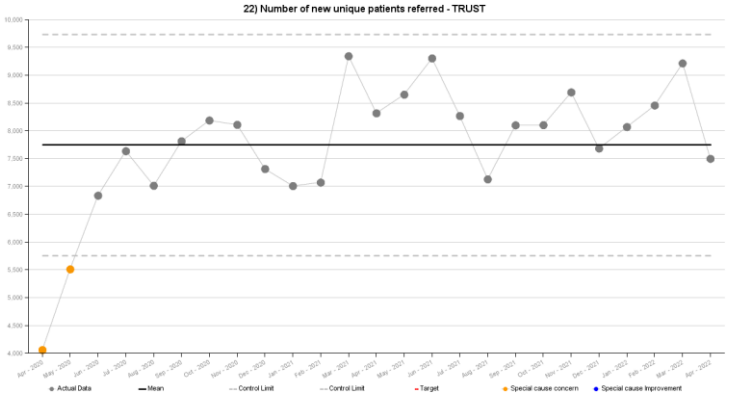
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment is important to ensure we maintain high standards of care. Without this there may be an impact on the delivery of care and may affect our patients' recovery, as well as the wellbeing of our staff.

7497 patients referred in April that are not currently open to an existing Trust service

Nothing to note. Our activity is within the expected levels of performance

DQ ★ 100%

No further action is needed at this point in time



Care Group\Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

Key Issue(s)	Action(s)	Progress Update	Impact
There are currently no specific trends or areas of concern identified in the number of new unique patients referred.	N/A		

23) Unique Caseload (snapshot)

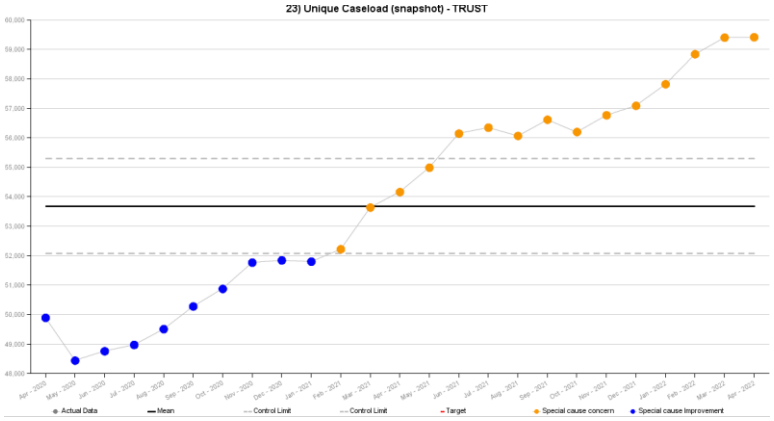
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment is important to ensure we maintain high standards of care. Without this there may be an impact on the delivery of care and may affect our patients' recovery, as well as the wellbeing of our staff.

59,419 cases were open, including those waiting to be seen, as at the end of April 2022.

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

We need to investigate this to understand what's happened and/or take action



Care Group/Directorate	Variation
TRUST	H
DURHAM, TEES VALLEY AND FORENSIC	H
NORTH YORKSHIRE, YORK AND SELBY	H

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that we have an extremely high caseloads within our services and that we need to build on the understanding we currently have, to identify key actions that we need to progress.	Head of Performance and Senior Performance Manager to engage the Planning Team in undertaking a deep dive into the service data to support a detailed discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group. Work will start the week commencing 23rd May 2022.	**Ongoing.** Team level data is currently being sourced.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, carers, families, staff and Partners by ensuring we can manage our resources and finances effectively.

We delivered a **(£0.9m)** deficit to 30th April against a planned year to date deficit of **(£0.9m)**.

(£0.0m) variance to plan.

We need to investigate this to understand what's happened and/or take action

Summary

On the 28th April 2022 the Trust submitted, and the Trust Board approved, a final draft 2022/23 financial plan to NHSI, pending external feedback on the national financial plan position and status of individual organisation and Integrated Care System aggregate plans.

Recently £1.5bn additional funding has been allocated to Integrated Care Systems with an expectation that this will support systems to develop balanced financial plans in advance of a further final national plan submission for 2022/23 on 20th June 2022.

Due to later than normal final plan submissions, work continues to complete final detailed budget sign-off. This was acknowledged nationally with no requirement for the Trust to submit returns to NHSI for April 2022 performance.

The year to date position is an operational deficit of **£0.9m**. Whilst this is **in line with forecast expenditure** run rates prepared for the April submission, it means that the Trust needs to significantly reduce utilisation of independent bed capacity being used to mitigate operational bed pressures and to reduce agency expenditure and related premium pay rates from quarter two to deliver expected annual plan requirements.

Key Issue(s)	Action(s)	Progress Update	Impact
Agency expenditure is high which is impacting on our financial plan and will impact on our Use of Resources Rating when its reintroduced	CRES schemes are being developed in conjunction with the Care Groups for agency volume and rate reductions by 30th June 22	**Ongoing:** Work has commenced on the development of CRES Schemes	
Independent Sector Bed utilisation is high which is also impacting on our financial plan delivery	As above and further exploration of issues including length of stay and delayed discharges (timescales tbc)	**Ongoing:** Bed managers assessing numbers, reasons and bed days	

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

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
Agency expenditure and Independent Sector Bed utilisation is high which is also impacting on our financial plan delivery	Plans to re-open Scarborough beds to mitigate Locality pressures	**Ongoing:** Recruitment lead times mean re-forecast (from full capacity in May) to increase to 8 beds from June, 13 from September	

25) Underlying Performance - run rate movement

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, carers, families, staff and Partners by ensuring we can manage our resources and finances effectively.

The Oversight Framework is still in consultation with the metrics used to measure this indicator yet to be defined.

26) Use of Resources Rating - overall score

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, carers, families, staff and Partners by ensuring we can manage our resources and finances effectively.

We would be capped as a **3** for the period ending 30th April 2022 against a planned rating of **3**.

0 variance to plan.

Whilst there are no specific concerns at present, we want to continuously improve in this area

Summary

The **Use of Resources Rating** (UoRR) is impacted by Covid-19 with national monitoring suspended. However, the Trust has continued to assess the UoRR based on plan submissions and actual performance.

- The **capital service capacity metric** assesses the level of operating surplus generated, to ensure Trusts can cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 0.06x (can cover debt payments due 0.06 times), which is ahead of plan and is rated as a 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 34.5 days; this is ahead of plan and is rated as a 1.
- The Income and Expenditure **(I&E) margin metric** assesses the level of surplus or deficit against turnover, excluding exceptional items e.g., impairments. The Trust has an I&E margin of minus 2.6%, this is in line with plan and is rated as 4.

Agency expenditure of £1.6m is £0.5m (47%) higher than planned, and is rated as a 3. The **agency expenditure metric within UoRR** is currently suspended; however, the Trust has continued to assess agency expenditure against a capped (pre-pandemic) Trust target. It is unclear, once national monitoring is reintroduced what the Trust cap will be based upon e.g. pre pandemic cap was £6.6m or 2.4% of pay bill, which would suggest a significant variance from target (180% or £1m). This is a renewed area of focus for 2022/23 Cash Releasing Efficiency Schemes. Recent regional reporting of sickness levels suggests peer mental health providers have experienced similar challenges. The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to sickness absence but equally to securing alternative whole system models of care for specialist packages of care.

As a result of the Trust's Capital Service Cover and I&E Margin risk ratings the **overall UORR** would be capped as a **3** for the period ending 30th April 2022 and is **in line with plan**.

Key Issue(s)	Action(s)	Progress Update	Impact
Agency expenditure is high which is impacting on our financial plan and will impact on our Use of Resources Rating when its reintroduced	2022/23 CRES plans to reduce overall utilisation and off framework / premium rate contracts to be completed by 30th June 22	**Ongoing:** Work has commenced on CRES Schemes	

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

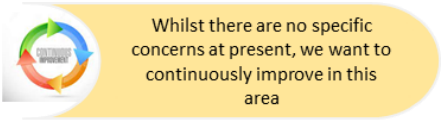
27) CRES Performance - Recurrent

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, carers, families, staff and Partners by ensuring we can manage our resources and finances effectively.

We planned to deliver **£0.7m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£0.7m**.

(£0.0m) variance to plan.



Summary

The Trust continues to identify and consider schemes to deliver future requirements. Activities will continue throughout Q1 2022/23 with key focus on:

- Individual scheme baseline assessment by Care Group, including identification and validation of targets.
- Quality impact assessments (QIA) to be completed for all schemes and signed off locally by relevant clinical and management leads, with final approval of schemes by Medical Director, Director of Nursing and Management Directors and Executive Director Group oversight.

Key Issue(s)	Action(s)	Progress Update	Impact
There is a risk to the commencement of plans that are phased to commence Quarter 2 which will impact on the delivery of our financial plan	CRES schemes are being developed in conjunction with the Care Groups	**Ongoing:** Work has commenced on the development of CRES Schemes	

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

28) CRES Performance – Non-Recurrent

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, carers, families, staff and Partners by ensuring we can manage our resources and finances effectively.

We planned to deliver **£0.0m** non-recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£0.0m**.

(£0.0m) variance to plan.

Whilst there are no specific concerns at present, we want to continuously improve in this area

Summary

The Trust continues to identify and consider schemes to deliver future requirements. Activities will continue throughout Q1 2022/23 with key focus on:

- Individual scheme baseline assessment by Care Group, including identification and validation of targets.
- Quality impact assessments (QIA) to be completed for all schemes and signed off locally by relevant clinical and management leads, with final approval of schemes by Medical Director, Director of Nursing and Management Directors and Executive Director Group oversight.

Key Issue(s)	Action(s)	Progress Update	Impact
There are no key issues currently identified in relation to non-recurrent CRES	N/A		

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

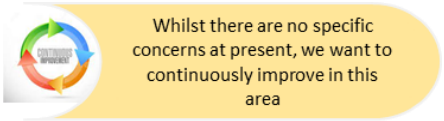
29) Capital Expenditure (CDEL)

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, carers, families, staff and Partners by ensuring we can manage our resources and finances effectively.

Capital expenditure at the end of April was **£0.49m** against planned expenditure of **£1.04m**.

(£0.55m) variance to plan.



Summary

A final draft capital plan of £10.1m for 2022/23 was submitted on 28th April 2022, alongside revenue plans.

Capital expenditure at the end of April was **£0.49m**, and is **£0.55m** below plan **(£1.04m)**. This is largely due to delayed receipt of ECG machines and some delays to works at West Park Hospital. Both schemes are expected to be caught up by the end of quarter 1.

Key Issue(s)	Action(s)	Progress Update	Impact
There are no key issues currently identified in relation to Capital Expenditure	N/A		

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

30) Cash balances (actual compared to plan)

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, carers, families, staff and Partners by ensuring we can manage our resources and finances effectively.

We have an actual cash balance of **(£78.0m)** against a planned year to date cash balance of **(£76.9m).**

(£1.1m) Favourable variance from plan

Whilst there are no specific concerns at present, we want to continuously improve in this area

Summary

Cash balances were **£78.0m** at 30 April 2022, which is **£1.1m** higher than plan **(£76.9m)**. This is linked to the slippage on the capital programme (£0.6m), and working capital movements, mainly Health Education England training funding, which has been paid in advance for quarter 1.

The Trust achieved the 95% Better Payment Practice Code (BPPC) target compliance for the prompt payment of both NHS and non-NHS suppliers.

Conversations are ongoing with organisations to take collection of all debt over 90 days. None of the amounts outstanding are currently disputed, the delay in payment is linked to process delays within organisations e.g., purchase orders not raised, invoices mislaid, and new financial year.

Key Issue(s)	Action(s)	Progress Update	Impact
There are no key issues currently identified in relation to our cash balances	N/A		

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

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Measures		Goal 1 - To co-create a great experience for our patients,	Goal 2 - To co-create a great experience for our colleagues	Goal 3 - To be a great partner
BIPD_01	Percentage of Patients surveyed reporting their recent experience as very good or good	√	√	
BIPD_02	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	√	√	
BIPD_03	Percentage of inpatients reporting that they feel safe whilst in our care	√	√	
BIPD_04	Percentage of CYP showing measurable improvement following treatment - patient reported	√		
BIPD_05	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	√		
BIPD_06	Percentage of CYP showing measurable improvement following treatment - clinician reported	√	√	
BIPD_07	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	√	√	
BIPD_08	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	√	√	√
BIPD_09	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider	√		
BIPD_10	The number of Serious Incidents reported on STEIS	√	√	
BIPD_11	The number of Service Reviews relating to incidents of moderate harm and near misses	√		
BIPD_12	The number of Restrictive Intervention Incidents	√	√	
BIPD_13	The number of Medication Errors with a severity of moderate harm and above	√		
BIPD_14	The number of unexpected Inpatient unnatural deaths reported on STEIS	√		
BIPD_15	The number of uses of the Mental Health Act	√		√

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	Measures	Goal 1 - To co-create a great experience for our patients, carers and families	Goal 2 - To co-create a great experience for our colleagues	Goal 3 - To be a great partner
BIPD_16	Percentage of staff recommending the Trust as a place to work	√	√	√
BIPD_17	Percentage of staff feeling they are able to make improvements happen in their area of work	√	√	√
BIPD_18	Staff Leaver Rate	√	√	√
BIPD_19	Percentage Sickness Absence Rate	√	√	√
BIPD_20	Percentage compliance with ALL mandatory and statutory training	√	√	√
BIPD_21	Percentage of staff in post with a current appraisal	√	√	√
BIPD_22	Number of new unique patients referred	√	√	√
BIPD_23	Unique Caseload (snapshot)	√	√	
BIPD_24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit			
BIPD_25	Underlying Performance - run rate movement			
BIPD_26	Use of Resources Rating - overall score			
BIPD_27	CRES Performance - Recurrent			
BIPD_28	CRES Performance - Non-Recurrent			
BIPD_29	Capital Expenditure (CDEL)			
BIPD_30	Cash balances (actual compared to plan)			

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	Measures	1. Recruitment and Retention	2. Demand	3. Involvement and Engagement	4. Experience	5. Culture & Wellbeing	6. Safety	7. Infrastructure	8. Cyber Security	9. Regulatory Action	10. Influence	11. Governance & Assurance	12. Roseberry Park	13. West Lane	14. CITO	15. Financial Sustainability
BIPD_01	Percentage of Patients surveyed reporting their recent experience as very good or good			√	√	√	√			√						
BIPD_02	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for			√	√	√	√									
BIPD_03	Percentage of inpatients reporting that they feel safe whilst in our care			√	√	√	√			√						
BIPD_04	Percentage of CYP showing measurable improvement following treatment - patient reported			√	√		√					√				
BIPD_05	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported			√	√		√					√				
BIPD_06	Percentage of CYP showing measurable improvement following treatment - clinician reported			√	√		√					√				
BIPD_07	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported			√	√		√					√				
BIPD_08	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	√	√		√	√	√					√				√
BIPD_09	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider		√		√							√				√
BIPD_10	The number of Serious Incidents reported on STEIS			√	√		√			√						
BIPD_11	The number of Service Reviews relating to incidents of moderate harm and near misses			√	√		√			√		√				
BIPD_12	The number of Restrictive Intervention Incidents			√	√	√	√			√						
BIPD_13	The number of Medication Errors with a severity of moderate harm and above				√		√			√						
BIPD_14	The number of unexpected Inpatient unnatural deaths reported on STEIS			√	√	√	√									
BIPD_15	The number of uses of the Mental Health Act		√	√	√	√	√			√		√				

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	Measures	1. Recruitment and Retention	2. Demand	3. Involvement and Engagement	4. Experience	5. Culture & Wellbeing	6. Safety	7. Infrastructure	8. Cyber Security	9. Regulatory Action	10. Influence	11. Governance & Assurance	12. Roseberry Park	13. West Lane	14. CITO	15. Financial Sustainability
BIPD_16	Percentage of staff recommending the Trust as a place to work	√		√	√	√	√			√	√	√				
BIPD_17	Percentage of staff feeling they are able to make improvements happen in their area of work	√	√	√	√	√	√			√	√	√				
BIPD_18	Staff Leaver Rate	√				√	√					√				√
BIPD_19	Percentage Sickness Absence Rate	√	√			√	√			√						√
BIPD_20	Percentage compliance with ALL mandatory and statutory training	√		√	√	√	√		√	√		√				√
BIPD_21	Percentage of staff in post with a current appraisal	√			√	√	√			√		√				
BIPD_22	Number of new unique patients referred		√				√					√				√
BIPD_23	Unique Caseload (snapshot)		√			√	√					√				√
BIPD_24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit									√		√				√
BIPD_25	Underlying Performance - run rate movement															
BIPD_26	Use of Resources Rating - overall score									√		√				√
BIPD_27	CRES Performance - Recurrent									√		√				√
BIPD_28	CRES Performance - Non-Recurrent									√		√				√
BIPD_29	Capital Expenditure (CDEL)							√		√		√	√			√
BIPD_30	Cash balances (actual compared to plan)									√		√	√			√

ITEM NO. 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30 June 2022**
TITLE:	**Feedback from Directors' Visits**
REPORT OF:	**Director of Corporate Affairs & Involvement**
REPORT FOR:	**Information & Assurance**

This report supports the achievement of the following Strategic Goals:	
To co create a great experience for our patients, carers and families	✓
To co create a great experience for our colleagues	✓
To be a great partner	✓

Report:

1 **Purpose**

1.1 The purpose of this report is to enable the Board to consider high-level feedback from recent Directors' visits.

2 **Background**

2.1 The Trust has a programme of regular visits to services. These visits are not inspections but enable teams to hold conversations directly with Board Members to raise any matters of importance.

2.2 From a Board perspective, the visits support a fuller understanding of the issues facing services and enable information and assurances to be triangulated, with the focus identifying actionable quick wins to support our teams.

3 **Key Issues**

3.1 Directors' visit took place face-to-face on 13 June 2022 at Roseberry Park Hospital, Middlesbrough, in the wards / services outlined below:

- Activity Hub
- Brambling
- Linnet
- Crisis Assessment Suite
- Bedale / PICU
- Bilsdale Ward

3.2 Feedback from the visits is summarised below.

Strengths:

- Committed workforce demonstrating cohesive and supportive team dynamics, with strong MDT focus, and positive culture around training and development, health and wellbeing and staff recognition.
- Patient and carer / family involvement and engagement activity encouraged and visible across settings.
- Focus on making sure everyone entering ward / activity areas are welcomed and learning in shared, evident in positive feedback from student placements.

Challenges:

- Recruitment remains challenging across Health Care Assistants and Registered Nurses, losing out to the private sector and community nursing (career progression).
- Bed capacity and delays in discharge due to level of risk, leading to increased length of stays.
- Impact of the pandemic in terms of increased demand and acuity of patients.

3.3 For assurance, Directors have followed up on feedback received to escalate issues and areas of concern where relevant and agree next steps.

3.4 A review of Directors' visits is being undertaken, and further details will be provided in due course.

Recommendations:

The Board is asked to:

1. Receive and note the summary of feedback as outlined.

2. Consider any key issues, risks or matters of concern arising from the Directors' Visits held on 13 June 2022.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Item no. 12

Quality Assurance Committee: Key Issues Report

Report Date to Board: 30 June 2022

Date of last meeting: 9 June 2022 **Membership:** Quoracy was met. Apologies - one

1 **Agenda items considered:**

- Board Assurance Framework and Corporate Risk Register – risks to Quality and Safety
- Trust Level Quality Assurance & Learning Report
- Trust status regarding the Well Led and Core Services Must Do action plan
- Update on CQC unannounced inspection of Adult Learning Disabilities Services
- Care Group Board Updates (North Yorkshire, York & Selby, Durham, Darlington, Tees Valley & Forensics
- Safe Staffing
- Reducing Suicide and Self-Harm Improvement Work
- Draft Quality Account 2020/21

2a **Alert (by exception) The Committee alerts the Board to the following:**

Board Assurance Framework (BAF) and Corporate Risk Register - risks relating to quality and safety:

There were no updates included in the BAF presented to Committee since its last meeting held on 5 May 2022. This is a concern, as some updates due at the beginning of the year are still outstanding. A full update of the BAF was requested for the July 2022 meeting.

Members of the Committee used the BAF as an aide memoir at the beginning of the meeting.

For the month of April 2022, there were 32 risks open on the Corporate Risk Register, (scoring 12 and above), of which 28 related to quality and safety. No new risks were added and five were downgraded or removed with six escalated to the Corporate Risk Register. This demonstrates slight progress month on month. The Care Group Boards will be reviewing risk registers and there is recognition that there is further work required. The Durham, Darlington, Tees Valley and Forensic Risk Group did not take place as planned; however an extraordinary meeting has been organised.

Committee members challenged the level of resources available in the patient safety team and Trust wide to deliver the level of oversight and scrutiny on the management of risks. It was acknowledged that the Head of Risk Management was commencing her role in August 2022, however the committee will continue to pursue assurance around capacity and capability.

Members acknowledged that there are training needs at all levels of the Trust in relation to risk management capability and a training needs analysis will be taking place to ensure we put in place the relevant education, training, support and coaching across the Trust.

Members sought assurance on the provision of mental health services to individuals in prison and how the risk of suicide was being mitigated against. The DDTVF Care Group Board agreed to scope an assurance piece of work and the outcome will be fed back to the Committee in due course. This will be an area of focus for the Committee going forward.

CQC Well-led and Core Services Inspection and Unannounced Responsive Inspection of ALD wards:

The Committee received a presentation which included:

- Progress against the CQC well led and core inspection actions
- Details of recent incidents involving restraint

- A whistle blowing concern raised with the CQC regarding staffing, environment, security, and culture for ALD wards
- An unannounced responsive CQC inspection of ALD Wards at LRH.
- The immediate actions the Trust has taken to ensure patients are safeguarded about quality of care, safety and staffing
- The inspection was ongoing

The Committee will continue to be provided with updates on all CQC inspections and action plans to ensure assurance is provided and concerns escalated where appropriate.

Members discussed whether there is progress being made in terms of culture within Forensic Services. Feedback from these in services is that there is a real commitment at every level of the organisation, however there is notable variation, and more focus is being given to have measures embedded to monitor this.

Trust Level Quality and Learning Report:
The committee has picked up interrelated items for this report as part of the BAF and CRR discussion previously. Notably, there is concern in relation to restrictive interventions which has been raised previously. It was noted there was a verbal update on the agenda.

Care Group Board Updates:
The DDTVF Managing Director gave an overview of the new approach within the Care Group Board in relation to quality, safety and risk. The Interim MD for NYY concurred. The intention is that with the introduction of the two new Care Group Boards, there will ultimately be two reports, with much less operational focus.

The messages from the two Care Group Boards remained consistent.

Staffing challenges, recruitment and retention and a lack of Registered Nurses for some shifts. Staff resilience, health and wellbeing in managing busy wards. Staff sickness in secure inpatient services of HCAs and RNs up to 25%. High bed occupancy with continued high acuity of patients and increasing levels of self-harm, particularly among female patients. Lack of community infrastructure to support discharges. The ongoing challenges to meet mandatory training and appraisal compliance, however it is slowly moving in the right direction.

Of particular concern was the Durham and Darlington Crisis Team. The Director of Operations gave the Committee a brief overview. The Committee agreed to receive a more detailed update at the July 2022 meeting.

Monthly Safe Staffing:
The use of bank and agency dropped marginally during the month of April 2022; however, usage continues to be high and was noted as a concern, but unavoidable.

Business Continuity Arrangements remained in place during April for SIS, Durham Crisis Tea, Esk Ward (part month), CAMHS Community York, CAMHS Community Northallerton and Bankfields Court.

With an increase of one extra ward there were 36 rostered wards that had a Registered Nurse (RN), on day shifts below the fill rate threshold of 90% during April. Daily huddles for oversight of staffing requirements continue to mitigate against this. The top concerning areas were Westerdale South, Newtondale Ward, Ramsey Talbot Ward, Merlin, Bedale (AMH), Wold View and Sandpiper.

There was a drop of shifts worked across the Trust that exceeded 13 hours from 106 to 74, which reflects the instances of ward acuity and to support Registered Nurses coming onto duty. Members of the Committee emphasised the importance of recognising the impact on staff wellbeing when staff leave their shifts late.

	Over recruitment of HealthCare workers and Registered Nurses to SIS, PICU and ALD is challenging due to the number of staff leaving. Two recruitment events are planned over June and July 2022 with a streamlined process of anyone interested being able to apply and interview on the same day. **Update on the proposals in relation to reducing incidents of self-harm and incidents** The committee expressed concerns that no firm plan had been presented, since this was discussed in the March QuAC meeting. It is due to report to the July 2022 meeting.
2b	**Assurance: The Committee assures members of the Board on the following matters:** **Draft Quality Account 2020/21** The Committee considered the latest version of the Quality Account and recommended that it be approved by the Board of Directors, at its Special meeting held on 15 June 2022, subject to the caveat that feedback from stakeholders will be included once received.
2c	**Advise:** The Committee members agreed that the key issues to draw to the Boards attention are: 1. The intention for more focus in Committee on Health and Justice services. 2. The ongoing review and update of the Corporate Risk Register. 3. The CQC Update on actions for the Well-led and Core Services inspection, the current CQC activity and concerns relating to Adult Learning Disabilities Services and that the Committee will receive and monitor the action plan in the coming months. 4. The concerns relating to Durham and Darlington Crisis Team with a request for an update on actions and progress for the July 2022 QuAC meeting. 5. That there is little change across the Care Group Boards reporting their key risks and concerns. 6. The programme of work in relation to suicide and self-harm is deferred to the 7 July 2022 QuAC meeting. 7. There are no new risks to be considered for inclusion in the BAF. 8. That the Committee recommended to the Board of Directors that the Quality Account for 2020/21 be approved, subject to the caveat of inclusion of feedback from stakeholders. 9. The Committee received the revised Trust segregation policy. 10. That there will be an update on actions to reduce incidents of self-harm to the July 2022 meeting.
Recommendation: **The Board is asked to** note the contents of the report.	
3	**Risks to be considered by the Board:** There were no risks that were considered should be escalated to the Board.
	Report compiled by Bev Reilly, Chair of Quality Assurance Committee, Avril Lowery, Director of Quality Governance, Donna Keeping, Corporate Governance Manager

Tees, Esk and Wear Valleys
NHS Foundation Trust

Item No. 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30 June 2022**
TITLE:	**Assurance Report on the Delivery of the CQC Action Plan**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance**
REPORT FOR:	**Assurance/Information**

This report supports the achievement of the following Strategic Goals:	
To co-create a great experience for our patients, carers and families	✓
To co-create a great experience for our colleagues	✓
To be a great partner	✓

Executive Summary:

The purpose of this report is to present to the Board of Directors a detailed update of the current status of all CQC must do actions. A summary of the current status as at 25/05/22 is as follows:

- 37% (30/80) complete of actions are complete
- 38% (30/80) are on track with little risk to delivery
- 25% (20/ 80) have some risk to delivery

A full status update for all must do actions is presented as Appendix 1 of this report.

The CQC action plan is subject to rigorous monitoring in order to ensure effective delivery of actions in line with agreed timescales. The new electronic share point folder developed and implemented in April 2022 has been supporting action owners by providing live access to the plan and has been successful in ensuring routine progress updates regarding delivery of individual actions.

There have been no scheduled CQC Engagement Meetings since the 9th March 2022. Dates are being agreed for the future meeting schedule.

In April 2022 there were three actions that were showing as red (11a, 13d and 19) which were recorded as not delivered/ significant risk to delivery. All three of these actions have now noted progress and are reporting as amber (some risk to delivery).

Recommendations:

The Board is requested to note the content of this report and agree the level of assurance as reasonable with regard to oversight and delivery of the action plan.

MEETING OF:	**Board of Directors**
DATE:	**30 June 2022**
TITLE:	**Assurance report on the delivery of the CQC Action Plan**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to the Board of Directors, the current status of the 'must do' actions arising from the CQC Trust core service and well-led inspection. In addition, it will describe the refreshed governance arrangements and ongoing activity.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Between 14 June 2021 and 05 August 2021, the Trust received a series of core service inspections from the CQC. This included inspection of Secure Inpatient Services, Adult Mental Health Crisis Services and Health Based Places of Safety, Adult Mental Health Community Services and Community Child and Adolescent Mental Health Services. Core service inspections were also followed by a well-led inspection of the Trust.

Following the inspection, the CQC formally raised several areas of concern with a Section 29A notification received for Secure Inpatient and Community Child and Adolescent Mental Health Services. Immediate action plans were developed in response to these issues and implementation has been well progressed, reporting weekly to QIB and now the new executive directors weekly meeting. The deadline for implementation was 31 March 2022. It is however recognised by the CQC that full implementation and embedding of some of these actions will require longer timescales. Section 29a issues have subsequently been encompassed by the CQC within the 'Must Do' regulatory actions.

The Trust CQC inspection report was issued 10 December 2021 and rated the Trust as 'requires improvement'. A copy of the report may be viewed at:
https://api.cqc.org.uk/public/v1/reports/39d313da-63b8-4a46-a423-11f1958c89b0?20211223164650
The report identified a number of Regulatory breaches from which twenty-seven 'must do' actions and twenty-one 'should do' actions were stipulated. A collective, collaborative approach was taken to the development of a comprehensive Trust action plan.

From August 2022 the delivery of the 'should do' actions will also be reported through to the Quality Assurance Committee.

3. KEY ISSUES:

3.1 Governance Arrangements

All action plans resulting from external inspections, assessment and accreditations are held within the Integrated Oversight and Reporting Database. The database enables the Trust to have oversight of the progress against all actions plans resulting from these reviews. It also enables the identification of emerging and recurring themes across a range of inspections and a co-ordinated approach to addressing these.

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From April 2022 all action owners commenced reporting progress against individual actions monthly directly to the Quality Governance Team via the T Drive share point folder thereby becoming a live document.

3.2 CQC Fundamental Standards Reporting Arrangements

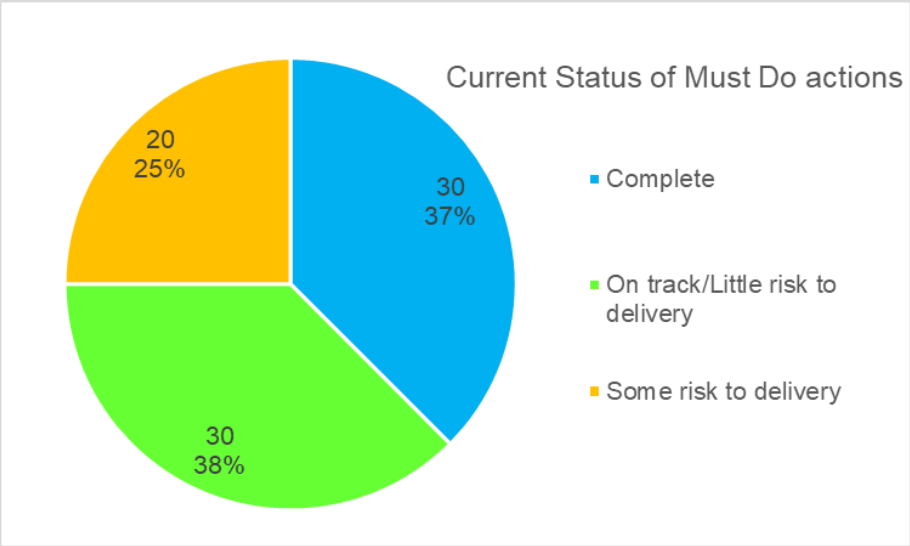
The Care Groups Fundamental standards groups have continued to meet and support progression and embedding of relevant CQC actions. The Strategic Fundamental Standards group is due to meet on the 1st July 2022.
During May and June 2022 there has been an enhanced focus on sharing themes and trends from CQC MHA inspections across services and gaining assurance that relevant actions within ward provider actions statements have been completed and signed off. Implementation of ward Provider Action Statements supports ongoing compliance with the CQC Fundamental Standards. A corporate evidence repository for all CQC MHA inspection actions continues to be maintained by the Quality Governance Team.

3.3 Current Must Do Action Plan Status

The Trust CQC must do action plan update is presented as Appendix 1 of this report.

The chart below provides the current status (as at 25/05/22) against all must do actions within the action plan. Overall, there is good progress noted however,

the delivery of some actions has been impacted by capacity restraints and service pressures. Our focus is on embedding the changes in practice and plans to assess the sustained improvement will be key to gaining assurance.



The detail against each action is documented within the CQC must do action plan update in Appendix 1. With regard to the three actions that were not delivered, or which had significant risks to delivery as reported to the Board in April 2022, these actions are now progressing and have been recategorised by the responsible action lead to 'some risk to delivery'. Updates are as follows:

Action 11a:
The trust must ensure they collect performance data relating to targets and quality standards so that senior managers can ensure there is appropriate governance and quality assurance. (Regulation 17)

a) Process owners for each operational policy will be requested to review their respective policies to identify any targets or quality standards and clarify what the processes for assurance is. [Improvement measure: Review of operational policies complete and the Trust will have identified those containing any local targets.]

Risks associated with regard to this action related to delivery in line with the anticipated timescales and an underestimation of the scale of the actions required to address this for all operational policies. Timescales for completion were reviewed by the Trust Quality Assurance & Improvement Group 26/04/22 and amendment to the target date for completion agreed. Work has now been progressed with regard to services identifying local policies and procedures that contain local metrics. Further actions will be dependent on the number of the policies that exist containing local metrics that will require review, to ensure we take a pragmatic approach aligned to the level of risk
This action is now categorised as amber (some risk to delivery).

Action 13d:
The trust must ensure that the use of restraint within the service is proportionate and used only as a last resort and that any restrictions placed on patients are individualised, proportionate, regularly reviewed and removed as soon as possible. (Regulation 13)

d) Based on the outcome of the review implement a continuous improvement plan that ensures current practice reflects Regulatory requirements and best practice in relation to blanket restrictions.

The risks with regard to this action related to delivery in line with the anticipated timescales. Considerable work has been undertaken in terms of a review and baseline assessment using the NHSE Reducing Restrictive Practice Benchmarking tool and these results will also inform a planned QI Event to further improve practice focussing on the areas highlighted. This is planned to take place on 30th June. Results demonstrate an improved staff awareness of restrictive practices (with particular improvements noted for agency staff). Patients have also reported improvements. An extension to the original timescales was Timescales for completion were reviewed by the Trust Quality Assurance Committee 26/04/22 and amendment to the target date for completion for 30th June agreed. This action is now categorised as 'some risk to delivery'.

Action 19 (SIS):
The trust must ensure that regular team meetings take place on all the wards within the service to ensure staff receive key information and have the opportunity to provide their own feedback on the service. (Regulation 17)
Refresh secure inpatient service governance - meeting structures to facilitate regular meaningful staff involvement and engagement.
[Improvement measures: Regular meetings take place for staff at ward level and attendance is monitored. Improved levels of staff engagement within the annual staff survey.]

When reported in April, work was ongoing to facilitate delivery of this action however, the required outcomes had not been achieved with regard to all wards consistently holding team meetings and attendance being hampered by staffing challenges. Staff survey engagement also remained a challenge. There is variability in terms of frequency and attendance at ward meetings. However, to mitigate this, the service have introduced a further range of communication mechanisms including increased visibility of leaders in wards, night-time visits and the introduction of calls to wards on a nightly basis to discuss issues and improvement activities. Pulse surveys are also providing helpful routine feedback from staff which is allowing the service to improve meaningful engagement.

3.4 There are currently 20 actions for which 'some risk to delivery' has been identified. Many of these relate to achieving full completion of the actions within given timescales or fully embedding the action prior to the action being signed off as complete. No significant risks have been escalated by action

owners regarding achievement of these actions. Tracking and monitoring of all actions will continue to support timely action plan delivery.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

The focus of this report is to provide assurance regarding compliance with key elements of the CQC Fundamental Standards which were not met during previous CQC core service and well-led inspections. The report provides assurance regarding progress made in relation to actions to address these and thereby ongoing assurance regarding compliance with the CQC fundamental standards.

4.2 Financial/Value for Money:

There are financial risks associated with failure of the organisation to achieve ongoing compliance with the CQC Fundamental Standards. These risks include Regulatory enforcement actions which include financial penalties for the organisations should it fail to make required improvements.

4.3 Legal and Constitutional (including the NHS Constitution):

There are legal and constitutional risks associated with failure of the organisation to consistently comply with the CQC Fundamental Standards. Legal risks may result in CQC enforcement actions, loss of reputation and ultimately loss of CQC Registration.

4.4 Equality and Diversity:

Compliance with the CQC Fundamental Standards is a key enabler in ensuring that services meet relevant equality and diversity obligations.

4.5 Other implications:

There are no other immediate implications resulting from this paper.

5. RISKS:

There are fundamental risks to patient safety, clinical effectiveness and patient experience, as well as the broader financial and reputational risks should the Trust fail to consistently comply with the CQC Fundamental Standards.

6. CONCLUSION:

Overall, positive progress is being made in the delivery of the CQC Must Do action plan. A number of actions are noted as having ‘some risk to delivery’ however, no new risk issues have been escalated by action owners with regard to delivery of these actions. Service pressures and capacity challenges

continue to present some risks with regard to delivery of individual actions. Work continues to progress all actions within the action plan.

7. RECOMMENDATIONS:

The Board is requested to note the content of this report and agree the level of assurance as reasonable with regard to oversight and delivery of the action plan**.**

Background Papers:
Appendix 1 CQC Must Do Action Update

Appendix 1 – CQC Must Do action status and level of assurance update

Current status key:	Complete	On track/Little risk to delivery	Some risk to delivery	Not delivered/ significant risk to delivery
Level of assurance key:	Substantial	Good	Reasonable	Limited

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 24/05/22
Trust wide	**1a**	The trust must ensure that it continues to deliver its board development programme to strengthen the scrutiny and challenge by boards members. (Regulation 17)	a) Review relevant section of the Good Governance Institute action plan.	Company Secretary	Review of Good governance institute action plan	28/02/2022	Complete	Good	Well-led Implementation Plan presented to Board on 31/03/22 with recommendations approved.
Trust wide	**1b**		b) Review Deloitte's Board Development Terms of Reference to ensure that all requirements are included.	Chief Executive Officer	Final Board Development Terms of Reference	30/06/2022	On track/Little risk to delivery		Board Workshop with Deloittes took place on 03 May 2022. Analysis of the Board effectiveness survey was presented and some clear actions resulted which will inform a plan for further development. To be discussed and considered at Board of Directors on 26 May 2022.
Trust wide	**1c**		c) Identify how we will know that the actions are having an impact - develop evaluation methodology e.g., Board feedback	Company Secretary	Board Performance Evaluation Scheme Feedback	31/03/2023	On track/Little risk to delivery		Evaluation being undertaken by Deloitte LLP. Results considered by the Board at a workshop held 03/05/22.
Trust wide	**1d**		d) Commission a further external governance review.	Company Secretary	Board and Committee Minutes	30/03/2024	On track/Little risk to delivery		See above.
Trust wide	**2a**	The trust must ensure that planned changes to the governance structure are implemented to provide assurance that patients receive safe, good quality care and treatment. (Regulation 17)	a) Develop a shared understanding and approach of how we will get assurance (both quantitative and qualitative) at different levels of the organisation (including escalation triggers). [Improvement measures: Structured assurance methodology for using quantitative and qualitative intelligence to draw out key themes and hotspots]	Director of Quality Governance, Associate Director of Performance and Company Secretary	Structured assurance methodology	30/06/2022	On track/Little risk to delivery		Progress is being made to develop an accountability framework. An event is planned to take place facilitated by the QI team in May 2022.
Trust wide	**2b**		b) Review Directors visits to ensure that they support gathering assurance on the delivery of fundamentals of care e.g., service users/carer experience [Improvement measures - Greater and deeper intelligence from the Directors visits and greater triangulation with other intelligence, demonstrable changes in response to intelligence gathered]	Director of Therapies	Review of director visits	30/06/2022	Some risk to delivery		A meeting has been arranged for Wednesday 11th May 2022 between Kath Davies, Avril Lowery and Shirley Richardson to review the paperwork and agree changes using a coaching framework and evidence based Leadership Walkabout literature which we will then ask to be piloted within the current Director Visit schedule. The pilot and pilot review date will need to be agreed. Once this is completed this new approach will be embedded across the Director Visits. An update from this meeting will be provided to the Board.

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 24/05/22
Trust wide	**2c**		c) Ensure there is a collective understanding at each level within the governance structure, including the clinical networks, of what good governance looks like and individuals' roles within it. [Improvement measures: Clearly defined expectations around risk tolerances including escalation triggers, strategic oversight, and quality methodology at each level i.e., standards]	Director of Quality Governance and Company Secretary	Terms of reference	30/06/2022	On track/Little risk to delivery		
Trust wide	**2d**		d) Implement the new Governance Structures and assess the impact and effectiveness of these changes. [Improvement measures: Provision of a handbook available that describes different tools and support that is available for use linked to safety quality and governance systems. Increased levels of skills for analysis, escalation, and assurance. Care Group Board development programme will be in place with suite of evaluation measures (as per Board Development Programme)]	Director of Quality Governance and Company Secretary	Agreed new governance structure	30/06/2022	Some risk to delivery		Capacity issues might delay provision of the handbook
Trust wide	**2e**		e) Develop a set of resources (e.g., templates, tools, and training) to support the delivery of good governance. [Improvement measures: Relaunch of QIS. Improvement in service led PDSA. Feedback from staff on ability to make changes to improve quality.]	Director of Quality Governance and Company Secretary	Reporting templates	30/06/2022	On track/Little risk to delivery		Executive Directors will determine when the reporting templates will come into effect
Trust wide	**2f**		f) Revisit the current work to re position QIS to provide a focus on the individual tools for quality and innovation for individual leaders including coaching support. [Improvement measures: Tools and evaluation]	Director of People and Culture and Head of Quality Improvement	Tools and evaluation	30/06/2022	On track/Little risk to delivery	Good	QI approach refreshed and aligned to Coaching and OD. Blended QI/Coaching OD approach utilised where beneficial. QI expert level includes coaching and mentoring elements as part of training and ongoing evaluation

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 24/05/22
Trust wide	3	The trust must ensure that fit and proper checks have been carried out as required by legislation. (Regulation 19)	Processes for Fit and Proper Persons assessment to be reviewed and revised to ensure that these are carried out as required by legislation. [Improvement measures: Internal Audit review of the personnel files]	Company Secretary and Director of People and Culture	Personnel files of Board and SLG Members, Internal Audit report	31/03/2022	Some risk to delivery		Personal files have been reviewed. Additional evidence is being collected and collated. Level of assurance on certain matters e.g., qualifications and OH assessments will be reviewed
Trust wide	4	The trust must ensure there is a safeguarding policy which clearly outlines the governance and accountability at each level within the organisation. (Regulation 17)	Safeguarding policy to be developed which clearly outlines the governance and accountability at each level within the organisation. [Improvement measures: Revised Safeguarding Policy ratified and available on the Trust intranet.]	Director of Nursing & Governance and Associate Director of Nursing - Safeguarding	Ratified Policy	30/06/2022	On track/Little risk to delivery		This information is already available within the existing safeguarding adult's procedure; however, it will now be explicit within Trust policy. 17/05/22 Policy went to Safeguarding and Public Protection Meeting. It was agreed that this would be circulated for a period of 6 weeks for consultation.
Trust wide	5a	The trust must ensure that work continues to develop the "Our Journey to change" strategy to clearly set out how it will achieve its strategic goals. (Regulation 17)	a) Implement the plan developed by the Strategy Deployment Group including how we support more personal responsibility through PDPs, and team development, refresh and reframe how we seek/use feedback in line with OJTC, Refresh business planning approach.	Associate Director of Strategic Planning & Programmes	Plan implemented by the Strategy Deployment Group	31/03/2023	On track/Little risk to delivery	Reasonable	New Business Plan document structured around the 3 goals; workplan investment agreed which will assist alignment of PDPs with Our Journey to Change.
Trust wide	5b		b) Ensure that Our Journey to Change is a key, prominent part of induction	Director of People and Culture	Evidence to support Our Journey to Change part of induction e.g. standard presentation	31/03/2022	Complete	Good	
Trust wide	5c		c) Develop the Trust Business Planning Framework	Associate Director of Strategic Planning & Programmes	Trust business planning framework	31/03/2022	Complete	Substantial	SLG agreed the new framework on 2nd March 2022
Trust wide	5d		d) Develop the Trust Programme/Project Management Framework	Associate Director of Strategic Planning & Programmes	Trust Programme/Project Management Framework	31/03/2022	Complete	Substantial	New framework approved by Executive Directors Group on 13th April 2022.
Trust wide	5e		e) Develop a more robust approach to communicating to and engagement of colleagues, service user, carers, and stakeholders with Our Journey to Change including celebrations	Director of Corporate Affairs & Engagement	Communication and engagement approach details	31/03/2022	Complete	Substantial	A communication strategy has been implemented across the Trust, setting out how we'll communicate and engage with all our audiences, and by what means. Two other pieces of work are also underway to (1) review / audit internal communications channels, with (2) a stakeholder mapping and audit exercise to follow.

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 24/05/22
Trust wide	**5f**		f) Identify the key metrics that will be used to monitor progress of delivery and establish monitoring mechanism	Associate Director of Strategic Planning & Programmes, Associate Director of Performance	Key metrics	30/04/2022	Some risk to delivery	Reasonable	Draft leading and lagging indicators have been identified for all 3 goals but some further work to do before Executive team can approve these, particularly the partnership related measures.
Trust wide	**6a**	The trust must ensure that it responds appropriately to allegations of bullying, discrimination, racial abuse or hate crimes. (Regulation 17)	a) Develop a clear framework and communication strategy on what support and processes are available to staff to not only raise concerns but challenge behaviour which is not aligned with the Trust values.	Associate Director for People and Culture and Head of HR	Framework and communication strategy	01/04/2022	On track/Little risk to delivery	Good	In progress - F2SU guardian and officer attended BAME network, ongoing sign posting to relevant support when concerns are raised, weekly bulletin continues to include how to raise a concern, refresh of Dignity at Work Champions is underway, B&H and managing concerns procedures followed for formal cases
Trust wide	**6b**		b) Further promote awareness of Staff Networks, encourage membership, and ensure that staff stories are part of the People, Culture and Diversity Committee.	Associate Director for People and Culture and Head of HR	Promotion	30/09/2022	On track/Little risk to delivery	Good	Staff networks day planned in May along with screensaver promoting staff networks. Awareness raising is ongoing and staff stories to the People Committee are continuing
Trust wide	**6c**		c) Develop a manager's toolkit, ensuring that this is part of the Managers bite size training which is planned.	Associate Director for People and Culture and Head of HR	Manager's toolkit	30/09/2022	On track/Little risk to delivery	Good	Training, HR operations and OD working on bitesize training toolkit for managers - in progress
Trust wide	**6d**		d) Undertake a thematic review and analysis of workforce data to highlight any patterns/trends (including in sickness absence, concerns and complaints, turnover, HR casework etc).	Associate Director for People and Culture and Head of HR	Thematic review	31/05/2022	On track/Little risk to delivery	Good	Scoping of review in progress
Trust wide	**6e**		e) The new management of potential concerns process ensures that protected characteristics are considered before any formal process starts and ensures that Equality Diversity and Inclusion support is sought.	Associate Director for People and Culture and Head of HR	New management of potential concerns process	31/07/2022	Complete	Good	Implemented
Trust wide	**6f**		f) Ensure that appropriate action is taken in those cases where allegations are upheld.	Associate Director for People and Culture and Head of HR	Evidence of appropriate action	30/09/2022	Complete	Good	Implemented in line with B&H and managing concerns procedure

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 24/05/22
Trust wide	**7a**	The trust must ensure it reviews its freedom to speak up and whistleblowing policy and processes to ensure they are effective. (Regulation 17)	a) A 3 day Quality Improvement Event planned for January 2022. To include: • reviewing the current process for Freedom to Speak Up and Whistle Blowing and producing standard work to ensure consistency across the trust. • update training for staff and managers • ensure that the policy is up to date and reflects best practice • communication plan to include the options staff have to raise a concern and the changes made following the QI event.	Freedom to Speak up Guardian and Head of Quality improvement	QI Event details and outcome	01/04/2022	Complete	Good	Delivery of all actions is ongoing.
Trust wide	**7b**		b) Monthly data collection on themes from the contacts with the Freedom to Speak up Guardian, alongside other feedback from the raising concerns group to be reported bimonthly to the Workforce Subgroup of the Senior Leadership Group.	Freedom to Speak up Guardian and Head of Quality improvement	Monthly data collection	01/04/2022	Complete	Reasonable	From May our renewed Speaking up forum will meet monthly, and will review numbers of cases, monitor themes and prepare lessons learned, which will be shared with the new care group boards.
Trust wide	**7c**		c) Further develop and promote Trust Dignity Champions	Freedom to Speak up Guardian and Head of Quality improvement	Promotion of Trust Dignity Champions	01/04/2022	Some risk to delivery		A training programme has been developed, and this will be delivered in May-June-22 slightly behind schedule. This will enhance the skills and more effective utilisation of the Dignity Champions within the Trust.
Trust wide	**7d**		d) Review the impact of the additional resource introduced into the Freedom to Speak Up Team.	Freedom to Speak up Guardian and Head of Quality improvement	Review impact of resource introduced	01/04/2022	Complete	Substantial	The six-month secondment of additional full time FTSU officer time has enabled delivery of the improvements identified in our quality improvement event in January. We now have a one data Management log, streamlined coordination between the FTSU team, The review commissioning manager, and the reviewers, and greater capacity to support staff who speak up
Trust wide	**8**	The trust must ensure that learning from incidents and complaints is implemented effectively to improve the safety and quality of care patients receive. (Regulation 17)	Hold a formal QI event to consider how we can improve embedding of learning and know that it is sustained (to include learning from good practice in other organisations).	Care Group Directors	QI event held. Improvement plan. Thematic Reviews and related action plans. Development of the Organisational Learning Database and Library. Analysis of agreed improvement measures.	31/08/2022	On track/Little risk to delivery		We have met with QI team and agreed an approach that does not involve a specific event but a programme of visits and consultation with staff across the organisation.

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 24/05/22
Trust wide	**9a**	The trust must ensure that its corporate risk register is current, has clear actions and timescales. (Regulation 17)	a) Review and refresh the Risk Management Policy that will set out roles and responsibilities aligned to new organisational structures. [Improvement measures: Ratified Risk Management Policy]	Director of Quality Governance, Company Secretary and Care and Group Directors	Reviewed Risk management policy	01/03/2022	On track/Little risk to delivery		Draft complete - now ready to go through approval process leading up to the Board in May
Trust wide	**9b**		b) Reconfigure the Trusts Risk Management organisational hierarchy within the electronic risk management system (Datix) to align to new operational structures and governance structures. [Improvement measures: Reconfigure hierarchy within the risk management system (Datix).]	Director of Quality Governance, Company Secretary and Care and Group Directors	Organisational hierarchy of risk management	01/04/2022	Complete	Substantial	
Trust wide	**9c**		c) Undertake a Training Needs Analysis (TNA) regarding risk management and utilisation of the risk register. [Risk management and risk register Training Needs Analysis]	Director of Quality Governance, Company Secretary and Care and Group Directors	Training Needs Analysis	30/04/2022	Some risk to delivery		This will be undertaken by the Head of Risk Management on appointment. New target date to be agreed via QA&I group.
Trust wide	**9d**		d) Develop and implement a stratified programme of education and risk management training based on the results of the TNA. [Stratified risk management training programme and compliance data]	Director of Quality Governance, Company Secretary and Care and Group Directors	Stratified programme of education and risk in place	30/06/2022	Some risk to delivery		As above re review of target date. This will be undertaken by the Head of Risk Management on appointment
Trust wide	**9e**		e) Undertake a full review and refresh of all risks currently recorded on the risk register starting with corporate risk level (25 and above). [Refreshed risk register for all corporate risks scored as 25 and above.]	Director of Quality Governance, Company Secretary and Care and Group Directors	Refreshed corporate risk register	01/04/2022	Complete	Limited	The review of the CRR identified improvement however there are still outstanding risk that require a review. It also identifies a number of data quality issues. Further work is required and his should be through the risk management meeting structures recently implemented. A further evaluation of the status of the CRR will take place June 2022
Trust wide	**9f**		f) Implement and support the new governance structures with regard to dedicated risk management meetings, that will provide greater focus and scrutiny of risk management. [Improvement measures: New governance structures, Terms of Reference, and minutes of the risk management meetings]	Director of Quality Governance, Company Secretary and Care and Group Directors	New governance structures re risk management meetings	01/04/2022	On track/Little risk to delivery		Terms of reference in place however first meetings are scheduled to take place in April / May.

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 24/05/22
Trust wide	**9g**		g) Advertise and appoint to the recently secured Head of Risk post that will provide the expertise and support required by the Trust in line with the Good Governance Institute recommendations. [Improvement measures: Head of Risk post established and appointed to.]	Director of Quality Governance, Company Secretary and Care and Group Directors	Head of Risk advertised and successfully in post	31/07/2022	Complete	Substantial	Start date to be confirmed
Trust wide	**10a**	The trust must ensure that the revised board assurance framework is implemented, and its effectiveness reviewed. (Regulation 17)	a) Implement new risk escalation structure as agreed by the Board of Directors (November 2021)	Company Secretary	Risk escalation structure	01/04/2022	Some risk to delivery		Implementation
Trust wide	**10b**		b) Increase capacity and capability for risk management as per Good Governance Institute recommendation.	Company Secretary	Increased capacity and capability	31/03/2022	Some risk to delivery		Decision on investment by Exec Directors continues to be awaited
Trust wide	**10c**		c) Establish the Risk Groups at Executive and Care Group levels of the new governance structure.	Company Secretary	Reports and minutes of governance groups.	01/04/2022	On track/Little risk to delivery		Risk Groups established as part of the governance structure on 1/4/22; however, yet to meet
Trust wide	**10d**		d) Undertake a Board Workshop on risk management as part of the Board Development Programme.	Company Secretary	Board workshop details	31/03/2022	Complete	Substantial	Board workshop, facilitated by Deloitte LLP
Trust wide	**10e**		e) Complete the Board and Committee business cycles aligned to the Board Assurance Framework. [Improvement measures: Internal Audit review of the Board Assurance Framework]	Company Secretary	Internal audit reports	31/03/2022	Some risk to delivery		Draft Board Business Cycle, aligned to the BAF, in place. Business Cycles for the Board's committees delayed due to capacity issues and ongoing restructure
Trust wide	**10f**		f) Implementation of revised Board/Committee reporting template aligned to the Board Assurance Framework.	Company Secretary	BAF risk profiles/ reporting templates	01/04/2022	Some risk to delivery		Awaiting sign off by Exec Directors
Trust wide	**10g**		g) Review and refresh the organisational Risk Management Policy that will set out roles and responsibilities aligned to new organisational structures.	Company Secretary	Reviewed risk management policy	28/02/2022	On track/Little risk to delivery		Draft complete - now ready to go through approval process leading up to the Board in May
Trust wide	**10h**		h) Responsibility for the management of the Board Assurance Framework risks is to be included in the Job Descriptions of Executive Directors.	Director of People and Culture	Job descriptions of Executive Directors	31/07/2022	On track/Little risk to delivery		

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 24/05/22
Trust wide	**11a**	The trust must ensure they collect performance data relating to targets and quality standards so that senior managers can ensure there is appropriate governance and quality assurance. (Regulation 17)	a) Process owners for each operational policy will be requested to review their respective policies to identify any targets or quality standards and clarify what the processes for assurance is. [Improvement measure: Review of operational policies complete and the Trust will have identified those containing any local targets.]	Director of Quality Governance and Associate Director of Performance	Operational policies reviewed	01/04/2022	Not delivered/significant risk to delivery		A paper was taken to SLG in March regarding the scope of this action and its potential to be vaster than originally recognised. It was agreed that action a would proceed and a further review of subsequent action would be taken once the scale of the issue was known. Email has been sent to services to identify local policies and procedures that contain local metrics. Deadline for response is 27th May.
Trust wide	**11b**		b) We will agree a Trust process for the identification, approval, monitoring and reporting of compliance with any targets and quality standards. [Improvement measure: Agreed Trust process for the identification, approval, monitoring and reporting of compliance with any targets and quality standards.]	Director of Quality Governance and Associate Director of Performance	Agreed Trust process	01/06/2022	Some risk to delivery		As above
Trust wide	**11c**		c) We will review and refresh the Trust policy guidance to ensure that it reflects the agreed approach regarding targets and quality standards. [Improvement measure: Refreshed Trust policy guidance reflecting the approach regarding targets and quality standards.]	Director of Quality Governance and Associate Director of Performance	Refreshed Trust policy guidance reflecting the approach regarding targets and quality standards	01/06/2022	Some risk to delivery		As above
Secure Inpatient Services	**12a**	The trust must ensure that all patients are safeguarded from abuse; all patients are treated with kindness, respect	a) Ensure compliance with Safeguarding training within the service. [Improvement measures: Target levels of training compliance are reached within specified timescales.]	General Manager / Associate Director of Nursing and Quality	Evidence of training compliance reached within specified timescales	30/06/2022	On track/Little risk to delivery	Substantial	Current levels of compliance in excess of 95% for Level 3 safeguarding 17/05/22

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 24/05/22
Secure Inpatient Services	12b	and dignity and that safeguarding referrals are sent to the local authority when appropriate to do so. (Regulation 13)	b) Supplement the Trust mandatory safeguarding package with additional local education and training programmes targeted responsive to themes and trends e.g., Boundaries and Raising Concerns processes. [Improvement measures: The internal patient experience survey data will evidence improvements in the delivery of care that is compassionate respectful and supports patient's privacy and dignity and their families. A review of safeguarding referrals to demonstrate assurance. Undertake a review of incidents that assesses compliance with the requirements for Local Authority safeguarding referrals.]	Safeguarding Team	Education and Training Programmes developed and implemented Detailed operational delivery plan in progress with evidence of implementation	30/06/2022	On track/Little risk to delivery	Reasonable	There have been increased opportunities to discuss and reflect on safeguarding issues through a combination of: visual aids, matron quality walkarounds, the re-introduction of ward improvement groups. The presence of the safeguarding nurse on site a number of days per week has proven very advantageous to support staff with safeguarding issues. Concerns reporting has increased, as has safeguarding supervisions provided. Awaiting formal outputs of safeguarding review of incidents. Robustness of Patient experience measures requires further work 17/05/22.
Secure Inpatient Services	13a	The trust must ensure that the use of restraint within the service is proportionate and used only as a last resort and that any restrictions placed on patients are individualised, proportionate, regularly reviewed and removed as soon as possible. (Regulation 13)	a) Undertake a review and assessment of current staff awareness, practice, and performance in relation to restrictive interventions in collaboration with the Trust's subject expert/ Senior Lead - Positive and Safe. [Improvement measures: Positive and safe dashboard data, Debrief used following every episode of restraint to understand service user experience and opportunities for learning. Benchmarking of restrictive interventions. Positive service user feedback. Improved staff awareness. Baseline and follow up results of the NHSE Toolkit.]	Associate Director of Nursing and Quality, Positive and Safe Lead	Review evidence	30/04/2022	Complete	Good	Further review is planned and to be led by Stephen Davison, Positive and Safe Lead and John Savage, Associate Director of Nursing for SIS. Positive and Safe Dashboard provides contemporaneous data including physical restraint, rapid tranquilisation incidents ad long term seclusion. Work on-going and John Savage and Stephen Davison visiting SIS wards and Stephen to undertake NHSE Benchmarking review w/c 16/5/22.
Secure Inpatient Services	13b		b) Based on the outcome of the review implement a programme of education that ensure current practice reflects Regulatory requirements and best practice.	Associate Director of Nursing and Quality, Positive and Safe Lead	Programme details	30/04/2022	On track/Little risk to delivery	Reasonable	
Secure Inpatient Services	13c		c) Undertake a review and assessment of current staff awareness, practice, and performance in relation to blanket restrictions in collaboration with the Trust's subject expert/ Senior Lead - Positive and Safe.	Associate Director of Nursing and Quality, Positive and Safe Lead	Review evidence	30/04/2022	On track/Little risk to delivery	Reasonable	Further review is planned and to be led by Stephen Davison, Positive and Safe Lead and John Savage, Associate Director of Nursing for SIS. Ward presence and visits is highlighting improvements in reduction of locked doors on wards.

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 24/05/22
Secure Inpatient Services	**13d**		d) Based on the outcome of the review implement a continuous improvement plan that ensures current practice reflects Regulatory requirements and best practice in relation to blanket restrictions.	Associate Director of Nursing and Quality, Positive and Safe Lead	Programme details	30/06/2022	Some risk to delivery	Reasonable	Plan for programme of improvement is 30/06/22 and the date has been changed to reflect this. No change from previous month.
Secure Inpatient Services	**14a**	The trust must ensure that the wards within the service are staffed in accordance with its assessed safe staffing numbers so that care and treatment is delivered in a safe way; patients have access to activities, psychological interventions, occupational therapy, escorted Section 17 leave and staff can take their breaks. (Regulation 18)	a) In line with the national quality board safe staffing guidance, undertake a further review of staffing establishments and refresh the current safe staffing processes to ensure the provision of safe staffing levels to meet patient needs (including access to activities, psychological interventions, occupational therapy, escorted Section 17 leave, and staff taking their breaks)	Associate Director of Therapies	Safe Care reports	01/03/2022	Complete	Reasonable	The Trust wide establishment review is complete. Received by Board 23/03/22. A key outcome is the undertaking of a granular review of establishment and workforce modelling within SIS. This is underway and a paper is being developed to describe the outputs of this for action. A dedicated leave management team has been established and this is having positive impact in consistently facilitating patient leave. The challenges of recruiting to the activity co-ordinator post are being resolved through commissioning independent sector providers. In terms of therapeutic activity, delivery of planned and urgent care is evaluated, and a report prepared for SIS QuAG every month. The number of planned and urgent care therapeutic activity is reported against: Ward, Pathway, Group/Individual activity, mitigation for non-delivery and action to address delays in treatment. In addition, the report monitors clinician caseload, referrals and wait times.
Secure Inpatient Services	**14b**		b) Monitor compliance with staffing escalation processes. [Improvement measures: Sustained improvements with the key performance indicators within the safe staffing reports. Monitoring of themes and trends using Safe Care, where staffing issues were escalated. Numbers of escorted Section 17 leave untaken, activities cancelled and psychological interventions cancelled. Improvement in patient and staff experience regarding availability of suitably skilled staff. Improvements in vacancy rates and recruitment to new roles.]	General Manager / Associate Director of Nursing and Quality	QuAG reports to LMG	30/06/2022	On track/Little risk to delivery	Reasonable	In progress – Freedom to Speak Up Guardian and Officer attended BAME network, ongoing sign posting to relevant support when concerns are raised, weekly bulletin continues to include how to raise a concern, refresh of D@WC underway, B&H and managing concerns procedures. Safecare is now fully embedded in the service and daily operational huddles mitigate any issues raised. Red flags that we are unable to mitigate are being thematically reviewed.
Secure Inpatient Services	**15a**	The trust must ensure that all staff receive and are compliant with a mandatory training programme which meets the needs of all patients within the service. (Regulation 18)	a) Improve training compliance rates through robust performance management systems which include oversight of staff who do not attend scheduled training. [Improvement measures: Mandatory training reports demonstrating compliance with the Board indicator (including to ward level).]	Care Group Director	Mandatory Training Reports to Team level. (with individual wards/ teams not falling below required targets)	01/03/2022	Complete	Reasonable	Improved compliance noted in mandatory and statutory training completion. However, some challenges remain with delivering face to face Mandatory Training. In particular these include PAT2 and STRD training. BLS is on an improving trajectory towards standard (currently 80%). A Red Flag has been added to Safecare to support identification and mitigation in terms of BLS trained staff in each environment.

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Secure Inpatient Services	**15b**		b) Increase training capacity for mandatory and statutory training courses for the service where this is required and utilise alternative modes of training delivery to support completion of training.	Care Group Director	Increased capacity for training courses	30/06/2022	On track/Little risk to delivery	Reasonable	Good progress has been made in increasing the training capacity e.g., onsite training provision including at weekends and evenings to enable improved attendance.
Secure Inpatient Services	**16**	The trust must ensure that all staff receive regular clinical supervision. (Regulation 18)	Undertake a review of current arrangements for the provision of clinical supervision within Secure Inpatient Services, identify the current barriers to compliance with the current supervision standards and work with staff to co-create an approach that ensures that staff receive regular clinical supervision. [Improvement measures: Clinical supervision compliance reports]	General Manager / Associate Director of Nursing and Quality and Associate Director of Therapies	Supervision compliance reports	30/06/2022	Some risk to delivery	Reasonable	A range of work has been undertaken and supervision compliance reports are in place however further work is required to ensure consistent high quality capture of supervision activity. Current compliance reports indicate some improvement, but further improvement needed. Fundamental standards group being used to support awareness raising and recording needs. Continues to be monitored monthly
Secure Inpatient Services	**17**	The trust must ensure that audits of care records identify any errors or omissions in relation to patients' risk management plans in order to ensure all risks are identified and mitigated in order to keep patients and others safe. (Regulation 17)	Taking into account the improvement work already undertaken, ensure that the Trust wide work in relation to safety summaries and plans is embedded and consideration of further quality improvement work. [Improvement measures: Audit demonstrates that safety summaries and plans are in place and that they effectively identify the appropriate risks and mitigations. Increase in clinical leadership to support quality assurance processes. Validation audits to strengthen quality assurance processes.]	Care Group Board	Quality Assurance reports	01/03/2022	Complete	Reasonable	Refreshed and enhanced quality assurance programme now in place. Evidence from audits demonstrates a fluctuating picture however, generally compliance in excess of 90%.
Secure Inpatient Services	**18**	The trust must ensure that all incidents within the service have been reported by staff using the trust's incident reporting procedure. (Regulation 17)	Implement a programme that will increase the knowledge and skills of staff in relation to patient safety, improve incident reporting and enable learning from patient safety incidents thereby developing a positive patient safety culture. To understand the level of staff confidence in raising concerns at ward level. [Improvement measures: Sustained high levels of service incident reporting. The service is able to evidence improvements as a result of learning from patient safety incidents. Cultural metrics and staff feedback regarding reporting of incidents.]	General Manager, Associate Medical Director	Incident reports (including to Ward level). Incident debriefs which include shared learning for the service where appropriate.	01/03/2022	Complete	Reasonable	Ways of raising incidents and learning form these is a significant focus of the fundamental standards group. Overall incident reporting does demonstrate an increase - though we still occasionally become aware of issues that should have been escalated.

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 24/05/22
Secure Inpatient Services	**19**	The trust must ensure that regular team meetings take place on all the wards within the service to ensure staff receive key information and have the opportunity to provide their own feedback on the service. (Regulation 17)	Refresh secure inpatient service governance - meeting structures to facilitate regular meaningful staff involvement and engagement. [Improvement measures: Regular meetings take place for staff at ward level and attendance is monitored. Improved levels of staff engagement within the annual staff survey.]	Care Group Director and Medical Director	Staff survey. Documentary evidence of staff attendance and contributions to team meetings.	01/03/2022	Some risk to delivery	Reasonable	This work is ongoing and there is variability in terms of frequency and attendance at ward meetings. Staff survey engagement remains a challenge. To mitigate this, we have increased visibility in wards, night-time visits and also calls to wards on a nightly basis to discuss issues and improvement activities.
Community mental health services for working age adults	**20**	The trust must have effective oversight of caseloads and case management within all community teams. (Regulation 17)	A Trust-wide quality improvement event will be held focusing on agreeing consistent clinical caseload management processes across teams to provide oversight of implementation and development of robust systems for monitoring and oversight. [Improvement measures: Quality improvement event. Compliance reports that will provide oversight of caseload management across the Trust.]	Managing Director and QI Event Sponsor	Caseload Management Process	30/09/2022	Some risk to delivery		Trust wide- Meeting held with QIS & CITO leads & AMH General Managers. We are currently gathering tools & undertaking a scoping exercise to identify different models and approaches. Currently planning the arrangements for the quality improvement event taking place in June 2022. This will focus on the development and agreement of a single caseload management tool, processes for oversight and monitoring as well as a programme of training and implementation.
Community mental health services for working age adults	**21**	The trust must ensure that they are delivering care and treatment that is appropriate and meeting the needs of all patients across the community teams. Assessments and treatment must be offered in a timely way. (Regulation 9)	A Trust-wide quality improvement event to take place with developed working groups or links to existing groups to support the delivery of appropriate care and treatment of patients across community teams. [Improvement measures: Quality improvement event. Compliance reports that will provide robust oversight of assessment and treatment waiting times across Community Teams.]	General Managers	Assessment and treatment waiting time reports demonstrating improved position.	30/09/2022	Some risk to delivery		Meeting arranged with General Managers, AMD and Clinical Networks leads in May to develop workplan and link to CMHF developments - Shaun Mayo DTV General Manager. NYY AMH - IIC dashboard in place at team level to track waiters & weekly performance report out monitors against 90% standard. Improvement plans in place where required & staffing escalation in place to support team capacity - reported into LMGB & linked to risks

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 24/05/22
Crisis services and health-based places of safety	**22**	The trust must ensure the proper and safe management of medicines. (Regulation 12)	The Trust will review the current storage and management of medicines within Crisis Teams and the Pharmacy support available to them. Separate reports will be produced for presentation to Quality Assurance Groups (QuAGs) for presentation and follow up of necessary actions. [Improvement measures: Targeted Community Medicines Management assessments undertaken in Crisis Teams to be undertaken to monitor compliance (existing audit). Locality Medicines Management Group to maintain oversight of any quality issues and mitigate any potential risks regarding safe medicines storage and management.]	Trust Chief Pharmacist and Urgent Care Pathways Lead	Medicines Management Assessments	30/09/2022	On track/Little risk to delivery	Good	05/05/22 - Audit results have been collected and report is currently being written. Direct support is being provided by Lead Medicines Management Nurse to each crisis team re: storage and other medicines issues.
Community child and adolescent mental health services	**23a**	The trust must ensure that there are enough staff in each team to meet the demands of the service. Staffing level must be reviewed and amended promptly at times of high pressure and demand. (Regulation 18)	a) Implement a robust recruitment and retention programme with additional support to develop bespoke campaigns to specifically attract CAMHS staff. Use of some agency staff in the interim.	General Managers (CAMHS)	Recruitment and retention programme	30/09/2022	Some risk to delivery		Support from colleagues in HR, as well as communications, is required in order to deliver targeted CAMHS recruitment campaigns.
Community child and adolescent mental health services	**23b**		b) Demand and capacity work (Planning and Finance) to be undertaken to determine baseline demand and then to determine appropriate resource required to meet the demand.	Heads of Services (CAMHS)	Demand and capacity reports	31/03/2022	Complete	Good	This has been reviewed in detail and a paper presented to consider future options. Summits planned by March target date; summits set to conclude by July-22. More transformation work will fall out of these summits.
Community child and adolescent mental health services	**23c**		c) Model of Service (iThrive etc.) to be considered in relation to where young people experience waits and how these can be addressed and also how wider services can support young people in the future.	Heads of Services (CAMHS)	Outsourcing of ASD assessments to be considered and either agreed or ruled out	28/02/2022	Complete	Good	IThrive is now the framework which has been adopted across the CAMHS service.
Community child and adolescent mental health services	**23d**		d) Consider how demand can be addressed as a system (ICS) with Partners to understand how patients' needs are best met (including staffing skill mix and getting it right first time). Consideration of outsourcing specific specialised ASD assessments.	General Managers (CAMHS)	System discussions and agreement of next steps	01/07/2022	Complete	Reasonable	This has been reviewed in detail and a paper presented to consider future options.

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 24/05/22
Community child and adolescent mental health services	24a	The trust must ensure that all staff are appropriately trained in the mandatory skills required to fulfil their roles. (Regulation 18)	a) Improve training compliance rates through robust performance management systems which include oversight of staff who do not attend scheduled training. [Improvement measure: Weekly review of team compliance data and appropriate actions identified and implemented.]	General Managers (CAMHS)	Weekly progress reports	30/09/2022	On track/Little risk to delivery	Good	Good compliance rates (significant improvements noted) - 89% for trust wide CAMHS
Community child and adolescent mental health services	24b		b) Increase training capacity for mandatory and statutory training courses for the service where this is required and utilise alternative modes of training delivery to support completion of training.	General Managers (CAMHS)	Increased capacity for training courses	30/09/2022	On track/Little risk to delivery	Good	Good compliance rates (significant improvements noted).
Community child and adolescent mental health services	25	The trust must ensure there is clear oversight of the waiting list management process and that it is robust enough to ensure all children and young people and reviewed and any risk acted upon. (Regulation 12)	To develop and implement an improved waiting list process including an initial risk assessment for every child and a robust Keeping in Touch process. [Improvement measures: Development of a Patient Tracker List and standard processes that are reviewed daily in a CAMHS service wide huddle by Locality Management. Additional development of an automated process for same to reduce resource required and ensure long term sustainability. Reduction in the waiting list and a more "managed" waiting list. This will be achieved by the delivery of standard processes, patient trackers and consistent utilisation of the Keeping in touch process.]	Heads of Services (CAMHS)	Patient Tracker List, Keeping in Touch letters Standard work processes. Daily huddle progress reports Oversight of waiting lists and KIT at appropriate governance groups. Reduced waiting lists for service users, evidence of increased utilisation of Keeping in Touch process. Progress reviews via the patient tracker.	28/02/2022	Complete	Reasonable	Actions were complete (with substantial assurance) on time, however, we are dealing with data quality issues with the waiters dashboard in IIC and unintended consequences from PARIS changes impacting reliability of the system. Requires further escalation due to changes in position.
Community child and adolescent mental health services	26a	The trust senior management team must respond promptly to address issues within the service to ensure effective service delivery without delay (Regulation 17)	a) Daily monitoring in place of children waiting for treatment and implementation of the revised Keeping In Touch process.	QuAG/LMGB, CAMHS Heads of Service	Evidence of daily monitoring in place. KIT process.	31/03/2022	Complete	Reasonable	As above.
Community child and adolescent mental health services	26b		b) Set and monitor statutory and mandatory training trajectories. [Improvement measures: Clear line of sight and assurance indicators for board.]	QuAG/LMGB, CAMHS Heads of Service	Mandatory and Statutory Training Compliance reports	31/03/2022	Complete	Good	-

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 24/05/22
Community child and adolescent mental health services	**26c**		c) Ensure recruitment to CAMHS posts is prioritised and engage agency market for fixed term staffing - explore the opportunity of using other professional groups in some roles. [Improvement measures: Improvements in vacancy rate, reduction in absence rate and caseload size, KIT monitoring huddles, reduction in average waits for assessment and treatment.]	Quality Assurance and Improvements Groups DTV&NYY&S, General Managers (CAMHS)	Vacancy rates Caseload Monitoring reports Patient Tracker List/ Keeping in Touch Letters	31/07/2022	Complete	Reasonable	Action complete however, noting change in assurance as per above with regard to Waiters and KIT.
Community child and adolescent mental health services	**26d**		d) Arrange system-wide (by Locality) summits to explore and problem solve drivers for demand.	Quality Assurance and Improvements Groups DTV&NYY&S, General Managers (CAMHS)	Summits	30/04/2023	On track/Little risk to delivery	Good	-
Community child and adolescent mental health services	**27a**	The trust must ensure that the service can be accessed promptly for all children who are referred (Regulation 9)	a) To develop and implement an improved waiting list process including an initial risk assessment for every child and a robust Keeping in Touch (KIT) process	QuAG/LMGB, CAMHS Heads of Service	Improved waiting list process. Patient Tracker List, Keeping in Touch letters. Standard work processes. Daily huddle progress reports	31/03/2022	Complete	Reasonable	Action complete however, noting change in assurance as per above with regard to Waiters and KIT.
Community child and adolescent mental health services	**27b**		b) Consideration of outsourcing specific specialised ASD assessments	QuAG/LMGB, CAMHS Heads of Service	Outsourcing of ASD assessments to be considered and either agreed or ruled out	31/03/2022	Complete	Good	Not being taken forward. Refer to action 23d.
Community child and adolescent mental health services	**27c**		c) Ensure recruitment to CAMHS posts is prioritised and engage agency market for fixed term staffing - explore the opportunity of using other professional groups in some roles	Quality Assurance and Improvements Groups DTV&NYY&S, General Managers (CAMHS)	Recruitment to CAMHS posts, and exploration of using other professional groups in some roles	31/07/2022	Complete	Good	Weekly huddles to track process and address issues. Regular problem solving with team managers to look at alternative roles when recruitment unsuccessful (e.g., support workers to run groups)
Community child and adolescent mental health services	**27d**		d) Arrange system-wide (by locality) summits to explore and problem solve drivers for demand and determine in which organisations some needs may be better met	Quality Assurance and Improvements Groups DTV&NYY&S, General Managers (CAMHS)	Summits	31/07/2022	On track/Little risk to delivery	Good	-

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Community child and adolescent mental health services	**27e**		e) Provide additional administration capacity to ensure phone calls are responded to in a timely manner - future consideration of electronic /telephony options for the service	Quality Assurance and Improvements Groups DTV&NYY&S, General Managers (CAMHS)	Additional administration capacity	31/07/2022	Complete	Good	Extra administrative support in place

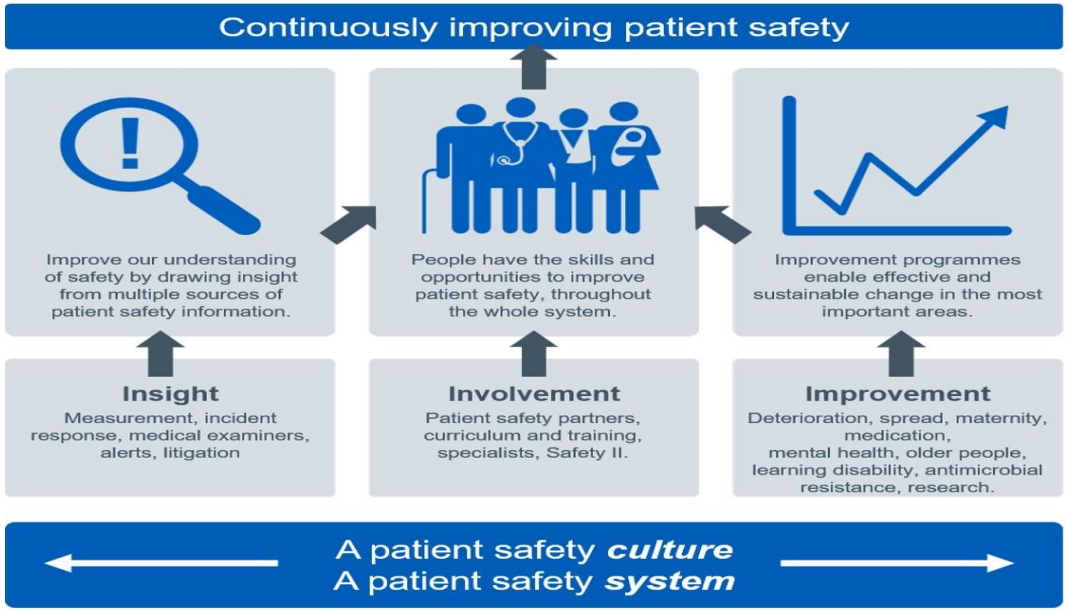
Patient safety specialists (PSS)

Executive briefing document

2021

NHS England and NHS Improvement

Patient safety specialists



Formally creating this role provides status and the expectation that having a patient safety specialist(s) who is fully trained in the national patient safety syllabus is standard across the NHS

Classification: Official

NHS

Identifying patient safety specialists

August 2020

Purpose of the role

The NHS Patient Safety Strategy[1] set the ambition for the new role of patient safety specialist to be introduced in every NHS organisation in England; this includes providers and commissioners of NHS-funded care. We consulted on a draft specification for patient safety specialists earlier in 2020 and this final specification is informed by the views of those who responded.

Patient safety specialists will be the lead patient safety experts in healthcare organisations, working full time on patient safety. They will be 'captains of the team' and provide dynamic, senior leadership, visibility and expert support to the patient safety work in their organisations. They will support the development of a patient safety culture and safety systems, and have sufficient seniority to engage directly with their executive team. They will work in networks to share good practice and learn from each other.

Patient safety specialist role

- Lead patient safety experts in their organisation, working full time on patient safety
- Able to escalate immediate risks or issues to Exec team
- ‘Captains of the team’, provide dynamic senior leadership, visibility and expert support
- Work with others including: Medication safety officer (MSO), Medical device safety officer (MDSO), Maternity safety champions
- Lead /support the local implementation of the NHS patient safety strategy: insight, involvement and improvement
- Support the development of a patient safety culture and safety systems
- Work in networks to share and learn
- Lead, and may directly support, patient safety improvement activity
- Ensure that systems thinking, and just culture principles are embedded
- Support patient safety partners (Framework for involving patients in patient safety)
- Learn and develop, complete the Patient safety syllabus

Key deliverables

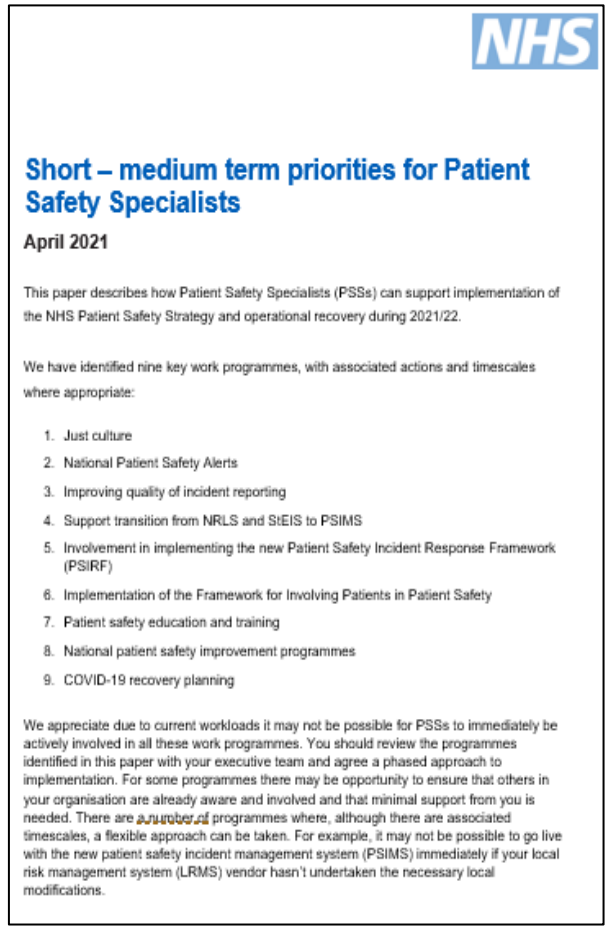
- 2019 - Role identified as part of the NHS patient safety strategy
- 2020 Mar - Patient safety specialists made a contractual requirement within the NHS Standard Contract 2021/22 section 33.7
- 2020 Aug/Nov - Identifying Patient Safety Specialists and providing nominations to NHSEI from every NHS organisation by 3011/20
- 2020 Nov – National webinars provided to support patient safety specialist training
- 2021 Apr – patient safety specialists to be full time in post
- 2021 Apr – patient safety specialist priorities document provided
- 2021 Jun - Patient safety syllabus available for patient safety specialists and training for the Board

Early milestones

- Over 700 Patient Safety Specialists representing 96% coverage of relevant organisations
- We have held 16 national meetings – topics including:
  - National patient safety improvement programmes
  - Views on patient safety culture
  - PSIRF progress update
- Involvement in two national safety issues:
  - Beckton Dickinson infusion devices
  - Phillips device recall
- Involvement in national working groups including:
  - National Patient Safety Syllabus
  - Development of NHSX digital strategy
- Development of FutureNHS Collaboration platform (access via patientsafetyspecialists.info@nhs.net)
- Patient safety priorities document provided
- Starting to create region and ICS patient safety specialist networks

PSS priorities (Apr-21)

- Just culture support and advice
- National Patient Safety Alerts advice
- Improving quality of incident recording
- Support transition from NRLS and StEIS to the new Learn from patient safety events (LFPSE) service
- Preparation for implementing the new Patient Safety Incident Response Framework (PSIRF) when it is launched in 2022
- Implementation of the Framework for involving patients in patient safety (published in June 2021)
- Patient safety education and training including the first two levels of the Patient safety syllabus launched in summer 2021
- Supporting involvement in the National Patient Safety Improvement Programmes, working with local AHSNs and Patient Safety Collaboratives
- COVID-19 recovery support – more information will be provided shortly



Short – medium term priorities for Patient Safety Specialists

April 2021

This paper describes how Patient Safety Specialists (PSSs) can support implementation of the NHS Patient Safety Strategy and operational recovery during 2021/22.

We have identified nine key work programmes, with associated actions and timescales where appropriate:

1. Just culture
2. National Patient Safety Alerts
3. Improving quality of incident reporting
4. Support transition from NRLS and StEIS to PSIMS
5. Involvement in implementing the new Patient Safety Incident Response Framework (PSIRF)
6. Implementation of the Framework for Involving Patients in Patient Safety
7. Patient safety education and training
8. National patient safety improvement programmes
9. COVID-19 recovery planning

We appreciate due to current workloads it may not be possible for PSSs to immediately be actively involved in all these work programmes. You should review the programmes identified in this paper with your executive team and agree a phased approach to implementation. For some programmes there may be opportunity to ensure that others in your organisation are already aware and involved and that minimal support from you is needed. There are a number of programmes where, although there are associated timescales, a flexible approach can be taken. For example, it may not be possible to go live with the new patient safety incident management system (PSIMS) immediately if your local risk management system (LRMS) vendor hasn't undertaken the necessary local modifications.

Executive PSS support requirements

1. The Patient Safety Specialist was required to be identified by Apr-21. The expectation is 1FTE at band 8 range, but this may be a shared role, or more than 1FTE across large organisations
2. The PSS's name(s) has been provided to NHSEI by executive lead for patient safety
3. An executive lead for patient safety should be identified as the direct contact point for the PSS. The PSS should also link with the NED who leads on patient safety.
4. All Board members should be aware of and support the PSS's role and discuss as a board agenda item
5. The PSS priorities document (circulated Apr-21) should be reviewed and a PSS work plan agreed with the patient safety executive lead
6. The PSS should be provided with sufficient time and resources to undertake their role, network and complete the patient safety training requirements (to level 5 of the Patient safety syllabus once available)
7. There should be sufficient support/ coaching / mentoring in place for the PSS to progress their personal and leadership development

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 15

People, Culture and Diversity Committee: Key Issues Report	
Report Date: 30 June 2022	**Report of: People, Culture and Diversity Committee**
Date of last meeting: 20 June 2022	The meeting was quorate, there were apologies for absence from Kath Davies, Phil Bellas and Sarah Dallal

1	**Agenda: The following agenda items were considered during the meeting:** • Colleague Experience – Schwartz Round • Board Assurance Framework and Corporate Risk Register • Executive PCDC Care Group feedback • Integrated Performance Report • Staff Networks Update
2a	**Alert: The Committee alerts members of the Board that:** Members stated that exit interviews are strategically critical to the organisation and sought further assurance that individuals leaving the Trust are offered a meeting with someone from outside their team and that this work is collated effectively and informs the strategy for recruitment and retention. Staff are contacted and invited to sessions lead by People & Culture and offered individual meetings, but there is further work required to improve this. There is some support coming to the Trust from NHSEI and a regional group and some assurance can be provided that there is a level of current provision to support staff leavers, however it is acknowledged there is more to do to improve this process and the collation of the intelligence. It is encouraging to note that the DDTVF Care Group Board have initiated a new process whereby any staff member advising of their intention to leave, will be contacted for an informal discussion to look at retention options and to understand the reasons why they want to leave. Seeking out this information at the earliest opportunity will be a rich source of learning for managers and leaders. There was challenge to the Committee on the comparative incentives offered for people to work for the Trust, compared to other places, such as the Priory or CNTW. Assurance is provided that the Trust has reviewed its reward and recognition package and some things fare more favorably in the Trust than other places. There are also some negative impacts of offering premia incentives as has been seen recently, with some complaints from staff feeling that the incentives are unfair.
2b	**Assurance: The Committee assures members of the Board that:** **Colleague Experience – Schwartz Round** Prof. Joe Reilly gave an overview of Schwartz rounds, progress to date and next steps**.** In sharing his personal experiences during involvement with the Trust Schwartz Rounds, a staff member in attendance at the meeting, gave a positive and encouraging insight into his “stories”. He told the Committee the real power of staff members being able to share their feelings and it had given him a sense renewed pride it his job. He had personally manged a very complex patient who was very challenging, over a long period, and he felt on reflection it had made him a better professional and he felt immense job satisfaction.

	Taking Schwartz rounds forward they will continue to be tailored to fit all staff engagement and can be delivered over a shorter 30-minute period in "pop up rounds". Consideration is going to be given to sending out the dates to all staff, similarly to staff being able to join the Chief Executive updates. **Board Assurance Framework & Corporate Risk Register** The Board Assurance Framework (BAF) and Corporate Risk Register were considered. In relation to the BAF, there is improvement to the risk describing the oversight of recruitment and this will be monitored via the new recruitment oversight group. There was some challenge and discussion in relation to whether recruitment matches staff leavers and the data for starters, leavers and movers is now available broken down by profession and service with a six-month view. The Care Groups will interrogate this data. In relation to the Corporate Risk Register, there are 35 risks currently open relating to People and Culture, with two new risks added in May and one escalated to a risk score of 15+, linked to complex patients being cared for in a temporary ward environment. Two new risks were added from North Yorkshire relating to patient safety and no risks are downgraded. Risks assigned in the past to the Chief Operating Officer will be reassigned by the end of June. There are 66% of risks due for review and progress on mitigating actions are not moving in the right direction. Some housekeeping will be undertaken in relation to updating the register and the care groups have begun this process. On reflecting on the BAF members, considered that it is important that the Board note that there was agreement that the narrative which relates to staff leavers should be reviewed to ensure it has the right emphasis and level of importance, due to its impact on recruitment and retention and the overall strategy of the Trust. This review will take place and cross checked with the Corporate Risk Register. The Committee requested a focus paper to bring together some of the elements buried in the BAF and CRR relating to staff starters/leavers/movers and exit interviews. The Committee also agreed that in future agendas discussion will start with CRR followed by BAF so the flow from one to the other is more overt.
2c	**Advise: The Committee advises the Board that:** **Staff Network Update** The 'BAME Network' has reviewed its leadership and continues to meet with very positive feedback from members who attend and say they feel supported and connected to other BAME members and able to share experiences in a safe place. The more informal 'Rainbow Staff Network' has supported Pride events in Durham and York this summer and now has two co-chairs. The 'Long Term Health Conditions Network' are ready to submit a paper to JCC and Executive PC&D Committee to propose a trial for a dedicated team to carry out reasonable workplace adjustments. The new armed forces network will start at the end of summer We are revisiting executive sponsorship of the networks with the changes in the Board. **Performance Report** The data has not changed significantly since last month. The starter/leaver/mover data is new, there are quality issues with the movers data (information on roles moved into is accurate but we cannot be sure which roles people have moved from), which is being worked through. Key matters are: Sickness fluctuates but remains lower than comparable Trusts and consistently under 7%.

	Percentage of staff in protected groups being bullied is dropping and is now at or below national average, however, needs to be at zero. Staff compliance with mandatory training will periodically drop as courses come back on stream following the pandemic. This will stop happening by the end of the year as all courses will be back in place. Committee members challenged the lower figure for medical mandatory/statutory training and there are four teams where further discussions will take place. There are other factors to consider, such as training for junior doctors, which has been undertaken elsewhere and not signed off.
2d	**Risks:** There are no new risks to be considered for the BAF but the narrative around knowing why people are leaving or moving needs to be strengthened.

Recommendation: The Board is asked to:
(i) note the contents of this report.
(ii) note that there will be a review of the BAF risk relating to staff leavers to ensure it is given sufficient importance and urgency
(iii) note that there will be a focus paper reported to the PCDC, to bring together recruitment and retention issues, including starters/leavers/movers and exit interviews.

3	**Any Items to be Escalated to another Board Sub-Committee/Board of Directors** None
4	**Report compiled by:** Donna Keeping, **Corporate Governance Manager** Shirley Richardson, ***Non-Executive Director/Interim Deputy Chair (Committee Chairman)*** Sarah Dexter-Smith, **Director of People and Culture**

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 16

FOR APPROVAL

TRUST BOARD - PUBLIC

DATE:	**30 June 2022**
TITLE:	**Data Security and Protection Toolkit Position**
REPORT OF:	**Liz Romaniak, Director of Finance and Information**
REPORT FOR:	**Decision**

This report supports the achievement of the following Strategic Goals:	✓
To co-create a great experience for our patients, carers and families	✓
To co-create a great experience for our colleagues	✓
To be a great partner	✓

Executive Summary:

This paper has been prepared to brief the Board on the activities to date in regard to the Data Security and Protection Toolkit and to gain their approval to the reporting and publication of the Trust's anticipated compliance with the toolkit as at 30th June 2022.

The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. The Trust is evidencing compliance against incrementally more challenging DSPT requirements, in particular strengthened technical requirements, a new mandatory assertion relating to medical devices connected to the Trust network, and alignment with the Information Commissioner's Office Data Protection Self-Assessment tool. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly.

The Trust has collated evidence against all Data Guardian standards but will not be able to return a fully met position this year. Along with many other Trusts, the one standard proving difficult to achieve relates to 95% of staff completing mandatory and statutory Data Security and Protection Training (the Trust needs to achieve 95% at any time in the rolling year). NHS Digital have advised that the 95% threshold will not be reduced due to the importance of cyber security awareness. It will therefore be necessary to remain in a position of 'approaching standards' until such time as improvement in sickness absence levels enable the Trust to evidence attainment of 95% completion. As the toolkit is a dynamic tool, we can have our status changed to 'fully met' once the remaining evidence item is achieved.

Full details are described below. The Board are required to have an understanding of the top three information risks identified and agreed with the Trust SIRO. The Digital and Data Services department currently has seven equally-rated risks identified in this paper together with the top three Information Governance risks.

Recommendations:

- That the Trust Board approves the final publication of the Data Security and Protection Toolkit as at 30 June 2022 with all evidence items in place and an internal action plan for the standard not yet met based on anticipated DSPT training compliance.

MEETING OF:	**TRUST BOARD**
DATE:	**30 June 2022**
TITLE:	**Data Security and Protection Toolkit Position**

1. INTRODUCTION & PURPOSE:

1.1 The Data Security and Protection Toolkit (DSPT - formerly IG Toolkit) is an online self-assessment tool published by NHS Digital that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly.

1.2 The purpose of this paper is to:

- Give the current completion status;
- Identify any evidence items not yet completed that will be reported with an action plan;
- Identify the Trusts top information risks for discussion and agreement;
- Provide an overview of incremental changes in DSPT requirements.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The toolkit is divided into ten standards, and each standard is broken down into a number of assertions. Evidence items are required against each assertion, some of which are mandatory, and some being non-mandatory.

2.2 There are 110 mandatory evidence items, and for an organisation to be rated 'satisfactory', they must have completed all mandatory evidence items in their toolkit by 30 June 2022.

3. CURRENT STATUS

3.1 Trust position <u>as at 20 June 2022</u>

As at 20 June 2022, ***one evidence item has been identified as not achievable***. This relates to 95% of staff having completed their mandatory and statutory Data Security and Protection training (the Trust needs to achieve 95% at any time in the rolling year). Similar to many other Trusts, sickness absence rates over the past 12 months have prevented us achieving the required level of compliance and supporting evidence. NHS Digital have advised that the 95% threshold will not be reduced due to the importance of cyber security awareness. Due to the number of Trusts in the same position, NHS Digital have advised that, if this is the only evidence item not achieved, an action plan is not required. The Trust position is anticipated to be 87%.

The final external audit report will be provided by AuditOne week commencing 27 June. It is anticipated that the final result will be to post the evidence of completion for the one remaining evidence item.

3.2 Outstanding evidence item

Assertion description	Action Required	Completion date
3.2.1 Have at least 95% of all staff, completed their annual Data Security Awareness Training?	• Work with governance groups to understand barriers to engagement with mandatory training • Develop a communication plan to raise awareness of mandatory requirement and deadlines to complete • Monthly reporting of progress to Digital Performance and Assurance Group (escalation into Executive Strategy & Resources Group as necessary) • Action plans with trajectories agreed with Care Group and Directorates	31 December 2022

3.3 Top three risks for the Information Governance Team

The Information Governance Team transitioned from Nursing and Governance directorate to Finance, Information and Estates with effect from 1st October 2021.

The three risks below are the highest rated within the Digital and Data Services department relevant to the area of information governance and DSPT compliance.

Description	2021/22			Risk Description
	Risk Assessment		Risk Rating 21/22	
	Impact (i)	Likelihood (l)		
Data storage	4	4	16 ⇔	Cause: The storage of sensitive data on spreadsheets or other local systems with no appropriate governance Event: Confidential or sensitive data accessed by those without relevant permissions or legitimate (legal) access. Impact: Exposes the Trust to data breaches and we would be unable to meet Caldicott principles. Data could be used maliciously against the patient, staff or Trust. Reputational damage and financial penalties, compromise to patient safety, harm to patient/ staff or Trust.
Email disclosure	4	4	16 ⇩ (from 20)	Emails requested by staff cannot effectively be disclosed without asking staff to self-declare. The DPA team could get copies of each email account but staff request emails of many staff at once and the DPA team do not have the resource to interrogate all of the email accounts needed. Staff are often requesting emails because of a disciplinary, bullying or freedom to speak issue and so when staff are asked to self-declare the requestor can feel or indeed be vulnerable to further problems. Staff side feel that this is unfair. Staff feel that the Trust is providing a barrier to their request and subjecting them to further harm.
'Missing' records	3	5	15 ⇔	Cause: Records are not accurately registered which makes locating them very difficult. Event: Records are requested for Subject Access Requests and we are increasingly having to inform patient and staff that we cannot find their records. This could lead to a breach of the DPA and increased complaints. Impact: This is a breach of DPA in several areas and could ultimately result in Litigation claims and an ICO fine.

3.4 Top seven risks for Digital and Data Services

With the exception of the Information Governance risks described above, Digital and Data Services are managing seven risks all with the same high rating that are relevant to DSPT compliance.

Description	2021/22			Risk Description
	Risk Assessment		Risk Rating 21/22	
	Impact (i)	Likelihood (l)		
Event logging policy	4	3	12 ⇔	Cause: Ineffective Monitoring and Incident Response As a result of limited event Logging (no Policy defined) (technical) Event: Cyber security Incident occurs Impact: This may result in exposed, corrupted and deleted medical records, and loss of accountability. Cost of investigation and remediation. A limited audit trail in the event of a cyber breach
Phishing or social engineering of staff who have not had specific training	4	3	12 ⇩ (from 16)	Cause: Lack of staff understanding and awareness of how to accurately spot a phishing email Event: Phishing Attack Impact: Malware or ransomware installed on trust systems
On call arrangements	4	3	12 ⇔	Cause: Local systems are not covered by on call arrangements. Event: The failure of a networking component out of hours Impact: Important local systems other than Paris e.g. Attend Anywhere and Health Roster become unavailable to staff out of hours with no support available resulting in clinical risk
Cyber security awareness at Board level	4	3	12 ⇩ (from 16)	Cause: Lack awareness of trust cyber security issues at board level Event: An identified risk occurs Impact: Limited opportunity to mitigate risk
Records retention in systems	3	4	12 ⇔	It's a risk that System Changes may not be technically possible in system to meet GDPR requirements. In particular with regard to retention and disposal schedules. Until this is available we do not meet the requirements of DPA 2018 (GDPR). Cause: legacy systems have not been able to do this (moved from paper) – so don't have records management functionality. Event: If we are not compliant with the DPA there are potential have financial ramifications. Impact: Reputational, financial and non-compliance with legislation.
Cyber security resource	4	3	12 ⇩ (from 15)	Cause: IT Staff having insufficient cyber security resources, and enforced cyber security policies and procedures, along with technical audit and assurance. Event: Cyber attack on Trust Impact: Trust is not able to identify, isolate and rectify the source of attack to prevent loss of data and or access to trust systems
Cyber security training	4	3	12 ⇩ (from 20)	Cause: Staff expose sensitive electronic data by mistake by not have sufficient cyber security training Event: Cyber security incident occurs Impact: Malicious actor gains access to Trust sensitive data and/or systems

3.5 Key changes in DSPT requirements 2021/22

The Trust is tracking and evidencing compliance against incrementally more challenging DSPT requirements.

Technical requirements have been strengthened for this year's toolkit submission, with specific improvements to evidence requirements relating to activity logging, asset management, unsupported systems and security patching/updates.

A new mandatory requirement has also been introduced to evidence that a register of medical devices connected to the Trust network is maintained. It is anticipated that this will be further strengthened in future iterations of the toolkit to ensure that medical devices are protected from exploitation of known vulnerabilities.

The DSPT has also been aligned to the Information Commissioner's Office Data Protection Self-Assessment which means that evidence also supports high level compliance with data protection legislation.

4. IMPLICATIONS:

4.1 Compliance with the Care Quality Commission (CQC) Fundamental Standards:

CQC do receive the DSPT ratings for all Trusts.

4.2 Financial/Value for Money:

There are no direct financial implications from this report other than those that could result from the Trust not meeting its mandatory requirements as part of the Data Protection Act 2018.

4.3 Legal and Constitutional (including the NHS Constitution):

If an organisation does not meet its mandatory requirements, this would be reported to the CQC, DHSC and NHS England/Improvement.

4.4 Equality and Diversity:

There have been no equality and diversity issues raised as part of the reporting of the Data Security and Protection Toolkit.

4.5 Other implications:

None identified

5. RISKS:

5.1 There are significant financial and operational/safety risks if information security breaches occur or information systems fail, impacting on the regulation and business of the Trust. The risk is also reputational and could affect the Trust's licence to practice depending upon the scale of a breach.

The risks and issues identified above could have an impact on the Trust.

6. CONCLUSIONS:

6.1 The proposal is that the action plan above is accepted and the Trust reports a ***status of "Not Met" as at 30 June 2022*** with a view to ***moving to "Approaching Standards" once agreed with NHS Digital***. A plan will be prepared to move to fully met by the end of quarter three 2022/23.

7. RECOMMENDATIONS:

7.1 That the Trust Board approves the final publication of the Data Security and Protection Toolkit as at 30 June 2022 with all evidence items in place and an internal action plan for the standard not yet met based on anticipated DSPT training compliance.

Author: Louise Eastham and Andrea Shotton
Title: Information Governance Manager and Data Protection Officer, Head of Information Governance

Background Papers:

Appendix One – Summary of Incidents notified to the ICO

DATE	REF	PROBLEM	ACTION	OUTCOME
07/03/2022	27289	Patient information was sent home with patient in error, which was accessed by patient's step-father who did not have a legal right of access. The step-father refused to return the information to the Trust and stated they had complained to the CQC.	Advice sought from ICO and communicated to step-father that retaining the information constitutes an offence in itself. Advice also sought from CQC.	ICO stated no further action required
18/02/2022	27105	Member of recruitment panel sent email detailing their issues following selection to several members of the panel including two of the unsuccessful candidates. The email contained details of the selection process including scoring received by several candidates. This caused distress to one of the recipients who was also an unsuccessful candidate.	Trust CEO responded to sender to inform that the email was inappropriate and constituted a breach. Deletion has been requested by all recipients including anyone to whom the email was forwarded. Additional support has been arranged for the unsuccessful candidates, the sender will no longer be involved on recruitment panels, panel process to be reviewed in terms of confidentiality understanding.	ICO stated no further action required
20/01/2022	26727	Clinician accessed the records of two patients without a business need to do so.	Detected via break glass report. Investigation discovered that the two patients were the children of two patients being treated by the clinician.	Not required to report
17/01/2022	26684	Clinician accessed the record of a family member without a business need to do so.	Detected via break glass report. Investigation discovered that the patient had the same last name as the clinician.	Not required to report
17/01/2022	26679	Clinician accessed the record of a family member without a business need to do so.	Detected via break glass report. Investigation discovered that the patient had the same last name as the clinician.	Not required to report
17/01/2022	26678	Clinician accessed the record of someone known to them without a clinical need to do so.	Detected via break glass report. Investigation discovered that the patient had the same last name as the clinician.	Not required to report
14/01/2022	26674	A data mismatch on a spreadsheet caused 1499 letters to be sent out with incorrect staff names, regarding updating the Trust's Covid-19 vaccination status records. The letters did not disclose the vaccination status of any staff member,	An apology was made to all involved staff with reassurances that no one's vaccination status had been disclosed only that our records needed to be updated in that regard. 6 staff submitted complaints. IT investigated	ICO stated no further action required.

		each letter had the incorrect staff name on it but no other information about any person.	issue with spreadsheet.	
13/12/2021	26335	Verbal disclosure of patient name via phone to patient's mother, which caused distress to patient.	Error had been caused by failure to ensure electronic patient record held up to date contact details and to update information sharing preferences. Formal complaint was expected but hadn't been received at time of investigation.	ICO stated no further action required.
03/12/2021	26333	Patient's mother's address disclosed in error to patient's father, causing distress.	Unable to evidence provision of reported bundle of information to patient's father; clear that some older letters had been copied without removal of mother's address and that current letters had also been copied to father including mother's address despite her requesting that this information remains confidential.	ICO stated no further action required.
09/11/2021	26030	Clinician accessed the record of someone known to them without a clinical need to do so.	Records access report had been provided to HR as part of another investigation however Privacy Team had not been informed that the access constituted a breach.	Not required to report
12/10/21	25744	Patient information disclosed in error via email to patient's mother against their wishes.	Patient informed team of error and correct details had been recorded in the case notes but not in the central index therefore a further four emails were sent to the patient's mother in error. Patient submitted a complaint. The incorrect details had also been printed and staff were continuing to use them inappropriately, which has now been stopped.	ICO stated no further action required. DHSC also informed but no response received.
22/07/2021	24907	Student nurse accessed the record of family member without a business need to do so.	Detected via break glass report. Investigation discovered that the patient had the same last name as the clinician. University also informed.	Not required to report
08/07/2021	24754	Clinician accessed the record of a family member without a clinical need to do so by asking a colleague to print out their assessments.	Clinician disclosed information about their family member's care to their manager and admitted the action when questioned. Referred to HR.	Not required to report

10/07/2021	24370	Clinician accessed the records of someone known to them without a clinical need to do so.	Close monitoring request identified access. Patient was open to the staff member's team. Referred to HR.	Not required to report
12/05/2021	23963	Clinician accessed the records of a family member without a clinical need to do so.	Close monitoring request identified access. Patient was open to the staff member's team. Referred to HR.	Not required to report
27/04/2021	23811	Verbal disclosure by clinician to a friend regarding a patient.	Clinician made an enquiry to a friend referring to the patient by their first name; the friend then made contact with the patient who submitted a complaint. Two year final written warning placed on clinician's staff record.	ICO stated no further action required.
16/04/2022	23684	Staff member inappropriately accessed and disclosed information from a colleague's email inbox.	Staff member resigned during investigation process. Interview carried out by locality manager but several questions were left unanswered.	Reported to ICO but no correspondence received from them.

ITEM NO. 17

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**30th June 2022**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Company Secretary**
REPORT FOR:	**Information**

This report supports the achievement of the following Strategic Goals:	
To co create a great experience for our patients, carers and families	✓
To co create a great experience for our colleagues	✓
To be a great partner	✓

Report:

In accordance with Standing Order 15.6 the Board is asked to note the following use of the Trust seal:

Ref.	Date	Document	Sealing Officers
425	26.5.22	Lease relating to Hartlepool Centre for Independent Living, Burbank Street, Hartlepool	Brent Kilmurray, Chief Executive Phil Bellas, Company Secretary

Recommendations:

The Board is asked to receive and note this report.