Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

12 December 2024 at 1.30pm

The Boardroom, West Park Hospital, Darlington, DL2 2TS and via MS Teams

AGENDA

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

Standard Items

1	Chair's welcome and introduction (verbal)	Chair	1.30pm
2	Apologies for absence (verbal)	Chair	
3	Declarations of interest (verbal)	All	
4	Minutes of the last meeting held on 10 October 2024	Chair	
5	Board Action Log	Chair	
6	Chair's report	Chair	
7	Questions raised by Governors in relation to matters on the agenda (verbal) *(to be received by 1pm on 10 December 2024)*	Board	

Strategic Items

8	Board Assurance Framework Summary Report	Co Sec	1.45pm
9	Chief Executive's Report	CEO	1.50pm
10	Integrated Performance Report	DCEO	2.05pm
11	Corporate Risk Register	CN	2.30pm
12	Our Journey to Change Delivery Plan Quarter 2 2024/25	DCEO	2.40pm
13	Charitable Trust Fund Annual Report and Accounts for 2023/24	EDoFE&F	2.50pm

BREAK (2.55pm – 3.05pm)

BAF RISK 1: Safe Staffing

14	Report of the Chair of People, Culture and Diversity Committee (verbal)	EDfP&C	3.05pm
15	Report of the Freedom to Speak Up Guardian	FTSUG D Williams	3.15pm

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

16	Report of the Chair of Quality Assurance Committee	Cmt Chair	3.30pm
17	Learning from Deaths Report	R Shah DTVF MD	3.40pm
18	Senior GP Education and Liaison Consultants, introduction and presentation	J Carlton S Akowuah	3.45pm
19	Annual Medical Education Report	H El-Sayeh DoME	4.00pm

Governance

20	Board Assurance Framework (verbal)	Chair	4.15pm

Matters for information

21	Leadership Walkabouts	EDoCA&I	-
22	Use of the Trust's Seal	Co Sec	-

Exclusion of the Public:

23	Exclusion of the public - the Chair to move: *"That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:* *Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office holder or applicant to become an office-holder under, the Trust.*	Chair	-

	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.*		

BREAK (4.25pm-4.35pm)

Standard Items

24	Confidential minutes of the last meeting held on 10 October 2024	Chair	4.35pm
25	Confidential Action Log	Chair	

Strategic Items

26	Chief Executive's Confidential report	CEO	4.45pm
27	Reportable Issues Log	CN	5.05pm
28	Proposed revisions to our Strategic Framework (Our Journey Change)	DCEO	5.10pm
29	Report of the Chair of Audit & Risk Committee	Cmt Chair	5.25pm
30	Risk Management Strategy and Policy	CN	5.35pm

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

31	Report of the Chair of Resources and Planning Committee	Cmt Chair	5.40pm
32	2024/25 Month 7 Finance Report	EDoFE&F	5.50pm
33	Cito update	CIO	6.00pm

BAF RISK 10: Regulatory Compliance

34	CQC Inspection Report (verbal)	CEO, CN	6.10pm

BAF Risk 13: Public Confidence

35	Communications Strategy	EDoCA&I	6.20pm

Governance

36	Membership of Board of Director's committees	Chair	6.30pm
37	Charitable Funds Terms of Reference	Co Sec	6.35pm

Evaluation

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

Matters for information

39	Minutes of meetings of board committees: a. Audit and Risk Committee, 17 June 2024 b. Quality Assurance Committee, 3 October 2024 c. Resources and Planning Committee, 18 September 2024 d. Audit and Risk Committee, 14 October 2024	Co Sec	-

David Jennings
Chair
6 December 2024

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

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

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Tees, Esk and Wear Valleys
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS HELD ON 10 OCTOBER 2024 AT WEST PARK HOSPITAL, DARLINGTON AND VIS MSTEAMS

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

In attendance:
P Bellas, Company Secretary
N Black, Chief Information Officer
K Christon, Deputy Company Secretary (minutes)
D Jessop, Deputy Chief Nurse (on behalf of B Murphy, Chief Nurse)
S Theobald, Associate Director of Performance

Observers:
K Evenden-Prest, Staff Governor

24/25/105 CHAIR'S WELCOME AND INTRODUCTION

The Chair welcomed everyone to the meeting and welcomed N Lonergan and K North to the board meeting in their new roles. He also took the opportunity to thank D Jessop for work she had undertaken during her time at the Trust.

He went on to note the length of the board agenda and the potential to establish a task and finish group to consider how best to maximise the board's time.

24/25/106 APOLOGIES FOR ABSENCE

Apologies for absence were received from C Carpenter, Non-Executive Director and B Murphy, Chief Nurse.

24/25/107 DECLARATIONS OF INTEREST

J Preston, Non-Executive Director, noted a non-pecuniary interest in relation to the Wellbeing in Mind Schools Programme, as Chair of a participating school.

24/25/108 MINUTES OF THE LAST MEETING HELD ON 8 AUGUST 2024

Agreed: *the minutes of the last meeting held on 8 August 2024 were an accurate record of the meeting.*

24/25/109 BOARD ACTION LOG

The following was noted:

- B Reilly, Chair of Quality Assurance Committee, confirmed that the committee had reviewed static risks relevant to the committee and S Dexter-Smith noted that People, Culture and Diversity Committee would consider a report at their next meeting [action 23-24/136].
- In respect of the 72-hour follow-up target, N Lonergan provided assurance that work had been undertaken to improve data quality and to ensure that, where the target was not achieved, all patients were safe. It was agreed that a progress update would be provided at the next meeting [action 24-25/83].

The Chair invited executive directors to update the board action log, where progress was able to be reported.

24/25/110 CHAIR'S REPORT

The Chair presented the report and drew attention to his key themes – the Trust's future direction and strategy, skills of the board and performance improvement.

24/25/111 QUESTIONS RAISED BY GOVERNORS IN RELATION TO MATTERS ON THE AGENDA

None.

24/25/112 BOARD ASSURANCE FRAMEWORK (BAF) SUMMARY REPORT

P Bellas presented the report, which provided information on risks included in the BAF, to support discussion at the meeting. He drew attention to the inclusion of an additional column on new and emerging risks.

In discussion the following points were raised:

1. The Chair noted BAF risks and mitigation would be considered by the relevant board committee in advance of the board meeting.
2. A query was raised about the level of detail included in the BAF, for example the risk that applicants may seek alternative employment due to length of time from advert to employment.

   S Dexter-Smith advised the risk had been removed from the BAF, as data had indicated this was no longer a concern and she proposed to discuss further at the next People, Culture and Diversity Committee.

   It was also proposed that operational risks would not be included in the BAF but would be linked to the strategic risk.
3. It was noted that the report had been completed prior to the last Quality Assurance Committee meeting and would be updated to reference a concern raised by the committee in relation to the BAF Risk 2 [demand].
4. The Chair welcomed development of the BAF and proposed that it would continue to be refined to provide board with assurance on action taken to reduce the gap between actual and target risk scores.
5. B Kilmurray advised that Executive Risk Group had commenced a review of all static risks and noted that a similar review would be undertaken of BAF risks.
6. The Chair confirmed that committee Chairs were content with the level of grip and control in relation to actions in place.

24/25/113 CHIEF EXECUTIVE'S REPORT

B Kilmurray spoke to the report, which provided a briefing on important topical issues of concern to the Chief Executive and he noted an intention to circulate briefings to the board in the period between formal meetings.

In discussion the following points were raised:

1. The Chair welcomed the opportunity for the board to remain sighted on areas outlined in the report, as the Trust moved forward and in the context of a new government. He went on draw attention to broader work by the Trust on health inequalities and the board briefing on suicide prevention, as areas of Governor interest. He proposed that Resources and Planning Committee would consider and report to board on the NHS Federated Data Platform.
2. K Kale noted the reported outcome of the GMC National Trainee Survey, where the Trust was placed ninth nationally – out of 226 Trusts - for training and support.

24/25/114 INTEGRATED PERFORMANCE REPORT (IPR)

P Scott spoke to the report, which provided oversight on the quality of services delivered and proposed there was: good controls assurance regarding the oversight of the quality of services delivered and corrective actions in place to address any gaps; good performance assurance regarding the integrated performance dashboard; and reasonable performance assurance regarding the national and local quality requirements.

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

- Ongoing concerns about bed occupancy in adult services in North Yorkshire and York and the findings of a recent review, which would be considered by the care group board.
- Work underway with partners in York to respond to an increase in delayed discharges from older people services due to lack of care packages in the community.
- Action taken in response to concerns about Early Intervention in Psychosis waiting times. Progress was expected from November and would be closely monitored.
- The improvement in waiting times between York Talking Therapies first and second appointments due to action taken through the performance improvement plan. The same target had not been achieved in North Yorkshire due non-attendance over summer and patients had been offered additional sessions. The position was expected to improve in the next quarter.

N Lonergan reported from Durham, Tees Valley and Forensic Care Group and noted:

- Further actions proposed in relation to concerns about bed occupancy. There had been an ongoing improvement in patients ready for discharge in Durham and the Integrated Care Board had offered to provide support in relation to challenges in Tees Valley.
- Roll out of OPTICA – a tool to monitor the treatment journey of admitted patients to support timely discharge – which would support implementation of the new OPEL framework.
- The focus on and improvement in use of restrictive intervention, including on Cedar and Overdale Wards, supported by clinical leads, the Autism Team and Positive and Safe Practitioners.
- The improvement in Clinician Reported Outcome Measures and work undertaken to support an improvement in paired outcomes at discharge by the end of September.

In discussion the following points were raised:

1. B Kilmurray noted the commencement of the flu campaign and advised that sickness absence and agency expenditure would continue to be monitored. Commenting

further, S Dexter-Smith noted the development of ward dashboards to support teams to monitor sickness absence and annual leave.

2. J Maddison proposed there had been a significant improvement in reporting and assurance provided to the board in relation to grip and control and impact. He went on to query the Trust's ability to respond to national and local quality indicators within existing resources.
3. A query was raised about the length of time it would take to achieve the proposed 85% bed occupancy standard, and whether, in the context of demand on services, an interim milestone would be appropriate.

   L Romaniak advised that the proposal reflected the level at which the Trust was commissioned and had been considered by Executive Directors Group and Resources and Planning Committee. Current challenges meant this was not currently deliverable and further work needed to be undertaken to understand the trajectory. For context, she advised that, if the figure for delayed transfers was removed, the standard would be achieved.
4. Responding to a query from the Chair, P Scott confirmed that the IPR would be strengthened to provide narrative and assurance on actions proposed to respond to persistent challenges.
5. B Reilly, as Chair of Quality Assurance Committee, noted that the committee had queried the level of assurance recommended to the board on the national and local quality requirements.

   In response, P Scott proposed the Trust was not at limited assurance, the level below that recommended to the board.

   B Kilmurray confirmed the board was invited to consider and agree the level of assurance and he proposed that the IPR was based on well-structured analysis of the position.

   P Bellas provided an overview of the definition of assurance levels used by internal audit - substantial assurance indicated that risks identified were managed effectively and there was compliance with the control framework; good assurance indicated risks identified were managed effectively and there was a high level of compliance with the control framework with remedial action required; reasonable assurance indicated that risks identified were managed effectively and there was inconsistent compliance with the control framework with moderate remedial action required; and limited assurance indicted that risks identified were managed effectively and there was no compliance with the control framework with fundamental and immediate action required.

   The Chair acknowledged the board may hold different views on the level of assurance and proposed that the concern raised by Quality Assurance Committee be noted and assurance continue to be considered and recommended by board committees, alongside information on proposed actions to address persistent areas of concern.

   P Scott proposed a further report be provided to Quality Assurance Committee on how the Trust intended to make substantial improvements in those areas of concern.

   Action: P Scott

6. J Maddison acknowledged progress made in relation to providing assurance to the board and proposed there was differing levels of assurance throughout the report, and the Trust was not consistently delivering to the level required.

Agreed: *that -*

i. The application of the 85% standard for the bed occupancy measure from 1 April 2024, be approved.

ii. The board notes concerns raised by Quality Assurance Committee and accepts the recommendation of the report, that there is substantial controls assurance on the operation of the performance management framework; good performance assurance on the IPD and reasonable performance assurance on the national and local quality requirements.

24/25/115 REPORT OF THE CHAIR OF PEOPLE, CULTURE AND DIVERSITY COMMITTEE

J Preston, Chair of the Committee, presented the report, which outlined matters arising from the meeting held on 16 September 2024.

Commenting further, S Dexter-Smith advised that positive feedback had been received from the first Trust Welcome Day and noted the Trust would be assessed for the Better Health at Work Award the following week.

In discussion, it was proposed that the level of Freedom to Speak up cases was not high in the context of the size of organisation, and the Trust would welcome that staff felt able to speak up.

24/25/116 WORKFORCE RACE EQUALITY STANDARD (WRES), WORKFORCE DISABILITY EQUALITY STANDARD (WDES), SEXUAL ORIENTATION WORKFORCE EQUALITY STANDARD (SOWES) – SUBMISSIONS AND ASSOCIATED ACTION PLANS

K North presented the report, which provided assurance that the Trust had met the requirements of the NHS Standard Contract by gathering data for the WRES and WDES for publication on the Trust website by 31 October 2024, and had undertaken and would publish a SOWES.

In discussion the following points were raised:

1. B Kilmurray noted that the Humber, North Yorkshire Integrated Care Board (ICB) had also identified no improvement in their WRES data and had discussed the potential for a risk on the Board Assurance Framework in the context of recent community challenges and increased level of international recruitment.

   S Dexter-Smith noted that an objective had been agreed and P Scott would provide support to the Leadership and Management Academy to consider how the Trust would respond.

   The Chair invited executive directors to consider further and provide feedback to a future board meeting. **Action: B Kilmurray/S Dexter-Smith/K North**
2. Assurance was sought on action taken in response to data that indicated BAME staff were more likely to enter the disciplinary process and K North confirmed that there was significant data and analysis on use of the disciplinary process and sanctions applied, in addition to detailed work undertaken by the BAME network.

   The Chair welcomed visibility through the committee and to board, as work progressed.

Agreed: *that -*

i. The board is satisfied there is good assurance that a robust process has been undertaken when developing the data and actions.

ii. The report and data are approved for publication on the Trust website.

24/25/117 APPRAISAL AND REVALIDATION OF DOCTORS – REPORT AND STATEMENT OF COMPLIANCE 2023-24

K Kale presented the report, which provided good assurance on the system in place for appraising and revalidating licensed doctors to ensure they were up-to-date and fit to practise.

Agreed: *that –*

i. The board is satisfied there is good assurance on the system in place to appraise and revalidate licensed doctors.

ii. The Statement of Compliance be signed by the Chief Executive and submitted to NHS England.

24/25/118 REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

B Reilly, Chair of Quality Assurance Committee, presented the report, which outlined matters arising from the committee meetings held on 5 September 2024 and 4 October 2024. She provided assurance that the committee was well sighted on the Trust's position and challenges outlined in the report and confirmed that committee had considered relevant static risks. She went on to draw attention to concerns in relation to bed occupancy, delayed transfers and waiting times.

In discussion the following points were raised:

1. P Scott advised that community transformation – through the urgent care programme - would be key to address bed occupancy levels and patient flow. Support had been provided by the GiRFT team, who had indicated the Trust was not an outlier in its position and some improvement had been noted.
2. The Chair reflected on the importance of the transformation programme to delivery of the Trust's strategy and welcomed a summary for Quality Assurance Committee on each theme, linked to the IPR/BAF Risk, and an overview for the board.

   Action: P Scott

   P Scott noted that work would also be undertaken to understand Trust capability and capacity requirements to deliver the programme.
3. B Reilly advised that representatives from North East and North Cumbria ICB had outlined support provided to acute Trust's to ensure timely discharge and had agreed to consider what they could do to support TEWV.

   D Jessop noted the impact on the quality of care for people in a 136 suite, as the equivalent to corridor care and welcomed the opportunity to work with the ICB where there were concerns about timely discharge.
4. H Crawford proposed that the clinical model would support development of the Trust's workforce plan and quality strategy.
5. Z Campbell commented on the range of interdependencies across the transformation programme, managed by the Urgent Care Transformation Board, and supported the proposal to provide an overview to the board.
6. B Kilmurray advised that transformation activity would be reported to Resources and Planning Committee, and he noted the opportunity to consider a deep dive as part of the board seminar programme.

   Noting the importance of transformation activity, the Chair welcomed the opportunity to consider the regularity of reporting to board via Resources and Planning Committee and B Kilmurray proposed that this be considered by the board task and finish group.

24/25/119 TEESSIDE ADULT LEARNING DISABILITIES RESPITE CARE

N Lonergan presented the report, which provided an update on plans to support families and staff through the transition of the current Teesside respite service into the future model. She alerted the board to unknown risks related to the future model and noted the Trust would continue to engage with families and the ICB, as work progressed.

In discussion the following points were raised:

1. On the financial position, L Romaniak advised that changes were expected to be minimal.
2. Responding to a query, N Lonergan advised that concerns had been expressed by some families and the ICB had offered the opportunity for individual contact. Skills for People and Inclusion North had also been engaged to work with families involved.

24/25/120 REPORT OF THE CHAIR OF MENTAL HEALTH LEGISLATION COMMITTEE

R Barker, Chair of Mental Health Legislation Committee, presented the report, which outlined matters arising from the committee meeting held on 2 September 2024. She noted that committee had taken good assurance from information provided and would consider how data presented to committee could be best used.

Commenting further, K Kale advised that the Trust would investigate data quality issues in relation to use of the app by crisis services to record use of s136. He also drew attention to committee approval of The Scheme of Delegation 2024.

In discussion the following points were raised:

1. K Kale confirmed that changes had been made to how detentions were reported, in response to concerns about data quality and whilst, the Trust did detain more people from a BAME background, this was lower than the level reported nationally.
2. J Preston noted that work had been undertaken to confirm that all detentions were valid and proposed that further consideration would need to be given to wider factors that may impact on increased detention rates for patients from BAME backgrounds.

Agreed: *the board ratifies committee approval of The Scheme of Delegation 2024.*

24/25/121 BOARD ASSURANCE FRAMEWORK

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

In discussion the following points were raised:

1. S Dexter-Smith proposed to reflect in the safe staffing risk that the Trust would review the experience of BAME staff in different ways.
2. It was proposed that the BAF reflect the earlier discussion on the transformation programme and how that would achieve grip and control to influence delivery of outcomes.
3. In the context of the transformation agenda, P Scott proposed that partnership and system working would be revisited in due course.

24/25/122 LEADERSHIP WALKABOUTS

Noted.

24/25/123 REGISTER OF SEALING

Noted.

24/25/124 EXCLUSION OF THE PUBLIC

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

On conclusion of confidential matters, the meeting ended at 5.20pm.

Board of Directors
Public Action Log

RAG Ratings:

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

Changes since the last board meeting are provided in bold

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
11/01/24	23-24/136	Patient outcomes	Timescales to be provided for completion of current work to improve the reporting of patient outcomes.	K Kale	Jul-24		Board seminar held 11 July 2024. **Dec24 update: Outcomes summit held on 6/11/24. An Improvement plan is in place. We are seeking PMO support for this. A number of updates from Cito are required to progress this further. Care group representation on outcomes steering group is now in place and quaterly events are planned for the next year led by care groups for clinicians.**
11/04/24	24-25/11	Corporate Risk Register	Committees to consider corporate risks that had remained static for 12 months and review target dates	Committee Chairs			Oct24 update: Confirmed that Quality Assurance Committee had reviewed static risks and People, Culture and Diversity Committee would do so at its next meeting.
13/06/24	24-25/36	Board Assurance Framework	Risk leads to red/amber/green rate the assurance they had that actions would mitigate the risk	Executive Leads	Oct-24		Discussion on the BAF to be held at Executive Directors Group on 13/08/24
13/06/24	24-25/47	Emergency prepardeness, resilience and response	Board update to be provided on progress against the NHS core standards, following discussion at Audit & Risk Committee in September.	Z Campbell	~~Oct 24~~ Dec-24		Audit & Risk Committee meeting to be held 14 October - feedback to be provided to the Board in December 2024 **Dec24 update: See ARC October Board report**
08/08/24	24-25/83	IPR - 72 hour follow up	Progress update to the next board meeting on progress to achieve the 72 hour follow-up target	N Lonergan, Z Campbell	Oct-24		**Oct24 update, N Lonergan: 72 hour follow up post validation - 13 occasions where follow up was not completed within 72hours. Confirmation received of patient safety received for all patients with the exception of 1 person where contact has yet to be made. Actions to improve data quality are in place and improvements are now being seen.**
08/08/24	24-25/83	IPR - themes	IPR executive summary to include narrative on themes that arose consistently	P Scott			Oct24 update: Report to be prepared for Quality Assurance Committee on how the Trust intended to make substantial improvements in those areas of concern - Action to move to QAC Action Log
08/08/24	24-25/83	Long term plan and Workforce metrics	Summary to be provided at the next meeting on the LT plan and workforce metrics, to provide assurance that where metrics have been static for a period of time, the position was understood and actions proposed would support progress.	S Dexter-Smith/ K North	Oct-24		**Dec24 update: verbal update to be provided at the board meeting following the PCDC meeting on 11Dec24**
10/10/24	24-25/116	Workforce Race Equality Standard (WRES)	Feedback to be provided to the Board on how the Trust will respond to the lack of improvement in WRES data	S Dexter-Smith/ K North	Mar-25		**Dec24 update: EDI discussions to be held at December and February committee meetings and January time out. The March board report will update the board on strategic plans in relation to areas of EDI static progress.**
10/10/24	24-25/118	Transformation Programme	Summary to be provided to Quality Assurance Committee on each theme of the transformation programme, linked to the IPR/BAF Risk and an overview to be provided to the Board.	P Scott			**Dec24 update: TSB reported to Resources and Planning Committee in Dec24.**

Agenda Item 5

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Chair's Report: 10th – 12th December 2024.

Headlines:

External:

- Discussions with our new NEDs Jane and Catherine.
- Meeting University Hospitals Tees Chair & Chief Executive, and Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust Chair & Chief Executives : scope for joint working.
- Meeting North East North Cumbria Integrated Care System Chief Executive & Chairs
- Mental Health Chairs NHS Confederation network weekly calls.
- NHS Providers (NHSP) Board Meeting and monthly check-ins, and NHSP Finance & general Purposes Committee. New Chair for NHSP, will be seeking a new Chief Executive as Julian Hartley goes to CQC. Discussions mostly focussed on new Government's NHS priorities, and NHS finances.
- NHSP Chairs discussion with CQC Chair over CQC and its future.
- NHSP Chairs discussion with Civil Service about proposals for the Government's new 10 Year NHS Plan.
- Discussions with NHS Executive (NHSE), with other North East and Yorkshire Chairs and Chief Executives, around the new proposals for how NHSE will work, how Integrated Care Boards will work (the new operating model).
- NHSP Annual Conference : Secretary of State keynote speech and Amanda Pritchard (NHSE Chief Executive) keynote speech.
- TEWV Annual General Meeting.
- TEWV STAR Awards.
- TEWV Ridgeway Recovery Awards.
- County Durham Care Partnership meeting : opportunity to initiate better links with Durham University Heath & Care School.
- Armistice Day wreath laying in Darlington.

Council of Governors (CoG)

- TEWV Council of Governors meeting.
- Locality meetings: North Yorkshire York & Selby : excellent agenda covering Crisis Line update, and Community Mental Health Transformation.
- 121 with Lead Governor.

Internal

- Carers Working Group
- Peer Support Workers Reconnection & Development Day
- Various 121 meetings with a number of Executive Directors (Finance, People, Therapies, Corporate Affairs), Head of Peer Support, Head of Co-Creation, Research & Development and Innovation.
- Roseberry Park Sub-Group

- Board Seminar (on our Future over the next 5 years, and developing the updated version of Our Journey to Change)
- Flu & COVID jabs.

Key themes for me:

1) Future expectations of the NHS from Government
2) A fundamental change to the operating model that manages performance in the NHS.
3) Real push around efficiency and effectiveness, and a real concern about NHS financial control.
4) That as a Trust, we must own and lead our future, irrespective of uncertainties that may surround us.

Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12 December 2024**
Title:	**Board Assurance Framework – Summary Report**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Report Author:	**Phil Bellas, Company Secretary**

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

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

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

Strategic Risks relating to this report:

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

Executive Summary:

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

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

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

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

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

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

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

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

- Reportable Issues Log (confidential)

Prior Consideration and Feedback	None relating to this report.
Implications:	None relating to this report.
Recommendations:	The Board is asked to take the strategic risks into account during its discussions at the meeting.

BAF Summary

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/ Negative Assurances identified since last ordinary meeting	New, Emerging or Increasing Risks	Material Reports for consideration at the meeting
	1	2	3												
1	✓	✓		**Safe Staffing** **There is a risk** that some teams are unable to safely and consistently staff their services **caused by** factors affecting both number and skill profile of the team. **This could result** in an unacceptable variance in the quality of the care we provide, a negative impact on the wellbeing and morale of staff, and potential regulatory action and a lack of confidence in the standard of care.	**DoP&C**	**PCDC**	**High 20** **(C5 xL4)**	**Moderate 10** **(C5 x L2)** **Q3, 25/26**	**Q1, 25/26** Workforce plans in place for all services (-1L)	**Good**	Knowing which staff we need and where	▪ Daily operational processes in care groups ▪ Monthly e-roster reviews re fill rates etc ▪ Safe staffing reports re shifts over 13 hours, missing RN, missed breaks	**Positive:** Reduction in reliance on agency staffing in HMP teams as recruitment position improves and teams plan to step away from BCP (Board IPR agency) **PCDC – 11/12/24 (Pre-Committee Review)** ▪ Good assurance on the progress of the People Journey Delivery Plan ▪ Good assurance that the Trust has robust processes in place for staff networks for staff from protected groups, allowing them the opportunity to raise concerns and for these to be heard and acted on ▪ Good assurance that the Trust is undertaking Anti – Racist training ▪ Good assurance that the Trust has followed a robust process in completing EDS 2022 and is meeting its obligations in regard to EDS 2022 ▪ Good assurance from the processes in place to hear and respond to concerns in the organisation ▪ Good assurance that the Trust has followed a robust process in developing its apprenticeship provision based on the update		**Public Agenda Item 10 –** *Integrated Performance Report* **Public Agenda Item 12 -** *Our Journey to Change Delivery Plan Quarter 2 2024/25* **Public Agenda Item 14 –** *Report of the Chair of the PCDC (verbal)* **Public Agenda Item 15 -** *Report of the Freedom to Speak Up Guardian* **Public Agenda Item 19 –** *Annual Medical Education Report*
											Ensuring that staff are recruited to and safely deployed to the right places	▪ Rosters for inpatient services ▪ Daily management huddles/ staffing calls ▪ Daily safety huddles on wards			
											Staff are appropriately trained to support people using our services	▪ Daily safety huddles on wards ▪ Increasing number of development JDs in place to ensure people are safely developed into more senior roles ▪ Individual and manager compliance reports available weekly			
											Staff are supported to maintain their wellbeing, feel they belong and choose to stay and work here.	▪ Quarterly reviews and annual appraisals support staff ▪ Supervision – managerial and clinical ▪ OH provision ▪ Multiple H&W interventions including comprehensive support and psychological services – all with outcome measures			
											Ensuring that local leaders and managers are equipped to lead and maintain safe staffing	▪ Recruitment processes inc LE panel members ▪ 3 year leadership programme and quarterly leadership events for service management level and above			
											Early understanding of when things go wrong	▪ Operational escalation processes ▪ Links from services to ePCD increasingly strengthening ▪ Thinking about leaving interviews ▪ 'Working in TEWV' monthly online meetings			

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	1	2	3										covering Quarter 2 of 2024-25 ▪ Good assurance of recent engagement on the issue of how resources are managed to ensure safe care and care that is financially efficient however assurance on impact cannot yet be provided **Negative:** **PCDC – 11/12/24 (Pre-Committee Review)** Reasonable assurance from the work underway on violence prevention and reduction anticipating this will rise to good assurance by Q1 25/26 once the work is completed on the assessment and review processes		
2	✓			**Demand** **There is a risk** that people will experience unacceptable waits to access services in the community and for an inpatient bed **caused by** increasing demand for services, commissioning issues and a lack of flow through services **resulting in** a poor experience and potential avoidable harm.	**Mng Dir**	**QuAC**	**High 16** (C4 xL4)	**Moderate 12** (C4 xL3) Q4 25/26	**Q4 25/26** Implement transformational developments (-1L)	**Good**	Partnership Arrangements Demand Modelling Operational Escalation Arrangements Integrated Performance	▪ Weekly operational interface meetings with Local Authority partners to support flow within inpatient services ▪ Associate Director of Strategic Planning and Programmes – Lead for demand modelling in the Trust ▪ Inpatient wards – Management of admissions through PIPA process and the operational daily escalation calls ▪ Bed Management Team – Responsible for the oversight and management of the use of beds ▪ On-call arrangements – Agreement of actions in response escalation ▪ Freedom to Speak Up Guardian – Point of contact for staff with concerns about quality e.g. the impact of demand ▪ Daily Lean Management Processes – to understand and escalate risks associated with operational delivery are in place across inpatient and community services ▪ Operational delivery of	**Positive:** **QuAC – 5/12/24** Good assurance that the Trust understands where people are waiting and the longest waiting times **Negative:** **IPR:** Bed Occupancy (AMH & MHSOP A & T Wards) (metric 8) - *reduced controls assurance* **QuAC – 5/12/24** Waiting times – ▪ Reasonable assurance for most community services ▪ Limited assurance for neurodevelopmental assessments		**Public Agenda Item 10 –** *Integrated Performance Report* **Public Agenda Item 16 –** *Report of the Chair of the QuAC*

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	1	2	3												
											Reporting ↑	performance standards by wards and teams ▪ Performance Department – Management of the IPR including validation of data, oversight of data quality and reporting to the various tiers of the governance structure	(CYP and adults) with recognition that improving this position is not within the gift of the Trust alone		
											Establishment Reviews	▪ Safe Nursing Workforce Staffing Standards Team – Responsible for managing and delivering the establishment review process. This is based on: ▪ Acuity dependency assessments for each ward using the MHOST tool and professional judgements ▪ General Management reviews, including discussions with Matrons, on the ward assessments ▪ Assessments of a range of data including benchmarking, patient outcomes, staffing information e.g. use of temp staff and overtime ▪ Care Group Boards – Review the outcomes of the establishment reviews and development of proposals (included in the Establishment Review reports to the BoD) ▪ Finance Department – Reviews of affordability of the outcome of establishment reviews *(Reports to the FSB/EDG)*			
											Strengthen voice of Lived Experience	▪ Role of peer workers. ▪ Expanding opportunities of lived experience roles, including lived experience facilitators and senior lived experience roles/peers ▪ Service level service user and carer user groups ▪ Triangle of care ▪ Patient Experience reporting ▪ Understanding our complaints themes and impact on services ▪ Patient Safety Partners - PSIRF ▪ Partnership with clinicals networks – cocreation of clinical care initiatives and models ▪ Commissioning VCS lived in core services to meet identified needs			
3	✓			**Co-creation** **There is a risk** that if we do not fully embed co-creation **caused by** issues related to structure, time, approaches to co-creation and power **resulting in** fragmented approaches to involvement and a missed opportunity to fully achieve	**DoCAI**	**QuAC**	**Moderate 12** (C4xL3)	**Low 4** (C4 x L1) **Q2/Q3 2024/25**	**Q2/Q3 2024/25** ▪ Co-creation Framework: final chapters to completed and rolled out trust-wide (-1L) ▪ Review to provide assurance on	**Good**	Further develop the co-creation infrastructure	▪ Director of Corporate Affairs and Involvement – Responsible for the delivery of the Cocreation priorities set out in Our Journey to Change (OTJC), and associated Delivery Plan ▪ Head of Co-creation ▪ Lived Experience Directors ▪ Involvement & Engagement (I&E) team ▪ Patient Experience team	**Positive:** **IPR:** ▪ Patients surveyed reporting their recent experience as very good or good (metric 1) - *improved controls*		**Public Agenda Item 10 –** *Integrated Performance Report* **Public Agenda Item 12 -** *Our Journey to*

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	1	2	3												
				OJTC					patient experience data (-1L)			▪ Peer Support team ▪ Clinical Leaders ▪ Service Managers	*assurance* ▪ Carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for (metric 2) - *improved performance assurance* ▪ Adults and Older Persons showing measurable improvement following treatment - patient reported (metric 5) - *improved performance and controls assurance* **QuAC – 7/11/24** ▪ Good assurance related to the significant progress made in relation to the co creation agenda **Negative:**		*Change Delivery Plan Quarter 2 2024/25* **Public Agenda Item 16 –** *Report of the Chair of the QuAC*
											Friends and Family / Patient Experience Survey	▪ Director of Corporate Affairs and Involvement – Overall accountability for ensuring that the patient experience data and reporting of such, meets the statutory requirements ▪ Head of Patient Experience ▪ Patient and Carer Experience Team – Responsible for the organisation of patient experience activities including the Patient Experience Survey ▪ Performance Team – Responsible for the delivery of the Integrated Performance Approach including the patient experience metric (based on FFT data)			
											Complaints Policy	▪ Chief Executive – Overall accountability for ensuring that the Complaints Policy meets the statutory requirements ▪ Director of Corporate Affairs and Involvement – Responsible for the development, implementation and monitoring of the complaints policy ▪ Head of Patient Experience - Responsible for facilitating the effective reporting, investigation, and communication of all complaint activity ▪ Complaints Team Manager – Responsible for managing the complaints' function including the central database for complaints and producing statistical data ▪ Trust Organisational Learning Group – triangulation between all sources of intelligence to identify and act on service improvements. ▪ General Managers/Service Managers ▪ Ward/Team Managers/Modern Matrons ▪ Complaints Team			
4	✓	✓	✓	**Quality of Care** **There is a risk** that we will be unable to embed improvements in the quality of care consistently and at the pace required across all services to comply with the fundamental standards of care; **caused** by short staffing, the unrelenting demands on clinical teams and the lead in time for significant estates actions **resulting** in a variance in experience and a risk of harm to people in our care and a breach in the Health and Social Care	**CN**	**QuAC**	**High 16** (C4 x L4)	**Moderate 9** (C3 x L3) **1/4/25**	A number of actions will cumulatively achieve target score: ▪ Achieve safer staffing across all services – to within tolerable levels (1/4/25) ▪ Reduce occupancy on inpatient	**Good**	Friends and Family/Patient Experience Survey	▪ Director of Corporate Affairs and Involvement – Overall accountability for ensuring that the patient experience data and reporting of such, meets the statutory requirements ▪ Head of Patient Experience ▪ Patient and Carer Experience Team – Responsible for the organisation of patient experience activities including the Patient Experience Survey ▪ Performance Team – Responsible for the delivery of the Integrated Performance Approach	**Positive:** **IPR:** ▪ Patients surveyed reporting their recent experience as very good or good (metric 1) - *improved controls assurance* ▪ Carers reporting that they feel they are actively involved in	**QuAC – 7/11/24** Risks relating to section 17 leave require more focus **QuAC – 5/12/24** The risks relating to section 17 and that we are working with	**Public Agenda Item 10 –** *Integrated Performance Report* **Public Agenda Item 12 -** *Our Journey to Change Delivery Plan Quarter 2 2024/25* **Agenda Item 16**

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	1	2	3												
				Act.					wards to 85% (TBC) ▪ Complete inpatient safety estates works (1/4/25) ▪ Transform community services and reduce waits for services (TBC) ▪ Achieve a minimum of 85% compliance across all services with mandatory training, supervision and appraisal (TBC) ▪ Demonstrate robust floor to board quality governance (1/9/25)			including the patient experience metric (based on FFT data)	decisions about the care and treatment of the person they care for (metric 2) - *improved performance assurance* ▪ Adults and Older Persons showing measurable improvement following treatment - patient reported (metric 5) - *improved performance and controls assurance* **QuAC – 5/12/24** ▪ Good assurance that the Trust understands where people are waiting and the longest waiting times ▪ Good assurance on progress being made to ensure sensor doors programme is completed across the inpatient estate **PCDC – 11/12/24 (Pre-Committee Review)** Good assurance of recent engagement on the issue of how resources are managed to ensure safe care and care that is financially efficient however assurance on impact cannot yet be provided **Negative:** **IPR** CYP showing measurable improvement following treatment - patient reported (metric 4) - *reduced controls assurance*	people to plan their leave in a way that keeps them safe needs to be adequately narrated in the BAF	**–** *Report of the Chair of the QuAC*
											Further develop the co-creation infrastructure	▪ Director of Corporate Affairs and Involvement – Responsible for the delivery of the Cocreation priorities set out in Our Journey to Change (OTJC), and associated Delivery Plan ▪ Head of Co-creation ▪ Lived Experience Directors ▪ Involvement & Engagement (I&E) team ▪ Patient Experience team ▪ Peer Support team ▪ Clinical Leaders ▪ Service Managers			
											Our Quality and Safety Strategic Journey	▪ Chief Nurse – Responsible for the development of Our Quality and Safety Journey ▪ Workstreams and key performance indicators have been developed for each of the Journey's four priorities ▪ The professional structure with the care groups have day to day oversight of the quality and safety of care ▪ Integrated Performance Dashboard is utilised to identify variance in care delivery ▪ Learning from serious incidents and near misses			
											Incident management policies and procedures	▪ Chief Nurse ▪ Responsible for ensuring the systems for incident reporting, identification of patient safety issues and reporting appropriate incidents through correct procedures is in place ▪ Clinical and operational Managers medical Staff, modern matrons responsible for the operational implementation of the policy and associated guidelines. ▪ MDT in teams ensure effective after action reviews.			
											Governance arrangements at corporate, directorate and specialty levels	▪ Individual Executive Directors – Responsible for the implementation and delivery of governance arrangements relating to their portfolios including: ▪ ERQ (CN) – Responsibilities include oversight of Serious Untoward Incident/Never Event management processes and receive lessons learnt for sharing across the Trust as appropriate ▪ CGBs (Mgt Dirs) – Responsibilities include Oversight of the day to day management of an effective system of integrated governance,			

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	1	2	3												
												risk management and internal control across the whole Care Group's activities	**QuAC – 5/12/24** ▪ Waiting times – ▪ Reasonable assurance for most community services ▪ Limited assurance neurodevelopmental assessments (CYP and adults) with recognition that improving this position is not within the gift of the Trust alone ▪ Reasonable assurance linked to the progress with delivering the physical health plan – sustained trend of improvement in physical health care now needed		
											Performance Management of Serious Incident Review	▪ Patient Safety Team - ▪ Responsible for ensuring all reportable serious incidents are reviewed within the agreed timescales following an internal governance process ▪ Daily patient safety huddles to review incidents of moderate harm and above to identify areas of immediate action and learning and support timely dissemination of information to mitigate risks ▪ Implementation of PSIRF Jan 24			
											Organisational Learning Group ↑	▪ PSIRF Policy ▪ PSIRF Implementation plan			
5	✓	✓	✓	**Digital – Supporting Change** There is a risk of failure to deliver OJTC goals, organisational and clinical safety improvements, caused by the inability to fully deploy, utilise, and adopt digital and data systems	**CEO (CIO)**	**RPC**	**High 20** (C5xL4)	**Moderate 10** (C5 x L2) **2025/26 Q4**	**30/6/2025** EPR deployment and optimisation programme control moves to substantial assurance (-1L)	**Good**	Embedded Digital Strategy and Delivery Plan	▪ Digital Management Meeting ▪ Digital Programme Board (DPB) ▪ Digital Programme Assurance Group (DPAG)	**Positive:** **Negative:** **RPC** Three sites that have Wi-Fi difficulties have been externally assessed and significant installation problems have been identified		**Confidential Agenda Item 31–** *Report of the Chair of the RPC* **Confidential Agenda Item 33 –** *CiTO Update*
											EPR deployment and optimisation programme:	▪ Executive Strategy & Resources Group (ESRG) ▪ Cito Improvement Group (CIG) ▪ Clinical Advisory Group (CAG) ▪ Transformation & Strategy Board			
											Integrated Information Centre optimisation programme:	▪ Digital Programme Board (DPB) ▪ Digital Programme Assurance Group (DPAG)			
6	✓	✓	✓	**Estate / Physical Infrastructure** **There is a risk** of delayed or reduced essential investment **caused by** constrained capital resources **resulting in** an	**DoFE**	**RPC**	**Medium 12** (C4 x L3)	**Low 6** (C3 x L2) **2028/29**	**2028/29** Estates Master Plan delivery achieves proposed rationalisation of estate to reduce	**Good**	NENC Infrastructure board	▪ Executive Director of Finance and Estates/Facilities and Director of Estates, Facilities & Capital (or their deputies) represent the Trust at NENC meetings	**Positive:** **RPC – 27/11/24** Good assurance on the significant Green Plan		**Public Agenda Item 12 -** *Our Journey to Change Delivery Plan Quarter 2 2024/25*

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	1	2	3	inability to adequately maintain, enhance or transform our inpatient and community estate, adversely impacting patient and colleague outcomes/experience.					call for capital and revenue funding on non-core assets (-1C & -1L) *(Note: Two other actions have been identified which may reduce or increase likelihood score but this will not be clear until the outcomes are known:* ▪ *NENC ICB CDEL funding methodology – March 2025* ▪ *Confirmation of national capital allocations - 2025/26 to 2027/28)*		Estates Master Plan	▪ EFM Directorate – Responsible for the preparation / delivery of the EMP in conjunction with the Care Groups based on an established prioritisation framework ▪ Finance Department – Responsible for the preparation of the annual capital and revenue financial plans for Board approval	progress since appointment of the Energy and Sustainability Manager in June 2024 and to catch up on Business Plan milestones **QuAC – 5/12/24** ▪ Good assurance on progress being made to ensure sensor doors programme is completed across the inpatient estate. ▪ Good assurance related to the process for the annual environmental risk assessment survey, which takes place at least once a year **Negative:** NENC ICB providers collectively forecasting risk of managing to within 2024/25 CDEL limit for capital expenditure. If realised would require repayment in subsequent financial period.		**Confidential Agenda Item 31–** *Report of the Chair of the RPC*
											CIG & CPSG	▪ Estates, Facilities, Capital and Finance teams work closely to ensure engagement across the Trust to collate capital investment priorities, risk / impact assess these and support agreement of final annual capital plan and medium term capital requirements			
											Estates, Facilities & Capital Directorate Management Team Meeting	▪ All of the directorate's functions provide monthly assurance reports to this meeting which is chaired by the Director of Estates, Facilities and Capital			
											ERIC, PLACE and PAM national annual reporting / benchmarks submission and monitoring	▪ EFM Directorate responsible for: ▪ **PLACE** ▪ Organising (with CA&I) the PLACE assessment visits ▪ Compiling the information ▪ Submission of the information to NHSE ▪ Preparation of the Action Plan ▪ **ERIC** Compiling and submitting ERIC submission to NHSE ▪ **PAM** Self-assessment against the questions included in the PAM and on the delivery of resultant action plans, processes in train to ensure timely submission			
											Green Plan submission and monitoring	▪ EFM Directorate responsible for compiling and submitting Green Plan submission to NHSE / ensuring progress to deliver milestones			
											Environmental Risk Group	▪ Director of Estates, Facilities and Capital ensures aligned CPSG and ERG agendas, including close collaboration with Chief Nurse / MD DTVF joint chairs ▪ Directors of Operations / Operational teams support identification of environmental issues ▪ Service desk tracks levels of maintenance issues			

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	1	2	3												
7	✓	✓	✓	**Data Security and Protection** There is a risk of data breach or loss of access to systems, caused by successful cyber-attack, inadequate data management, specialist resource gaps, and low levels of digital literacy resulting in compromised patient safety, impacts on business continuity, systems and information integrity, reputational damage and loss of confidence in the organisation.	**CEO (CIO)**	**RPC**	**High 20** (C5 x L4)	**Moderate 10** (C5xL2) **2025/26 Q3**	**30/6/2025** Internal Audit assurance on 2024/25 DSPT with submission of Meets Standards; and control moves to substantial assurance (-1 L)	**Good**	Digital, Data & Technology (DDAT) Skills and Knowledge	▪ Digital and Data Management Meeting (DDMM) ▪ Digital Programme Assurance Group (DPAG) ▪ Digital Programme Board (DPB)	**Positive:** **RPC** ▪ As at the end of Oct 2024, Digital and Data had no overdue audit actions remaining ▪ Trust each month ranked in the top 5% (of all NHS organisations) on the NHS England Microsoft security metrics & top in Yorkshire on the majority of cyber metrics monitored by the IT Health dashboard ▪ 2023/24 DSPT was completed and submitted with a 'Standards Met' assurance level **Negative:**		**Confidential Agenda Item 31–** *Report of the Chair of the RPC*
											Secure IT infrastructure and asset management.	▪ DPAG			
											Cyber Security and Incident Management	▪ DPAG			
											Data Security and Protection Toolkit (DSPT) and Information Risk Management fully operational	▪ DPAG			
											Robust Clinical Safety and Change Control	▪ DPAG ▪ DPB ▪ Digital Change Assurance Board			
											Digital service delivery monitoring	▪ Digital Programme Assurance Group (DPAG)			
8	✓	✓	✓	**Quality Governance** **There is a risk** that our floor to Board quality governance does not provide thorough insights into quality risks **caused by** the need to further develop and embed our governance and reporting including triangulating a range of quality and performance information **resulting in** inconsistent understanding of key risks and mitigating actions, leading to variance in standards.	**CN**	**QuAC**	**Moderate12** (C4 x L3)	**Moderate 9** (C3 x L3) **01/01/25**	A number of actions will cumulatively achieve target score: ▪ Implement the Quality Dashboard ▪ Embed the Executive Review of Quality and supporting forums as an enabler to identifying and managing risks to quality of care ▪ Develop the role of the Associate Director of Nursing and Quality to increase curiosity into the Fundamental Standards of Care ▪ Review and relaunch the Quality and Safety priorities within Our	**Good**	Open and transparent culture working to organisational values steered by Our Journey to Change ↑	▪ Cohesive Board ▪ Engaged and visible Executive ▪ High Quality Care Group Directors ▪ Substantive recruitment of service leadership and clinical teams	**Positive:** **QuAC – 7/11/24** ▪ Good assurance related to the progress with the quality priority measures for 2024/25 ▪ Good assurance on progress with the Quality Impact Assessment Programme ▪ Good assurance related to progress being made by medical devices services to have a robust understanding of the risks related to medical devices. ▪ Good assurance linked to the management of infections and prevention and that policies and	**QuAC – 7/11/24** Risks relating to section 17 leave require more focus **QuAC – 5/12/24** The risks relating to section 17 and that we are working with people to plan their leave in a way that keeps them safe needs to be adequately narrated in the BAF	**Public Agenda Item 10 –** *Integrated Performance Report* **Agenda Item 16 –** *Report of the Chair of the QuAC* **Agenda Item 16 –** *Learning from Deaths Report*
											Executive and Operational Organisational Leadership and Governance Structure	▪ Chief Executive – Responsible for the Operational Leadership and Governance Structure ▪ Executive Directors – Responsible for the delivery of key elements of the Leadership and Governance Structure within their portfolios ▪ Co Sec – Responsible for the provision of secretariat services within the governance structure ▪ Care group clinical leaders responsible for the oversight of care delivery			
											Quality Management System	▪ The QI team is well established and embedded into services. ▪ There is an operational, clinical and professional leadership structure. ▪ There are Improvement plans for incidents, complaints and inspections. ▪ The IPD tracks performance monthly. ▪ The Care Group Board oversees delivery of services.			

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	1	2	3						Journey to Change ▪ TEWV Leadership Academy will help all leaders enact their role to safeguard and improve quality		Oversight / Insight / Foresight ↑	▪ Performance team are responsible for measuring and reporting performance ▪ Chief Nurse leads the nursing and quality directorate who have responsibility to measure and report out on - patient safety - quality governance -audit - infection, prevention and control - safeguarding - risk -Use of Force ▪ Chief Nurse lead the executive review of quality reporting to QuAC ▪ Medical Director leads on a number of patient safety priorities including Mortality review and Sexual Safety ▪ Care groups have dedicated clinical leaders at director delivery levels with a role to assess delivery of care standards	procedures are aligned to national recommendations **QuAC – 5/12/24** ▪ Good level of assurance that the IPD is underpinned by the Performance and Controls Assurance Framework ▪ Good assurance related to the process for the annual environmental risk assessment survey, which takes place at least once a year ▪ Good assurance provided on the quarterly tracked progress with safeguarding priorities ▪ Good assurance from the final report from NICHE that care is in line with standards and that there is good quality governance in place **Negative:** **QuAC – 7/11/24** Limited assurance with compliance for ILS training **QuAC – 5/12/24** ▪ Reasonable assurance linked to the operational and strategic oversight of the key quality and safety areas of patient care described in the Trust Quality and Learning report ▪ Limited assurance about the rates of supervision and		

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	1	2	3										recording on TEWVision, there is a drive to improve this ▪ Although the position with planning section 17 leave has improved, audits currently do not provide assurance of consistent application of the practice standards that is required. Both care groups whilst confident that the improvement work will lead to improved practice, they will put in place daily oversight until this improvement is evident. The Committee did not have assurance and focused on the potential impact on safety		
9			✓	**Partnerships and System Working** **There is a risk that** failure to take a proactive role and engage effectively with partners **caused by** capacity challenges including spanning 2 ICSs and multiple local authorities **limits** our ability to influence service transformation and improve the health of the communities we serve.	DCEO	RPC	**Medium 12** (C4 x L3)	**Low 6** (C3 x L2) **Q3 – 31st Sept 2024**	-	**Good**	Place-based commissioning and partnership leads working for TEWV	▪ Engagement in a wide range of partnership functions and committees/ groups across each place, in line with individual place governance structures ▪ Joint work / operational processes with local authorities and other partners including PCNs ▪ Development of alliances and partnerships with other organisations, including the voluntary sector, to deliver services into the future	**Positive:** **Negative:**		**Confidential Agenda Item 26 –** *Chief Executive's Confidential Report* **Confidential Agenda Item 31–** *Report of the Chair of the RPC*
											Supporting North East and North Cumbria Mental Health and Learning Disabilities Specialised Services Partnership	▪ Operational service leads from DTVF Care Group are members of the different groups in the Partnership			
											Supporting Humber North Yorkshire Provider Collaboratives	▪ Attendance at specialist provider collaborative governance groups			
											Placing AD Strategy into NENC ICB MHLDA Transformation Team	▪ AD Strategic Planning and Programs placed into NENC ICB MHLDA Transformation Team for one day per week. Asked to lead on Inpatient Quality			

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	1	2	3									Transformation (including bed census)			
											Attending HNY ICB Operations Group	▪ AD Strategic Planning and Programs and Finance Business Partner attend			
10			✓	**Regulatory compliance** **There is a risk** that failure to comply with our regulatory duties and obligations, at all times, could **result** in enforcement action and financial penalties and damage our reputation	**CEO**	**Board**	**Moderate 12** (C4 x L3)	**Moderate 8** (C4 x L2) **31/03/25**	**31/3/25** Delivery of CQC Improvement Plan (-1L)	**Good**	Statutory Reporting	▪ Reporting requirements and timetables developed by the Company Secretary ▪ Information provided by designated leads ▪ Reports produced by Corporate Affairs and Communications based on submissions received. ▪ Annual Accounts timetable drafted by Head of Accounting and Governance ▪ Annual Accounts (and related TAC submissions) undertaken by the Finance Staff ▪ Head of Financial Accounting and Governance considers and coordinates annual training needs for annual accounts team ▪ Accounting ledger and accounts payable entries reviewed including to ensure accurate coding to support reporting as well as VAT recovery	**Positive:** **ARC – 14/10/24** ▪ The External Auditors concluded in their Auditors' Annual Report that there was good assurance that sound systems of internal control, governance and risk management were being applied consistently ▪ Good assurance relating to the adequacy of the processes underlying and supporting the BAF ▪ Good assurance relating to the systems and processes for oversight and monitoring of the CQC Improvement plan **QuAC – 7/11/24** ▪ Good assurance that the systems and processes for oversight and monitoring of the CQC Improvement Plan are robust ▪ Good assurance with the reporting and learning from deaths **QuAC – 5/12/24** ▪ Good assurance provided on the quarterly tracked progress with safeguarding priorities ▪ Good assurance	Draft annual accounts timetable references earlier requirement for receipt of draft annual and remuneration reports for external audit (option to vary with local agreement) – reduces timeline for production of high quality output	**Agenda Item 16 –** *Report of the Chair of the QuAC* **Confidential Agenda Item 26 –** *Chief Executive's Confidential Report* **Confidential Agenda Item 29 –** *Report of the Chair of the ARC* **Confidential Agenda Item 30 –** *Risk Management Strategy and Policy* **Confidential Agenda Item 34 –** *CQC Report*
											Provider Licence	▪ Board certification processes undertaken by the Company Secretary ▪ Delivery of related by policies by operational and corporate departments ▪ Commissioning of external governance reviews, preparation of evidence for and support by the ACE and Co Sec ▪ Delivery of improvement plans by designated leads			
											Environmental Sustainability	▪ The Estates, Facilities and Capital Team are maintaining day to day BAU ▪ Estates & Facilities DMT maintain routine operational oversight			
											Statutory Financial Duties	▪ Processes overseen by the Head of Financial Management including annual budget holder sign off of budgets / establishments following agreement of annual budget setting processes ▪ Annual budget prepared by DoFEF ▪ Monthly financial reports and refreshed forecast outturn positions prepared by Finance Department to support agreement with Care Groups / Directorates and returns for submission to NHSE ▪ Budget holder management of individual budgets ▪ Accountability Framework			

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/ Negative Assurances identified since last ordinary meeting	New, Emerging or Increasing Risks	Material Reports for consideration at the meeting
	1	2	3									sets out responsibilities for financial management	from the final report from NICHE that care is in line with standards and that there is good quality governance in place **PCDC – 11/12/24 (Pre-Committee Review)** ▪ Good assurance that the Trust has followed a robust process in completing EDS 2022 and is meeting its obligations with regard to EDS 2022 ▪ Good assurance that the strategic risk assigned to the Committee continues to be managed effectively **RPC – 27/11/24** Good assurance that the Committee's strategic risks were being managed effectively **Negative:** **IPR** Uses of the Mental Health Act (metric 15) - *reduced performance assurance* **ARC – 14/10/24** ▪ Reasonable assurance that risks were being overseen by the Executive Risk Group ▪ Reasonable assurance related to the development and embeddedness of the Risk Management Framework ▪ Reasonable		
											Compliance with the CQCs Fundamental Standards of Quality and Safety	▪ Day to day delivery of the fundamental standards by ward and team staff ▪ Responsibility for delivery of each element of the CQC Action Plan designated to lead Directors ▪ Chief Nurse is the lead Executive for relationship management with the CQC			
											Compliance with Mental Health Legislation (MHL)	▪ Delivery of the requirements of MHL by ward and team staff			
											Equality, Diversity, Inclusion and Human Rights	▪ The Director of People and Culture has operational responsibility for Equality, Diversity, Inclusion and Human Rights throughout the Trust in both Employment and Service Delivery ▪ EDIHR Lead and officers: ▪ Provision of support for inclusion networks ▪ Compilation of Equality Act 2010 data ▪ Compilation of evidence and consultation on the EDS ▪ Support for the development of the Trust's equality objectives ▪ Designated managers/leads: ▪ Completion of equality analyses ▪ Delivery of actions under the EDS ▪ All staff are responsible for co-operating with measures introduced by management to ensure equality of opportunity and non-discriminatory practices, including making sure that people have equality of access to service provision ▪ Public Health Consultant engaged to develop the Trust's approach to tackling health inequalities			
											Risk Management Arrangements	▪ Care Group Managing Directors, General Management Tier and Service Management Tier – ▪ Consider capture and maintain risks raised by staff in local risk registers ▪ Develop and implement action plans to ensure risks identified are appropriately treated ▪ Ensure that appropriate and effective risk management processes are in place and that all staff are made aware of the			

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	1	2	3									risks within their work environment ▪ Other Executive Directors - Responsible for ensuring effective systems for risk management, are in place within their directorate ▪ Head of Risk Management – Day to day management of the Trust Risk Register	assurance relating to the progress with the CQC Improvement Plan **QuAC – 7/11/24** Reasonable assurance linked to progress against the CQC Improvement plan **RPC – 27/11/24** ▪ Reasonable assurance relating to the developing approach, direction of travel and governance in place through the Transformation and Sustainability Board and oversight of the portfolio for major change and transformation initiatives ▪ Reasonable assurance relating to the management of risks in the CRR **PCDC – 11/12/24 (Pre-Committee Review)** Reasonable assurance over the risk management processes in place		
											Health Safety and Security (HSS)	▪ The Trust has a Health, Safety and Security Team who manage the day-to-day Health and Safety requirements in line with all relevant parliamentary acts ▪ Reporting system is in place for the reporting of incidents which fall under the requirements of Reporting of Incidents of Disease and Dangerous Occurrences regulation (RIDDOR) ▪ Provision of HSS information for new employees at Trust induction. ▪ HSS awareness training forming part of all staff mandatory package. ▪ HSS online tool kit available for all services, wards and departments across the trust. ▪ Regular workplace audits undertaken by the HSS team. ▪ Incidents recorded on 'InPhase' are shared with relevant service leads, including HSS. This enables investigation of incidents to identify trends and flag any remedial actions			
											Executive and Care Group Leadership, management and governance arrangements	▪ Individual Executive Directors – Responsible for the implementation and delivery of governance arrangements relating to their portfolio ▪ Individual staff compliance with the range of policies relating to regulatory compliance e.g. health and safety			
											Inquests and Coroners	▪ Inquest Team - Management of the Inquest process from a Trust perspective including: ▪ Arranging and compiling witness statements and submission to Coroner ▪ Instruction of Solicitors ▪ Co-ordination and compilation of information ▪ Provision of support for staff ▪ Preparation of responses to Regulation 28 Reports by staff nominated by the CEO			

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/ Negative Assurances identified since last ordinary meeting	New, Emerging or Increasing Risks	Material Reports for consideration at the meeting
	1	2	3												
11	✓	✓	✓	**Roseberry Park** **There is a risk that** the necessary Programme of rectification works at Roseberry Park and impacted by limited access to capital funding **could adversely affect** our service quality, safety, financial, and regulatory standing.	**DoFE**	**Board**	**High 16 (C4xL4)**	**Moderate (12) (-1L)**	Two actions have been identified to support achievement of the risk score; however, delivery dates are uncertain: ▪ Roseberry Park Rectification Works complete ▪ Medium Term NHS and ICB Capital allocations confirmed nationally	**Good**	Roseberry Park Rectification Programme	▪ Programme Director and Programme Manager – Responsible for managing the RPRP including key risks and issues log (Assurance to weekly huddle)	**Positive:** RPH: Commercial interest from contractors in phase two procurement RPH: Trust attending mediation event in London re related legal claim blocks 1-14 **Negative:** RPH: Slippage into early 2025/26 to ensure right procurement process and contractor engagement / due diligence		**Confidential Agenda Item 26 –** *Chief Executive's Confidential Report*
											Capital Programme	▪ Trust CPSG overseeing agreement of priorities for capital investment / impact assessment ▪ DMT overseeing detailed milestone capital project planning ▪ NENC Infrastructure Board (ICS Estates & Finance Directors)			
											External Audit				
12	✓	✓	✓	**Financial Sustainability** **There is a risk that** constraints in real terms funding growth **caused by** government budget constraints and underlying financial pressures **could adversely impact** on the sustainability of our services and/or our service quality/safety and financial, and regulatory standing	**DoFE**	**RPC**	**High 20** (C5 x L4)	**High 20** (C5 x L4) **2028/29**	**2028/29** A number of actions have been identified which might cumulatively reduce the risk score; however, the target score is being maintained at the present level given national and regional uncertainty	**Good**	ICB Financial Governance including Mental Health LDA Sub Committee and CEO and DoF financial planning groups and sub groups	▪ DoFE member of ICS DoF/CFO group ▪ DoFE member of ICS Resource Allocation Steering Group ▪ CEO member of NENC CEO provider collaborative group ▪ CEO leading HNY provider collaborative work for MHLDA ▪ COOs leading Provider collaborative work to assess implications for beds / pathways and clinical models	**Positive:** In year performance at Month 7 remains ahead of plan. Non recurrent funding offsetting run-rate deterioration on pay award. FSB received first I&E report via Costing Transformation Plan – on track for March I&E validation deadline **RPC – 27/11/24** The Finance and Payroll internal audit received good assurance **Negative:** Refresh of underlying position suggests deterioration in underlying budgeted position (inc due to recurrent unfunded additional pay award cost c £2.7m). **IPR** ▪ Financial Plan:	Unfunded recurrent pay award £2.7m budget pressure	**Public Agenda Item 10 –** *Integrated Performance Report* **Confidential Agenda Item 31–** *Report of the Chair of the RPC* **Confidential Agenda Item 31–** *Finance Report*
											Financial Sustainability Board	▪ Financial reporting using intelligence from Care Groups, Directorates and costing transformation programme to inform management of underlying financial position			
											Business Planning and Budget Setting Framework and in Year Financial Forecasting & Recovery Arrangements	▪ ACE -Responsible for the delivery of the Business Planning Framework ▪ DoFE and ESRG – Responsible for arrangements to develop the Financial Plan including tracking the recurrent and non-recurrent implications and underlying financial position and cost drivers ▪ Managing Directors (for Care Groups) and other Execs (for their Directorates) responsible for management of costs with budgets and/or agreed forecasts and informing assumptions to underpin financial planning using business planning processes. *(Reporting into FSB and ESRG into EDG with assurances into S&RC and Board)*			

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	1	2	3										Agency expenditure compared to agency target (metric 24a) - *reduced controls assurance* ▪ Capital Expenditure (Capital Allocation) (metric 29) - *reduced performance and controls assurance*		
13	✓	✓	✓	**Public confidence** **There is a risk that** ongoing external scrutiny and adverse publicity **could lead to** low public and stakeholder perception and confidence in the services we provide	**DoCAI**	**Board**	**High 20** (C5 x L4)	**Moderate 10** (C5 x L2) **June 24**	**Q1 2024/25** (-2L) Refreshed trust-wide communications strategy	Reasonable	Communications Strategy	▪ Director of Corporate Affairs and Involvement ▪ Head of Communications ▪ Communications team	**Positive:** **Negative:**		**Confidential Agenda Item 35 –** *Communications Strategy*
											Stakeholder Communications and Engagement Strategy	▪ Trust Board ▪ Director of Corporate Affairs and Involvement ▪ Care Group Board Directors ▪ Head of communications ▪ Corporate Affairs and Stakeholder Engagement Lead ▪ Communications team			
											Social Media Policy	▪ Director of Corporate Affairs and Involvement – responsible for the development, implementation and monitoring of the social media policy ▪ Head of communications ▪ Comms team – responsible for ongoing monitoring of social media ▪ General Managers/Service Managers – ▪ Ward/Team Managers/Modern Matrons – as above ▪ Complaints team ▪ Patient experience team ▪ Clinical leaders ▪ Service managers ▪ People and Culture			

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Agenda Item 9

Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12 December 2024**
Title:	**Chief Executive's Public Report**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Author(s):	**Brent Kilmurray**

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

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

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

Strategic Risks relating to this report:

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

Executive Summary:

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

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

Overview: A Range of topics to update the board

Prior Consideration and Feedback n/a

Implications: No additional implications.

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

NHS England Operating Model

On 13th November NHSE set out a in a letter to Trust and partners how the national and ICB operating model is evolving. We had previously fed into an engagement exercise on oversight and there has been a good deal of work underway nationally on a new operating framework. Both Amanda Pritchard, CEO of NHSE and the Secretary of State made announcement about this at the NHS Providers conference in Liverpool in November.

The changes are consistent with the frequently repeated message about no further large-scale top-down reorganisations.

There are four aspects to the changes:

- Simplify and reduce duplication, clarifying roles and responsibilities and being clear on the place of performance management.
- Shift resources, time and energy to neighbourhood health, creating momentum that makes clear the role of the provider sector in neighbourhood health and how to work with local partners.
- Devolve decision-making to those best placed to make changes, clarifying the role of integrated care partnerships (ICPs) and health and wellbeing boards.
- Enable leaders to manage complexity at a local level, supporting leaders with new strategic commissioning frameworks to include national best practice.

The letter references encouraging self-managing and self-improving systems and that Integrated Care Boards will still have a critical strategic commissioning role in delivering the mission shifts, providing system leadership, convening the system. Top performing systems will be given more powers and involvement in national policy making. The new framework that follows this statement will also make clear how those systems that are less well performing will be supported and experience intervention. This will be captured through an updated NHS Oversight and Assessment Framework and underpin this with a new NHS Performance, Improvement and Regulation Framework.

ICBs will still also ensure the sustainability of primary care, rebuilding the provision of dentistry and community pharmacy, alongside developing strong GP practices and the wider primary care family that are attractive to newly qualifying GPs.

ICBs will receive a new Strategic Commissioning Framework. They will have the primary responsibility for ensuring the delivery of neighbourhood health, identifying population health needs and acting on reversible risk factors to improve healthy life expectancy and reduce utilisation of secondary care. This vital work must continue at pace for us to deliver a neighbourhood health model.

All providers in a health system must still work together to deliver transformation, integration and improvement because these changes do not signal a move away from collaboration and system working and we will also ensure that the duty to collaborate mechanisms are tested in how we work with organisations.

Importantly, ICBs will continue to have oversight of how providers deliver the outcomes that they have been commissioned for. But where performance is below an acceptable level, and the use of commissioning levers has not secured improvement, NHS England will step in

with both the ICB and provider to support rapid improvement and using our regulatory powers in a defined set of circumstances.

The new framework will set out interventions for all types of NHS organisations with quality, financial or performance problems. This will include aligning regulatory approaches, mandatory recovery plans and board accountability requirements.

These changes should allow us to streamline how different parts of the health system work together to support our collective focus on improving the delivery and recovery of urgent and emergency care and elective performance, at the same time as the medium- and long-term changes required to meet the needs of our communities, shifting care to where it is delivered best in a joined-up and integrated way.

On board accountability and improvement, NHSE has published the Insightful Board guides, which we will circulate. These guides provide clarity around the critical information boards need to understand their organisations, and the culture and governance necessary to support information flow, so it can be used most effectively when overseeing their organisations.

Regulation of Managers

The Government has launched a consultation on the regulation of NHS managers.
The proposal is put forward to take further action to strengthen the accountability of NHS managers, with the overarching aim of ensuring patient safety. The government's manifesto committed to introducing professional standards for and regulating NHS managers.
The consultation will seek partners' views on the type of regulation that may be most appropriate for leaders and managers, such as:

- which managers should be in scope for a future regulatory system.
- what kind of body should exercise such a regulatory function.
- consideration of the types of standards that managers should be required to demonstrate as part of a future system of regulation.

The consultation will also seek views on matters relating to candour, including first on the possibility of delivering a professional duty of candour for NHS managers and leaders. It will also seek views on making managers accountable for responding to concerns about the provision of healthcare patient safety.
Our Leadership and Management Academy Board will consider our response and we will share a draft with the Board before the February 2025 deadline.

NHS England Oversight Framework Segmentation

The Trust has made significant progress in working through the requirements set by the NHS regional team as part of their quality oversight. As Board members are aware, we have been held in segment 3 of their framework (scale 1-4 with 1 being considered the best category).
Having delivered on our requirements the regional team will work with Trust to make an assessment during quarter 4 and the results will feed into the next segment review in 2025/26.

Star Awards

On 23rd October 160 colleagues, volunteers, partners and sponsors joined us for an evening of celebration in Middlesbrough. We received over 500 nominations across the nine main categories. The evening ended with the Chairman's Award, which went this year to Laura Wilkinson from Perinatal services.
It was a great evening, celebrating the best of what we do. I would like to thank everyone who nominated their colleagues, the judges, our sponsors and those who organised a great evening.

Humber North Yorkshire Mental Health, Learning Disability and Autism Collaborative

Work continues on the development of a business case for the Contractual Joint Venture, which will see the collaborative take on full responsibility for the commissioning budgets for MHLDA across the Humber North Yorkshire system.
Financial due diligence is currently underway, governance models are being considered and work on the strategy and priorities is progressing well, including proposals on the development of a core model/offer based on standards and outcomes for each place.
A further, more detailed report will be brought in the New Year to consider the timelines, governance arrangements, scope and risk issues.

Communications Dashboard

October - November 2024

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

These months we...

- Launched our new CAMHS web section
- Celebrated our #TEWVStars at our annual Star Awards
- Showed racism the red card by wearing red in support
- Came together for the 2024 Nursing Conference
- Celebrated Black History Month with the signing of our anti-racism charter
- Celebrated achievements of our patients at the Ridgeway Recovery awards
- Continued to promote our NHS Staff Survey and our flu vaccination campaign

Highlights

We celebrated our #TEWVStars at our annual Star Awards

Our Annual General Meeting was held at the Darlington Arena

Jenny's Pasta, a project to improve access to healthy and affordable food, won a Bright Ideas in Health Award

Our Ridgeway Recovery Awards celebrated the achievements of adult mental health patients.

Our leadership team proudly signed UNISON's Anti-Racism Charter and wore red to support Show Racism the Red Card

Older people on our inpatient unit at Lanchester Road welcomed a selection of reptiles for an animal therapy session

Media and online

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

14
Media enquiries handled by the team

7
Media releases issued

45
Total pieces of coverage across online news, TV, and radio

News stories

- **83-year-old Pat with 'strong desire' to help others recognised for 18 years of service –** *Teesside Live*
- **Funding boost for local mental health research –** *BBC Online*
- **Unique project helps young people express their feelings through art –** *Scarborough News*
- **Investigation into postnatal depression suicide on Wear Valleys NHS Trust –** *BBC York*
- **Northeast NHS Trust ranked top in region for doctor training –** *Northeast Online*
- **Local NHS Trust supporting young people into employment –** *Scarborough News*
- **High tech virtual tours offered to anxious patients in pioneering project –** *The Yorkshire Post Online*

Our website

112,909
page views

Top three visited pages

1. Careers
2. Services
3. Locations

Staff intranet

220,995
page views

Top staff intranet news stories

1. Staff flu vaccinations launch
2. Stoptober
3. Recruitment of 16-17 year olds
4. Austistic clinicians become bestsellers
5. Kelly Conway wins a BBC Tees award
6. NHS staff survey launch

Social Media

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

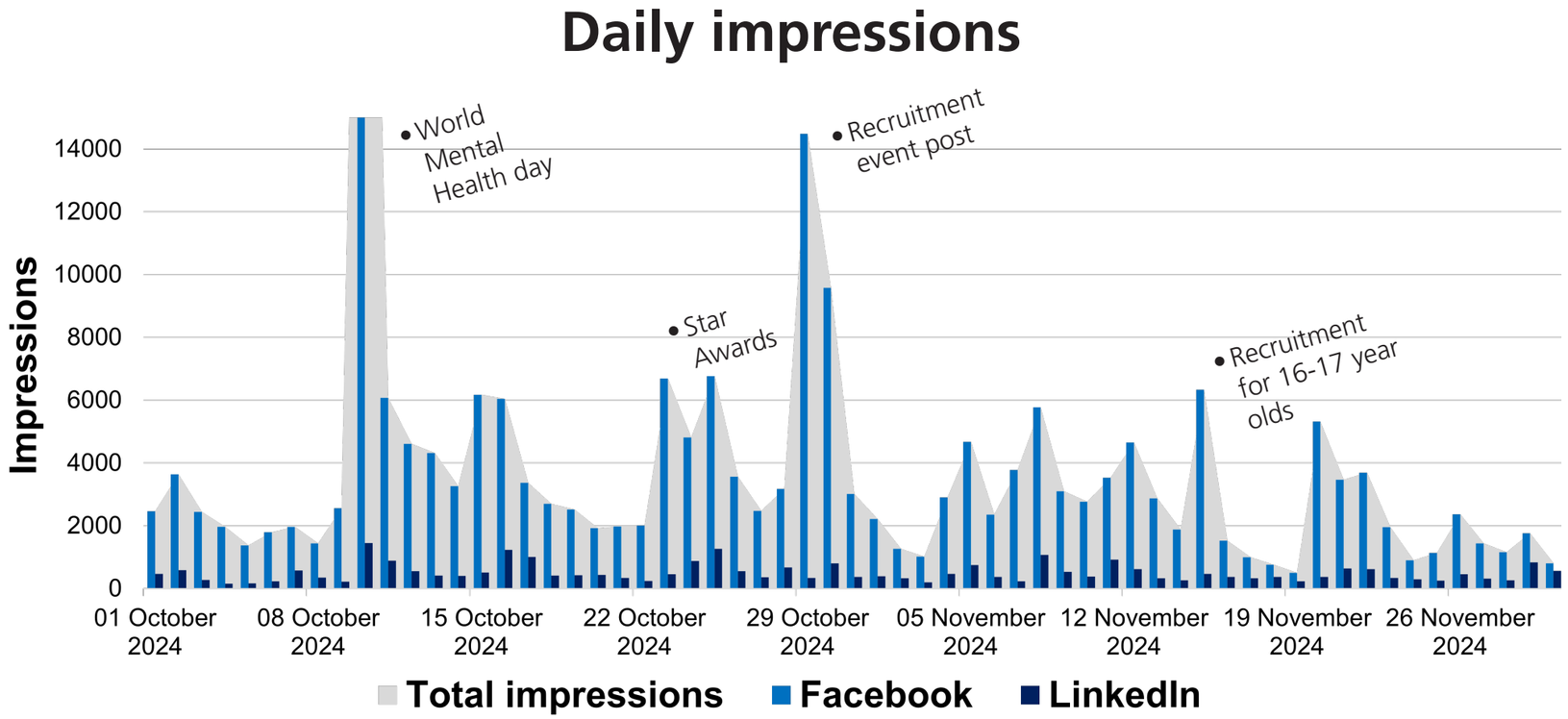
Our audience

27,594
Total followers

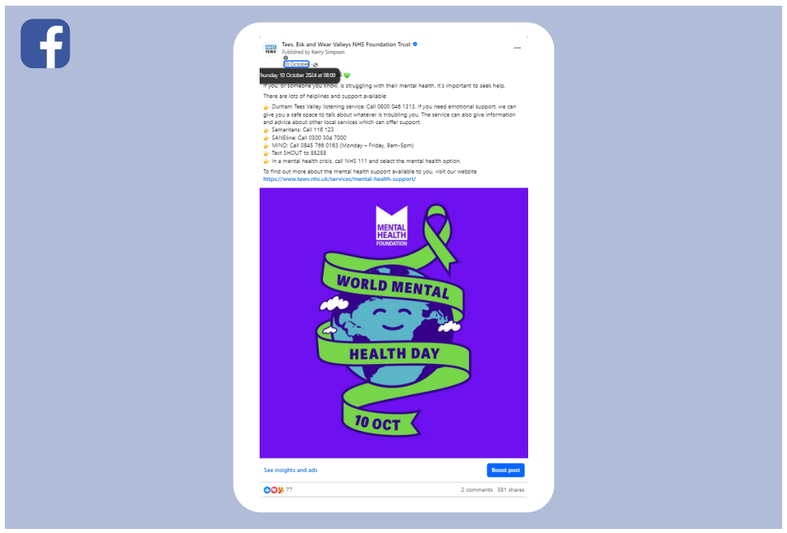
280
New followers

293,299
People who saw our content - impressions

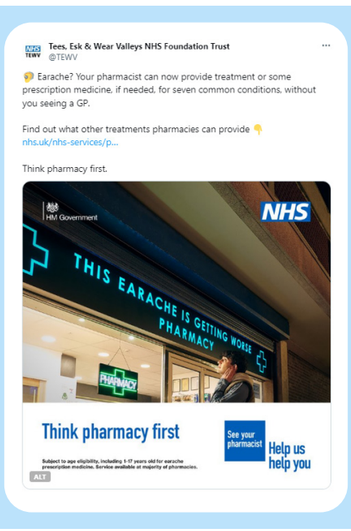
96
Total posts



Top posts



Impressions 60,335 - Engagement 2,884



Impressions 88 - Engagement 3

Impressions 2,484 - Engagement 113

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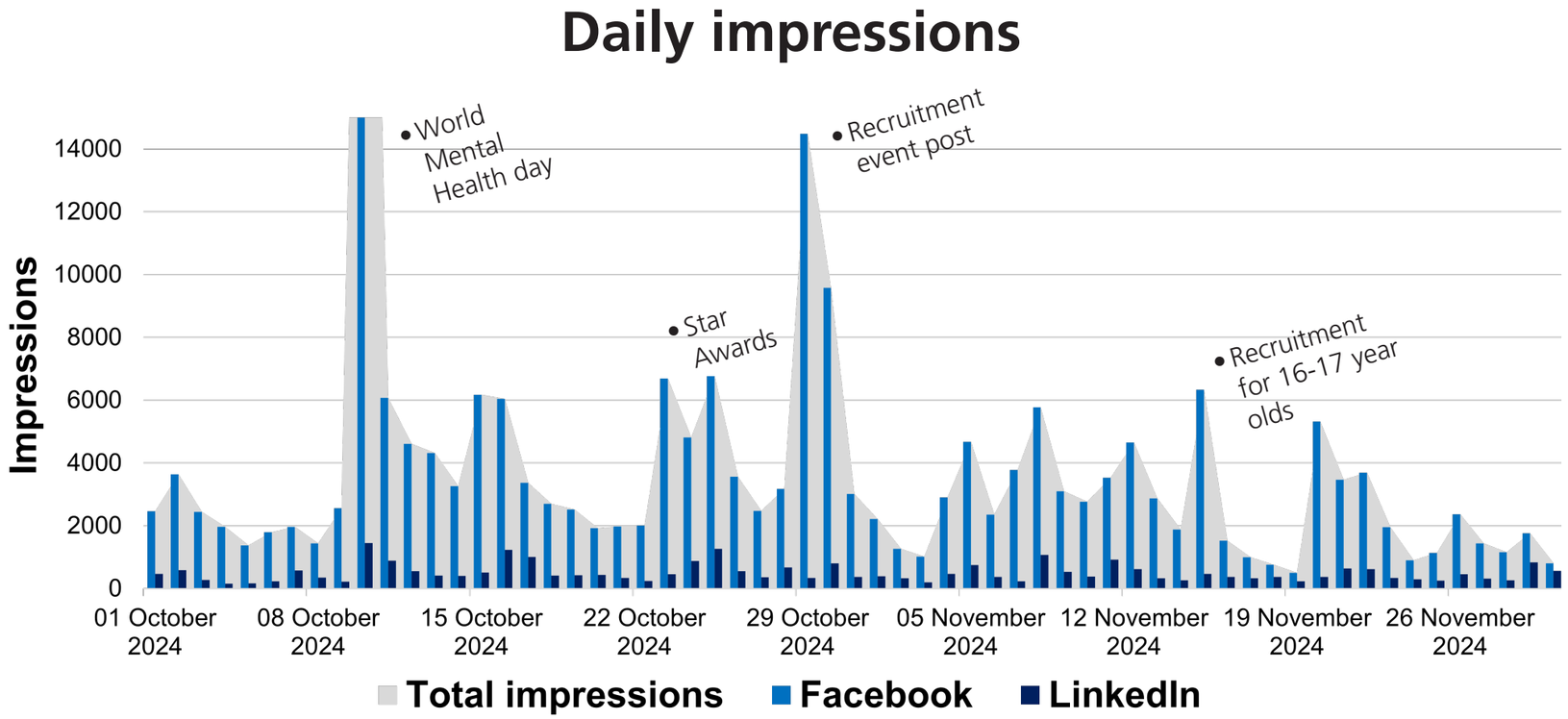

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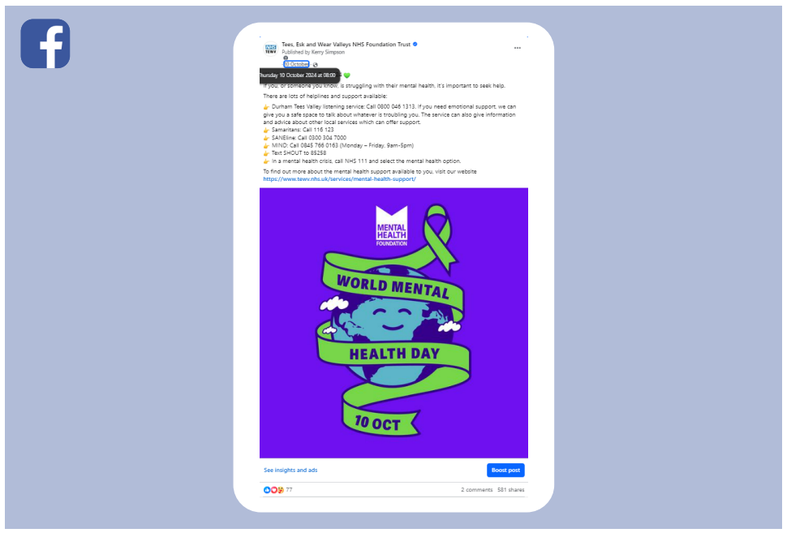

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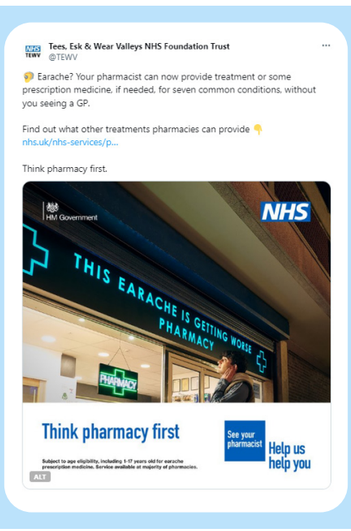

Impressions 88 - Engagement 3

Impressions 2,484 - Engagement 113

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NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12th December 2024**
Title:	**Board Integrated Performance Report as 31st October 2024**
Executive Sponsor(s):	**Patrick Scott, Deputy Chief Executive**
Author(s):	**Sarah Theobald, Associate Director of Performance** **Ashleigh Lyons, Head of Performance**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
1	Safe Staffing	There is a risk that some teams are unable to safely and consistently staff their services caused by factors affecting both number and skill profile of the team. This could result in an unacceptable variance in the quality of the care we provide, a negative impact on the wellbeing and morale of staff, and potential regulatory action and a lack of confidence in the standard of care.
2	Demand	There is a risk that people will experience unacceptable waits to access services in the community and for an inpatient bed caused by increasing demand for services, commissioning issues and a lack of flow through services resulting in a poor experience and potential avoidable harm.
4	Quality of Care	There is a risk that we will be unable to embed improvements in the quality of care consistently and at the pace required across all services to comply with the fundamental standards of care; caused by short staffing, the unrelenting demands on clinical teams and the lead in time for significant estates actions resulting in a variance in experience and a risk of harm to people in our care and a breach in the Health and Social Care Act.
5	Digital – supporting change	There is a risk of failure to delivery Our Journey To Change goals, organisational and clinical safety improvements, caused by the inability to fully deploy, utilise, and adopt digital and data systems.
6	Estates/Physical Infrastructure	There is a risk of delayed or reduced essential investment caused by constrained capital resources resulting in an inability to adequately maintain, enhance or transform our inpatient and community estate, adversely impacting patient and colleague outcomes/experience.
8	Quality Governance	There is a risk that our floor to Board quality governance does not provide thorough insights into quality risks caused by the need to further develop and embed our governance

		and reporting including triangulating a range of quality and performance information resulting in inconsistent understanding of key risks and mitigating actions, leading to variance in standards.
9	Partnerships & System Working	There is a risk that failure to take a proactive role and engage effectively with partners caused by capacity challenges including spanning 2 ICSs and multiple local authorities limits our ability to influence service transformation and improve the health of the communities we serve.
10	Regulatory Compliance	There is a risk that failure to comply with our regulatory duties and obligations, at all times, could result in enforcement action and financial penalties and damage our reputation.
12	Financial Sustainability	There is a risk that constraints in real terms funding growth caused by government budget constraints and underlying financial pressures could adversely impact on the sustainability of our services and/or our service quality/safety and financial, and regulatory standing
13	Public Confidence	There is a risk that ongoing external scrutiny and adverse publicity could lead to low public and stakeholder perception and confidence in the services we provide

Executive Summary:

Purpose:

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

Proposal:

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

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

Overview:

Controls Assurance

The overall **good** level of **controls assurance** has been determined based on the Performance Management Framework we have in place and the recent internal audit report by AuditOne, which provided substantial assurance on the integrated approach to performance. Whilst we have robust controls in place, we have reduced the level of assurance from substantial to good this month, as we have several actions that are outstanding completion dates, and several issues have no confirmed actions.

Performance Assurance

The overall **good** level of **performance assurance** for the IPD has been underpinned by the Performance and Controls Assurance Framework. We have then analysed each measure in more detail to determine the actual areas of concern which are as follows:

1. **Outcomes** – whilst three of the measures indicate improvement; we remain concerned about the low number of timely paired outcomes which impacts the reliability of what the measures are representing. The first Trust-wide Outcomes & Safety Summit held in November 2024, was well attended by a range of clinical and operational staff across the specialties. The discussions helped us to better understand the local challenges and what more can be done to improve outcome collection and the outputs of the event will be considered by the Clinical Outcomes Steering Group. The Trust-wide outcomes improvement plan was approved by EDG in December and oversight will be maintained through monthly reports into EDG.

2. **Bed Occupancy** – whilst we have moved back into special cause concern, we do have a sustained improved position with out of area occupied bed days. There are several mitigating actions in place to support the increased need for inpatient beds, in addition to the work of the Urgent Care Programme Board, including:
   - Daily and weekly operational and executive level oversight.
   - The Bed Management Team who are helping maximise the use of beds and minimising the use of out of area beds
   - The pilot of Optica (a digital tool to support flow for inpatient wards) across a number of inpatient wards in both care groups which is due to conclude in December prior to wider roll-out
   - Sustained improvement in our crisis line call pick up rates
   - Agreed joint work with the NENC ICB to have oversight of patients clinically ready for discharged who are delayed.

   The Quality Assurance Committee are continuing to review the

potential impact on quality of being over occupancy.

3. **Mandatory & Statutory Training –** Whilst we are achieving the standard, we are concerned about the face-to-face training compliance below the 85% standard. There are several actions within the Trust-wide QI improvement work which include the follow up of all staff who do not attend their appointments, a review of positive and safe training and additional dates to support Incident Level Training 1. An update on the QI improvement work was presented to EDG in November. The trajectory for Resuscitation – Level 3 – Adult Immediate Life Support – 1 Year has not been achieved and we are now expecting to achieve 84% compliance by the end of March 2025, pending the release of new training dates in April.

4. **Agency Price Cap Compliance** – Most price cap breaches during 2024/25 have related to medical locum or prison mental health nursing cover for hard to fill vacancies. To address this, we have developed a Performance Improvement Plan that defines the actions that are being taken to support improvement and increased assurance.

5. **CRES Recurrent** - The Efficiency Hub oversees the delivery of CRES, supporting early interventions should any schemes fall off track and identifying mitigating schemes and/or new schemes for development. The Hub will co-ordinate and collate trackers for each scheme, receive exception reports, signpost/support on those schemes at risk, and in turn report into Financial Sustainability Board. A 2025/26 CRES Planning Event took place on the 25th October 2024; the proposals from Care Groups and Corporate Services will form the basis of the 2025/26 plans.

The overall **reasonable** level of **performance assurance** for the National and Local Quality Requirements has been underpinned by Statistical Process Control Charts. We have then analysed each measure in more detail to determine the actual areas of concern which are as follows:

1. **EIP Waiting Times** (Vale of York) – a recovery plan is in place and it is anticipated the backlog of patients waiting will be addressed by the middle of December and from the end of December new patients will start treatment within 2 weeks.

2. **Talking Therapies 1st to 2nd treatment, Reliable Recovery and Reliable Improvement** (County Durham, Tees Valley) – Whilst there are several mitigations described in the IPR, we are concerned about this service's reported performance in relation to these key quality standards. A meeting has been arranged in December with Talking Therapies and Care Group leads (trust-wide) to understand and agree a more robust position describing the associated issues and actions we are going to take.

3. **Talking Therapies 1st to 2nd treatment** (Vale of York) – a performance improvement plan is in place; it had been anticipated that the full impact will be visible by the end of November (December report); however, this is not on track for delivery. Next steps are being considered and will be confirmed by the end of December 2024; therefore, this remains an area of concern.

4. **CYP 1 contact** – The County Durham and Tees Valley 2024/25 plans were based on month 9 of 2023/24 where activity was inflated by short-term realignment of staff and overtime, particularly to address screening backlogs in neurodevelopmental services. The General Manager is working with Finance to confirm the decrease is

attributable to the return of staff to their substantive posts and the cessation of overtime. A recovery plan is in place for the North Yorkshire and York and Selby SPA teams; however, at this stage no trajectory for improvement has been established; therefore, this remains an area of concern.

5. **Childrens Paired Outcomes** – *please see Outcomes narrative (1) in the IPD section on page 3.*

6. **Access to transformed community services** (County Durham, North Yorkshire & Vale of York) - Three PCNs are still to transform in County Durham; they will be transformed by the end of March 2025. There are 2 confirmed teams within North Yorkshire & Vale of York that are impacting access and both teams are in business continuity with recovery plans in place. Following the move of 14 GPs from Vale of York to North Yorkshire from the 1st of April 2024, data has now been revised and analysis will be undertaken by the end of November 2024 to identify any further underlying areas of concern.

7. **Specialist Community Perinatal Mental Health Services** (North Yorkshire & Vale of York) – It had been anticipated that impact of the PIP actions would increase the number of women accessing services and achievement of standard by end of January 2025; however, due to ongoing capacity issues, the Perinatal teams are currently being supported through a service recovery plan in line with business continuity processes. There are several mitigating actions in place to support improvement and to identify and remedy any inefficiencies in process and structure which will then further inform the service recovery plan.

The overall **reasonable** level of **performance assurance** for Waiting Times has been underpinned by Statistical Process Control Charts. We have then analysed each measure in more detail to determine the actual areas of concern which are as follows:

1. **Waiting for neurodevelopmental assessments (Children & Young People and Adults)** – The Mental Health, Learning Disability and Autism Subcommittee for NENC have agreed to put in place an all-age neurodiversity group. The group's scope will encompass ADHD and / or Autism services for children, young people, transitions, and adults and collaboration primarily within NHS structures but also with local authority partners across the ICB's geographical footprint. The group will develop a clear exposition of the current position which will inform the development of the proposed future state. In addition, a recovery plan is in place within Durham and Tees Valley Children & Young People's services (CYPS) to address the long waiting times and progress is being monitored by the Care Group Board. Within North Yorkshire & York CYPS, alternative approaches and skills mix are being considered; a consolidated list of the actions has been shared with Executive Directors for oversight and assurance.

2. **Adults waiting for their second contact with Talking Therapies** – *please see Talking Therapies narrative (2 & 3) in the National and Local Quality Requirements section on page 4.*

<u>Positive Assurances</u>

We have positive assurances in the following:

- ✓ Patient Experience
- ✓ People (leaver rate, sickness, appraisals)
- ✓ CRES Performance – Non-Recurrent
- ✓ Talking Therapies waiting times (6 and 18 weeks)
- ✓ Active OAPs (inappropriate)

Other Information

- **Trust-wide PIP (Financial Plan)** – The revised PIP for e-Roster effectiveness has not achieved 80% of teams for annual leave level loading by the extended date of the 31st October 2024. Trajectory to be discussed and agreed at the December Safer Staffing Group.

- **Data Quality Audit** – AuditOne have completed the audit on Sickness Absence Rate, reporting Good external assurance on the measures.

Prior Consideration and Feedback

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

Implications:

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

- Safe Staffing
- Demand
- Quality of Care
- Digital – supporting change
- Estates/Physical Infrastructure
- Quality Governance**
- Partnerships & System Working
- Regulatory Compliance
- Financial Sustainability
- Public Confidence

***The introduction of any new Electronic Patient Record has a negative impact on Data Quality. Following the introduction of Cito in February 2024, data quality issues have impacted several patient-based measures across the organisation, to address this, the Cito Improvement Group has been established. This group has two core workstreams, Cito Stability and Cito Improvement. These workstreams are running in parallel to address the technical and performance aspects of the application; and to focus on system utilisation, data quality and the consistency of use. The delivery outcome metrics the group monitors will be focussed on improvements in data quality from Cito and is supported by the Data Quality Working Group. Data Quality workstream progress will be monitored via the standard Digital and Data Services project framework and will be formally reported via Digital Programme Board to Transformation and Strategy Board.*

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

Recommendations:

Board of Directors is asked to:

- either confirm that there is good controls assurance on the operation of the Performance Management Framework; good performance assurance on the IPD and reasonable performance assurance on the National and Local Quality requirements and Waiting Times and that the strategic risks are being managed effectively; or
- identify the levels of assurance it considers to be appropriate; the reasons for this; and any corrective measures/improvements it considers should be put in place.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

As at 31st October 2024

Report produced by: Amy Walford, Performance Lead (Corporate) and Ashleigh Lyons, Head of Performance
Date the report was produced: 3rd December 2024

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

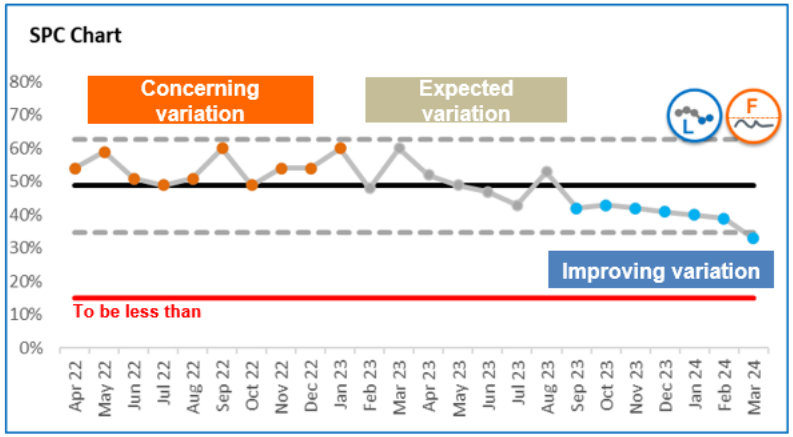
CONTENTS

Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys
NHS Foundation Trust

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

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



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

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

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

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

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

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

NHS
Tees, Esk and Wear Valleys
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These icons provide a summary view of the important messages from SPC charts.

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

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

Our Approach to Data Quality

Tees, Esk and Wear Valleys NHS Foundation Trust

Data Quality

On a bi-annual basis we undertake a data quality assessment on our Board measures as part of our assurance to the Board. Our data quality assessment focuses on 4 key elements: robustness of the measure, data source, data reliability and audit. The last assessment was completed in quarter 1 2024/25 and the next assessment will be completed in quarter 3 (reported to Board in quarter 4 2024/25).

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

Our Approach to Performance and Controls Assurance

Tees, Esk and Wear Valleys NHS Foundation Trust

Our Performance Assurance

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

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

Our Controls Assurance

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

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

Glossary of Terms

Tees, Esk and Wear Valleys NHS Foundation Trust

ACE	Assistant Chief Executive Directorate
ADHD	Attention deficit hyperactivity disorder
ALD	Adult Learning Disabilities
AMH	Adult Mental Health
ASD	Autistic Spectrum Disorder
CA&I	Corporate Affairs & Involvement
cCBT	Computerised Cognitive Behaviour Therapy
CNTW	Cumbria, Northumberland and Tyne & Wear NHS Foundation Trust
CRES	Cash Release Efficiency Savings
CROM	Clinician Reported Outcome Measure
CYP	Children & Young People
CYPS	Children and Young People Services
DTVFCG	Durham Tees Valley and Forensic Care Group
EDG	Executive Directors Group
EIP	Early Intervention in Psychosis
HNY ICB	Humber & North Yorkshire Integrated Care Board
ICB	Integrated Care Board
IPD	Integrated Performance Dashboard
MHSOP	Mental Health Services for Older People
MoJ	Ministry of Justice
NENC	North East & North Cumbria Integrated Care Board
Neuro	Neurodevelopmental services
NYYSCG	North Yorkshire, York & Selby Care Group
OAP	Out of Area Placement
PACE	Patient and Carer Experience
PCN	Primary Care Network
PIP	Performance Improvement Plan
PMH	Specialist Community Perinatal Mental Health
PROM	Patient Reported Outcome Measure
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Framework
PWP	Psychological Wellbeing Practitioner
QI	Quality Improvement
ROM	Routine Outcome Measures
SICBL	Sub-Integrated Care Board Location
SOCI	Statement of comprehensive income
SPC	Statistical Process Control
STEIS	Strategic Executive Information System
TEWV	Tees, Esk & Wear Valleys NHS Foundation Trust
UoRR	Use of Resources Rating

Board Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

- **Patient and Carer Experience:** there is special cause improvement for patient experience; no significant change for carer experience and inpatients feeling safe; all are achieving standard. There is no significant change in the responses received for all three questions.
- **Outcomes:** in CYP there is special cause concern and we are below standard for the PROM; however, there is special cause improvement for the CROM and we are above standard. In AMH/MHSOP there is special cause improvement for both the PROM and the CROM; however, we are below standard for both. Whilst some of the SPC charts indicate special cause improvement, this remains an area of concern as there is special cause concern in the number of timely paired outcomes recorded for all measures.
- **Bed Pressures:** there is special cause concern for bed occupancy and the last 6 months have reported over 100% occupancy. Whilst there is special cause improvement for the inappropriate out of area bed days, there were 3 active OAPs as at the end of October.
- **Patient Safety:** there is special cause improvement for patient safety incident investigations; however, this is not necessarily an actual improvement, as there was a change in process at the end of January 2024 when we Trust transitioned to the National Patient Safety Incident Framework (PSIRF). There is a reduction (indicated as special cause improvement in the SPC chart) for incidents of moderate of severe harm and no significant change for restrictive interventions and medication errors. There was 1 unexpected Inpatient unnatural death reported on STEIS during October.
- **Uses of Mental Health Act:** there is no significant change.
- **People:** There is special cause improvement for all measures and we are achieving standard for leaver rate, mandatory training and appraisal. Whilst we are achieving the standard for mandatory training, we are concerned about the face-to-face training compliance below the 85% standard.
- **Demand:** There is no significant change in referrals. Whilst the SPC chart indicates there is special cause concern for caseload, this is not necessarily an actual concern as we know from the detailed analysis previously undertaken, unique caseload is impacted by the increase in patients waiting for a first contact.
- **Finance** The Trust's 2024/25 financial plan targets delivery of a break-even position. The year-to-date plan at Month 7 reflected a £2.734m deficit. When adjusted to remove technical items that are excluded from assessment of Trusts' financial performance the actual position is a deficit of £1.026m; or £1.708m favourable variance to plan. Whilst financial performance is better than planned, the year-to-date deficit needs to be recovered in the remaining 5 months of 2024/25, including through CRES targets that are more heavily weighted to deliver reduced costs in the second half of the year. The position therefore requires ongoing focus, grip and control. The nationally agreed pay awards cost £8.6m more than was assumed in plan for the year to date (based on a national 2.1% generic assumption) and will be c £14.7m in 2024/25 based on existing staffing (the pressure on budgeted establishment, and therefore the underlying position, is to be confirmed). The actual in–year cost is mitigated by increased income, although £1.3m income is non-recurrent funding.

Board Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

- Patient Experience
- Inappropriate OAP bed days
- People (leaver rate, sickness, appraisals)
- CRES Performance – Non-Recurrent

Risks & Issues

- Outcomes
- Bed occupancy
- Mandatory & Statutory Training
- Finance (Agency Price Cap Compliance & CRES Performance Recurrent)

Mitigations

Outcomes

The first Trust-wide Outcomes & Safety Summit took place on the 6th November 2024, which was well attended by a range of clinical and operational staff across the specialties. Presentations were given on the importance of understanding our outcomes by our Clinical Lead for Community Transformation and the NHS England Senior Project Manager – Outcomes and Experience, as well as local examples of good practice by our CYP and Talking Therapies services. There were a number of group exercises undertaken to better understand the local challenges and what more can be done to improve outcome collection. The outputs of the event will be considered by the Clinical Outcomes Steering Group. The Trust-wide outcomes improvement plan was approved by EDG in December and oversight will be maintained through monthly reports into EDG.

Bed Occupancy

There are several mitigating actions in place to support the increased need for inpatient beds, in addition to the work of the Urgent Care Programme Board, including: daily and weekly operational and executive level oversight; the Bed Management Team who are helping maximise the use of beds and minimising the use of out of area beds; the pilot of Optica (a digital tool to support flow for inpatient wards) across a number of inpatient wards in both care groups which is due to conclude in December prior to wider roll-out; sustained improvement in our crisis line call pick up rates; and agreed joint work with the NENC ICB to have oversight of patients clinically ready for discharged who are delayed. Quality Assurance Committee are continuing to review the potential impact on quality of being over occupancy.

Mandatory & Statutory Training

We are currently focusing on all face-to-face training that is below the 85% standard and there are several actions to support improvement, which include the follow up of all staff who do not attend their appointments, a review of positive and safe training, additional dates to support Incident Level Training 1, and the focused Trust-wide QI work. The trajectory for Resuscitation – Level 3 – Adult Immediate Life Support – 1 Year has not been achieved and we are now expecting to achieve 84% compliance by the end of March 2025, pending the release of new training dates in April.

Finance – Agency Price Cap Compliance & CRES Performance Recurrent

To support improved compliance, the Executive Directors Group (formerly Executive Workforce and Resources Group) will oversee a Performance Improvement Plan to ensure optimal rosters. The Efficiency Hub is now established to oversee delivery of CRES, to support early interventions should any schemes fall off track and to support the identification of mitigating schemes and/or new schemes to develop, with approval of a finance post in summer 2024 to support delivery. With PMO support, it has co-ordinated and collated trackers for each scheme, and will receive exception reports, signpost/support on those schemes at risk, and in turn reports into Financial Sustainability Board. Following liaison with Care Group colleagues, some functions will operate virtually going forward, to make optimal use of colleague time and existing governance. In addition to CRES, ongoing grip and control measures are required to deliver the 2023/24 exit run-rates based 2024/25 plan.

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

Durham Tees Valley & Forensic Care Group IPD Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

- **Patient and Carer Experience:** no significant change for patients rating their recent experience as good or very good and carer involvement. Special cause improvement for inpatients feeling safe. Achieving the standard for patients rating their recent experience as good or very good and for inpatients feeling safe. There is no significant change in the responses received for any of the measures.
- **Outcomes:** CYP special cause concern and below standard for the PROM; however, special cause improvement for the CROM and above standard. AMH/MHSOP no significant change in the PROM and special cause improvement in the CROM. Below standard for the PROM and CROM.
- **Bed Pressures –**special cause concern in bed occupancy; however, special cause improvement for the inappropriate out of area bed days.
- **Patient Safety**. Special cause Improvement for patient safety incident investigations and incidents of moderate of severe harm No significant change for medication errors, unexpected inpatient unnatural deaths or the number of restrictive interventions used.
- **Uses of Mental Health Act** special cause concern
- **Staff.** For recommending the Trust as a place to work we achieved 51.91 % and for staff feeling able to make improvements we achieved 62.57%. Special cause Improvement in appraisals mandatory and statutory training sickness absence and staff leaver rate.
- **Demand** No significant change in referrals; however special cause concern in caseload driven by Adult Mental Health and Children and Young Peoples services.
- **Finance** The care group planned to spend £152.6m as at October, and actual spend was £157m, which is £4.4m more than planned. The movement from M6 of £4.9m primarily relates to the pay award impact of £4.7m associated with the pay award. As at M7 CRES delivery was £0.3m behind plan.

Durham Tees Valley & Forensic Care Group IPD Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

•Patient Experience
•Inappropriate OAP bed days
•People (leaver rate, sickness, appraisals)

Risks / Issues*

- Bed Occupancy
- Outcomes

Mitigations

Outcomes
CYPS have developed a PIP in relation to the PROM, which will be presented to the November Care Group Board for approval. Actions include establishing ROMs links in every team and a Task & Finish Group to support the new access standards by the end of December 2024, embedding reporting through governance and quality and performance discussions by the end of January 2025, reviewing the CAMHS core pathway guidance and undertaking targeted work to embed ROMs within the neuro teams by the end of March 2025.
The first Trust-wide Outcomes & Safety Summit took place on the 6th November 2024, which was well attended by a range of clinical and operational staff across the specialties. Presentations were given on the importance of understanding our outcomes by our Clinical Lead for Community Transformation and the NHS Lead for outcomes, as well as local examples of good practice by our CYP and Talking Therapies services. There were a number of group exercises undertaken to better understand the local challenges and what more can be done to improve outcome collection. The outputs of the event will be considered by the Clinical Outcomes Steering Group. The Trust-wide outcomes improvement plan is being finalised and will be taken back to EDG for approval.

Bed Occupancy
The Care Group and working with colleagues in North Yorkshire and York Care group to develop a Trust-wide clinical model for the MHSOP organic bed base (end of Q4 2024/25). Trust-wide groups are also to be established to progress workstreams for Transforming Patient Flow and Transforming Mental Health Discharge within AMH services as part of the Urgent Care Programme Board.

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

- **Patient and Carer Experience:** No significant change in either of the measures or in the number of carer responses, with the exception of patients who have responded to their experience which continues to report special cause improvement.
- **Inpatients Feeling Safe:** No significant change and in the number of responses to this measure.
- **Outcomes:** CYP PROM is reporting no significant change and CROM is reporting special cause improvement. AMH/MHSOP PROM are reporting special cause improvement, AMH/MHSOP CROM are reporting no significant change, MHSOP remains low
- **Bed Pressures:** Bed Occupancy is reporting no significant change at Care Group and both specialities, both are above the mean; Inappropriate out of area beds days continues to report special cause improvement
- **Patient Safety:** Special cause improvement
- **Uses of Mental Health Act:** No significant change at Care Group and all other specialties, AMH is reporting special cause improvement.
- **Staff:** For recommending the Trust as a place to work we achieved 47.62% and for staff feeling able to make improvements we achieved 58.57%. **Staff leaver, Sickness, Mandatory Training and Appraisals are all** special cause improvement.
- **Demand:** Referrals and caseload are both reporting no significant change.
- **Finance:** Significant challenges in relation to financial recovery to achieve breakeven by the end of the year.

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Positive Assurance

- Inappropriate OAP
- Staff Leaver Rate
- Sickness
- Mandatory & Statutory Training
- Appraisals

Risks / Issues

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

Mitigations

Finance

The Care Group financial position is forecast to be £244k above plan, with the key factor being out of area patients, which are impacted by delayed discharges.

Improved performance relative to control totals set in year to support financial recovery provide increased assurance that the Trust will deliver our 2024/25 breakeven plan, based on a mid-case scenario. A small number of external factors have potential to impact the financial outturn however these are currently projected as being manageable within the overall position.

Performance & Controls Assurance Overview

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

Board Integrated Performance Dashboard

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC	H	?	92.00%	93.34%	92.00%
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	QAC		?	75.00%	73.74%	75.00%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC		?	75.00%	80.18%	75.00%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	L	F	35.00%	22.96%	35.00%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	H	F	55.00%	44.38%	55.00%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	F	50.00%	52.04%	50.00%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	H	F	30.00%	23.39%	30.00%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC	H	F	85.00%	100.95%	85.00%
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	L			82	
10)	The number of Patient Safety Incident Investigations reported on STEIS	QAC	L			18	
11)	The number of Incidents of moderate or severe harm	QAC	L			271	
12)	The number of Restrictive Interventions Used	QAC				6,986	
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				3	
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				5	
15)	The number of uses of the Mental Health Act	MHLC				2,451	

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
16)	Percentage of staff recommending the Trust as a place to work	PC&D				51.61% (Jul - 2024)	
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				60.51% (Jul - 2024)	
18)	Staff Leaver Rate	PC&D	L	F	11.00%	10.73%	11.00%
19)	Percentage Sickness Absence Rate (month behind)	PC&D	L	?	5.50%	5.80%	5.50%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	H	?	85.00%	86.69%	85.00%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	H	F	85.00%	87.55%	85.00%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
22)	Number of new unique patients referred	S&RC				56,532	
23)	Unique Caseload (snapshot)	S&RC	H			63,823	

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	2,735,000	1,025,513
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	7,493,385	6,680,482
25b)	Agency price cap compliance	S&RC	67.00%	57.95%
26)	Use of Resources Rating - overall score	S&RC	3	3
27)	CRES Performance - Recurrent	S&RC	9,252,724	8,806,318
28)	CRES Performance - Non-Recurrent	S&RC	1,275,833	2,008,089
29)	Capital Expenditure (CDEL)	S&RC	4,762,000	3,293,553
30)	Cash against plan	S&RC	53,638,000	57,649,565

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

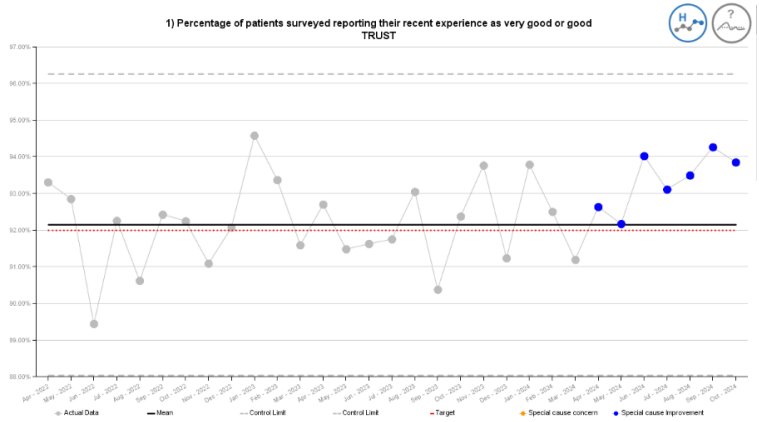
What does the chart show/context:
During October **1089** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **1022 (93.85%)** scored "very good" or "good".

There is special cause improvement at Trust level in the reporting period and no significant change in the number of patients who have responded to this question. There is no significant change at Care Group; however, there is special cause improvement for Secure Inpatient Services.

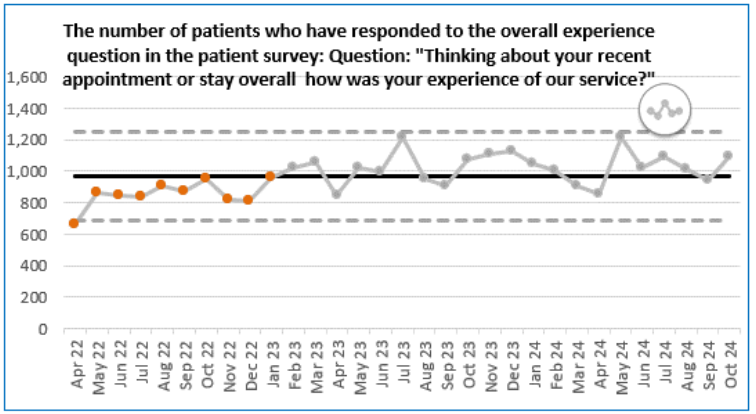
The latest National Benchmarking data (August 2024) shows the England average (including Independent Sector Providers) was **87**% and we were ranked **12** (1 being the best with the highest ratings).

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

Actions:
- Each month, the Patient and Carer Experience (PACE) team share with the care group leadership teams a list of those wards/teams who have not provided feedback in the month. This is also reflected in the current Quality Assurance and Improvement Group reports to both Care Groups. In addition, the PACE Team use this intelligence to focus on who we see and when, as part of the quality visit programme. *NB. This is standard work for the PACE Team*
- The Patient & Carer Experience Reference Group established a task and finish group with service user and carer membership to understand the performance of each individual team and what key things they might look for. Nine areas for consideration have been agreed which will be part of a wider programme of QI work going forward. **(Completed)**



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



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

Tees, Esk and Wear Valleys NHS Foundation Trust

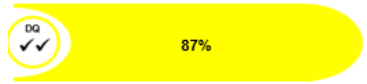
Background / standard description:
We are aiming for 75% of carers reporting they feel they are actively involved in decisions about the care and treatment of the person they care for.

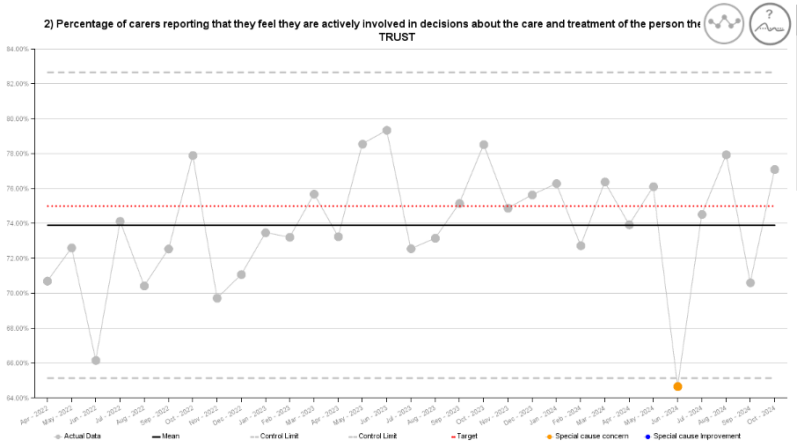
What does the chart show/context:
During October, **406** carers responded to the question in the carer survey: Question: "Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?". Of those, **313 (77.09%)** scored "yes, always".

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

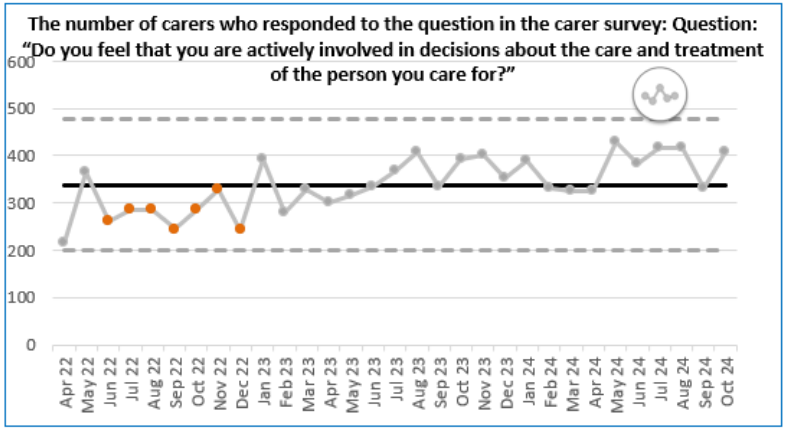
Underlying issues:
- Engagement with various carer groups
- Barriers to collecting feedback include:
    - Access to and up to date surveys through the various mechanisms
    - Up to date carer and team information
    - Lack of feedback including display of feedback

Actions:
- The Patient & Carer Experience Team are reviewing the output from the recent Quality Improvement focused work and will develop a work plan by the end of January 2025.





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



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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
During October **155** patients responded to the overall experience question in the patient survey: “During your stay, did you feel safe?”. Of those, **128 (82.58%)** scored “yes, always“ and “quite a lot”.

There is no significant change at Trust level and for North Yorkshire & York Care Group and in the number of patients who have responded to this question. There is special cause improvement for Durham Tees Valley & Forensic Care Group and for Adult Learning Disabilities and Secure Inpatient Services within that Care Group.

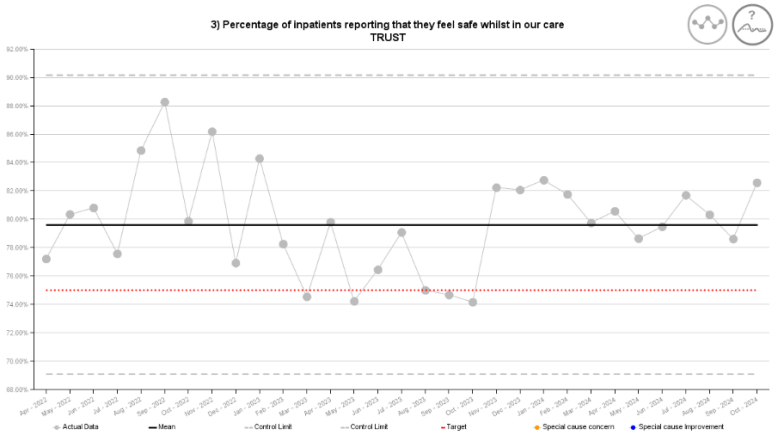
There are several factors that can influence whether a patient feels safe, e.g. staffing levels, other patients (including self-harm), environment, the acuity of other patients and violence & aggression and the use of restrictive interventions on wards.

Underlying issues:
There are no underlying issues to report.

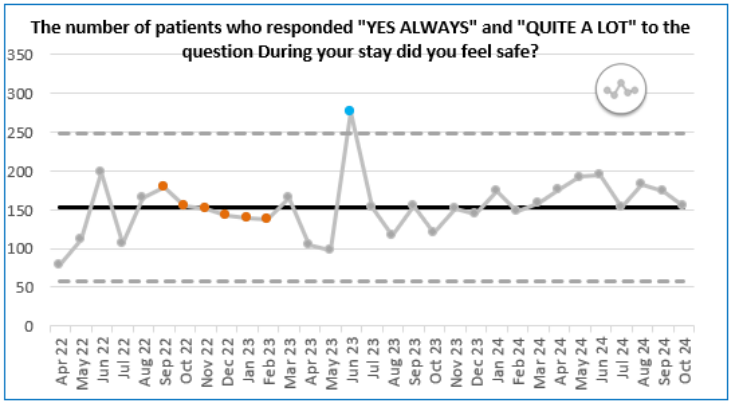
Actions:
There are no specific improvement actions identified.

DQ

87%



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



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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
For the 3-month rolling period ending October **621** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 123 (19.81%)** made a measurable improvement.

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

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

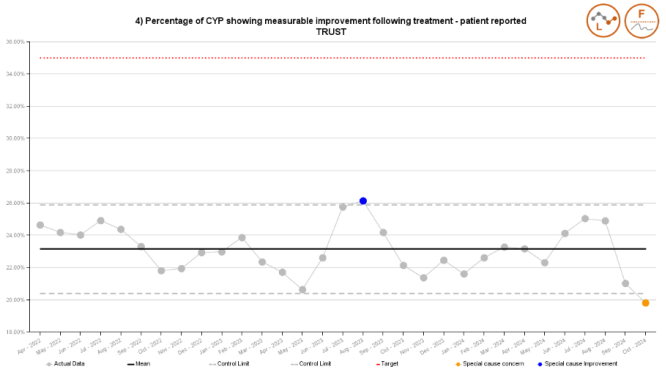
Underlying issues:
There are a range of issues currently impacting this measure.

- We are not capturing timely, paired outcome measures for all of our patients that are discharged; therefore, this is not a comprehensive picture. One contributory factor is the length of time taken to record an outcome measure on Cito.
- We do not fully understand the reasons why our children and young people are not demonstrating measurable improvement.
- This measure currently does not report the full suite of patient-related outcomes as a number of measures do not have a reliable change index.

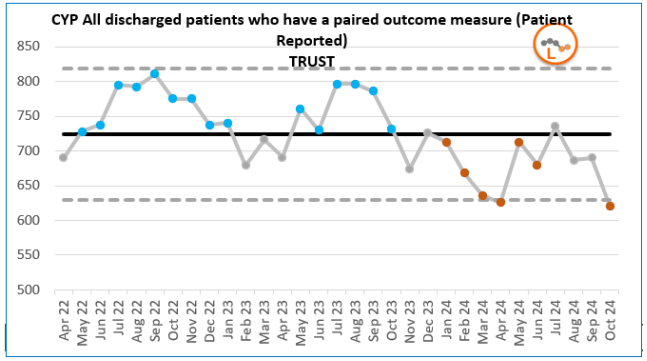
Actions:

- The Trust-wide outcomes improvement plan was approved by EDG in December and oversight will be maintained through monthly reports into EDG.
- The Business Intelligence Team are working with the Child Outcome Research Consortium (CORC) to establish a national reliable change index for EDE-Q in collaboration with other member organisations. We are now establishing Information Governance considerations for data sharing and Research ethics.

DQ ✓✓ 87%



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



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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

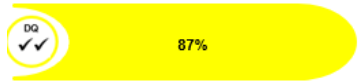
What does the chart show/context:
For the 3-month rolling period ending October **1641** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 786 (47.90%)** made a measurable improvement.

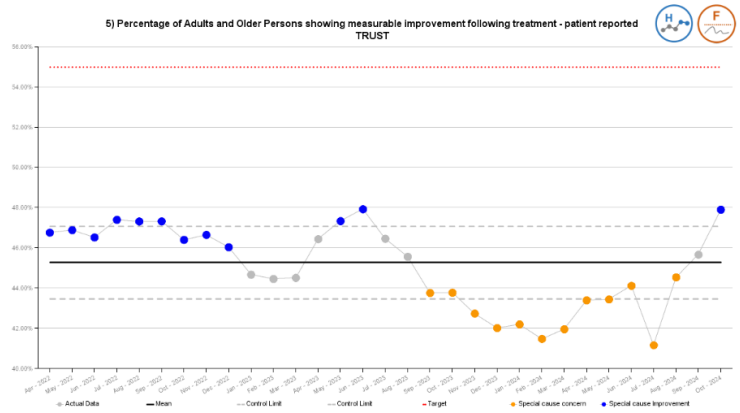
There is special cause improvement at Trust level and for North Yorkshire, York & Selby Care Group in the reporting period. There is no significant change for Durham, Tees Valley & Forensic Care Group. There is special cause concern at Trust and Care Group level in the number of patients discharged with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

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

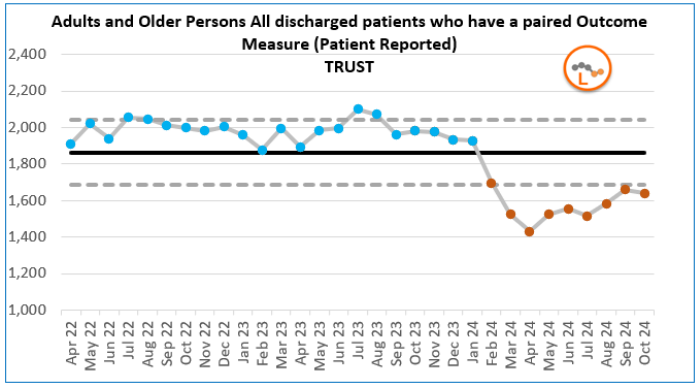
Underlying issues:
- We are not capturing timely, paired outcome measures for all of our patients that are discharged; therefore, this is not a comprehensive picture.
- We do not fully understand the reasons why our adult and older persons patients are not demonstrating measurable improvement.
- The measure includes patients that have died due to natural causes.

Actions:
- The Trust-wide outcomes improvement plan was approved by EDG in December and oversight will be maintained through monthly reports into EDG.
- Care Group Clinical Quads presented their outcomes and actions to the November EDG meeting for focused discussion. **(Completed)**
- Business Intelligence to implement the change to exclude patients that have died. Timescale to be confirmed.





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



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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
For the 3-month rolling period ending October **670** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 363 (54.18%)** made a measurable improvement.

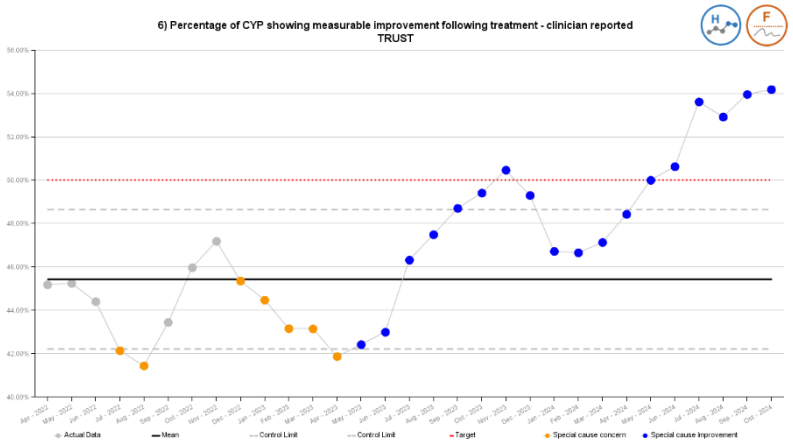
There is special cause improvement at Trust and Care Group level in the reporting period, and performance is above standard at all levels. There is special cause concern at Trust and Care Group level in the number of patients discharged with a paired outcome measure.

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

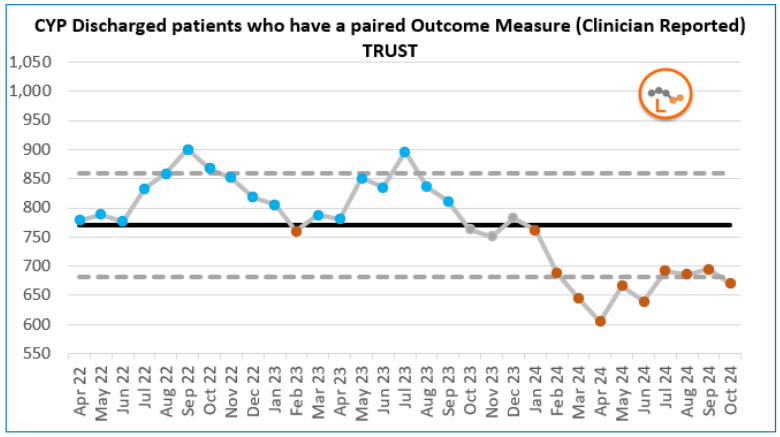
Underlying issues:
- We are not capturing timely, paired outcome measures for all of our patients that are discharged; therefore, this is not a comprehensive picture.

Actions:
- The Trust-wide outcomes improvement plan was approved by EDG in December and oversight will be maintained through monthly reports into EDG.

DQ ✓✓ 87%



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



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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

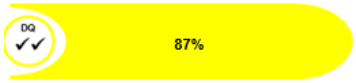
What does the chart show/context:
For the 3-month rolling period ending October **2552** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 601 (23.55%)** made a measurable improvement.

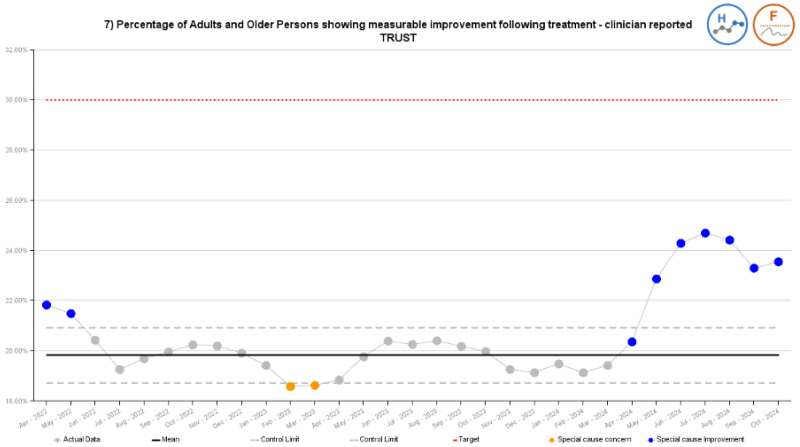
There is special cause improvement at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period, with both underlying specialties reporting special cause improvement. There is no significant change for North Yorkshire, York & Selby Care Group and for AMH Services; there is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

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

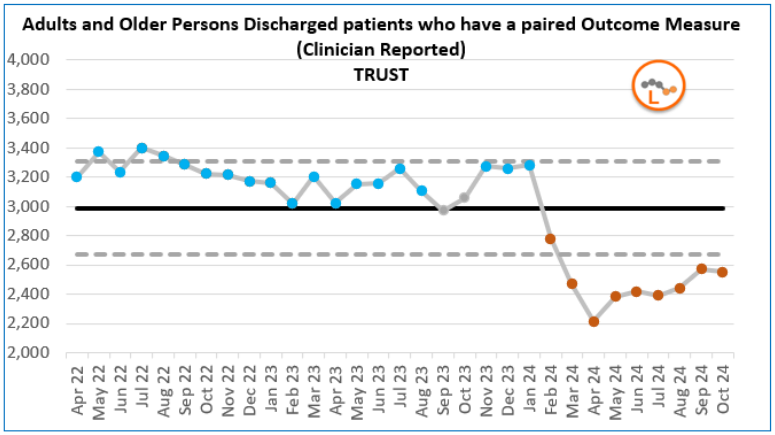
Underlying issues:
See measure 5, Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported.

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





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



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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Background / standard description:
We are aiming to have a maximum bed occupancy of 85%. (Agreed October 2024)

What does the chart show/context:
During October, **10,850** daily beds were available for patients; of those, **10,943 (100.86%)** were occupied. Overall occupancy including independent sector beds was **101.21%**.

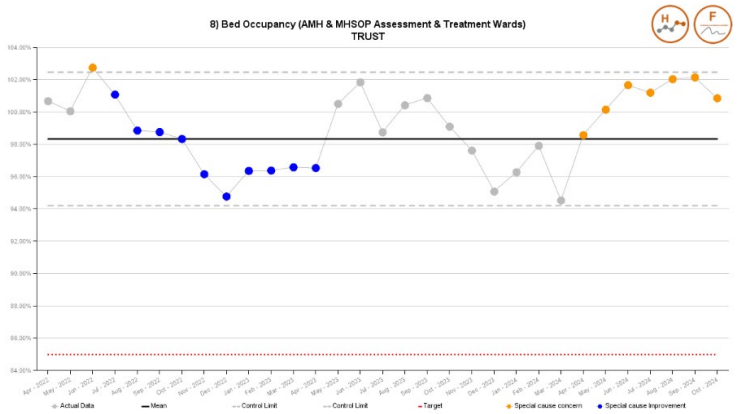
There is special cause concern at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period. North Yorkshire, York & Selby Care Group is showing no significant change. There is special cause concern for Adult Mental Health Services in DTVFCG, and whilst there is no significant change in Mental Health Services for Older People in both Care Groups, an increasing position is seen.

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

Underlying issues:
- Delayed transfers of care – specifically in Adult Mental Health Services in DTVFCG.
- At Trust level (both Care Groups) patients classified as clinically ready for discharge equated to an average of 28.6 Adult and 18.7 Older Adult beds in October 2024, with an associated direct cost of c.£3.87m (including £678k independent sector bed costs). Of the cost, c.£2.53m relates to Adult and c.£1.33m relates to Older Adult.
- Patient flow
- Length of stay (linked to above issues)
- Greenlight admissions
- Ministry of Justice (MoJ) patients

Actions:
- DTVFCG have one outstanding action on their PIP, to implement a revised discharge policy. Following review at the September Care Group event, further amendments have been completed and the policy circulated Trust-wide for consultation, prior to being presented to Care Group Board for final approval in December 2024.
- Care Groups to work together to develop a Trust-wide clinical model for the MHSOP organic bed base by the end of Q4 2024/25.
- Trust-wide groups to be established to progress workstreams for Transforming Patient Flow and Transforming Mental Health Discharge within AMH services as part of the Urgent Care Programme Board.

DQ ✓✓ 80%



Costings attached to patients clinically ready for discharge:

FYTD	Average Beds for Patients Classified as Clinically Ready for Discharge		Associated Cost for Patients Classified as Clinically Ready for Discharge	
	AMH	MHSOP	AMH	MHSOP
2023/24	25.8	16.5	£4.7m (*inc £3.34 IS bed costs*)	£1.96m
April 2024	34.1	16.8	£417k (*inc £118k IS bed costs*)	£154k
May 2024	30.8	17	£815k (*inc £215k IS bed costs*)	£325k
June 2024	32.8	17	£1.312m (*inc £311k IS bed costs*)	£450k
July 2024	29.9	17	£1.411m (*inc £458k IS bed costs*)	£0.633m
August 2024	23.2	17.9	£1.489m (inc £463k IS bed costs)	£0.878m
September 2024	34.5	18.2	£2.47m (inc £568 IS bed costs)	£1.08m
October 2024	28.6	18.7	£2.53m (inc £678k IS bed costs)	£1.33m

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming to have no out of area bed days by the end of March 2025.

What does the chart show/context:
For the 3-month rolling period ending October **82** days were spent by patients in beds away from their closest hospital.

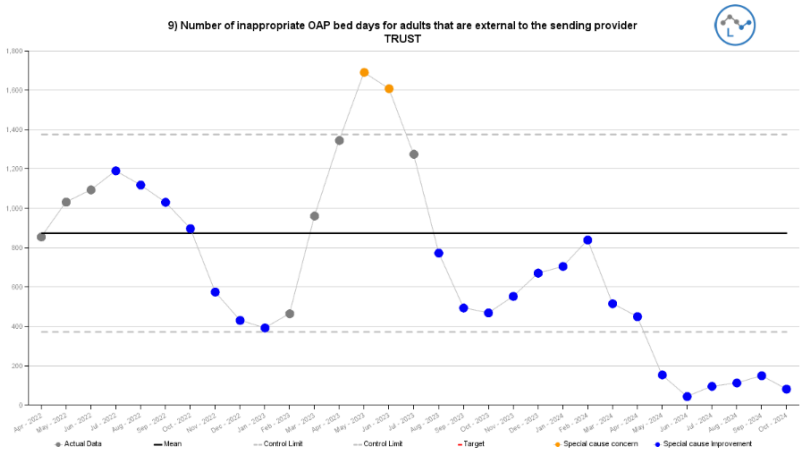
There is special cause improvement at Trust and Care Group level in the reporting period.

There were 3 active OAP placements as at 31st October 2024 (2 in Tees Valley SICBL and 1 in North Yorkshire). As at the 18th November 2024, the placements accounted for 59 bed days.

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

Actions:
See measure 8) Bed Occupancy

DQ ✓✓ 73%



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

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

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

Tees, Esk and Wear Valleys NHS Foundation Trust

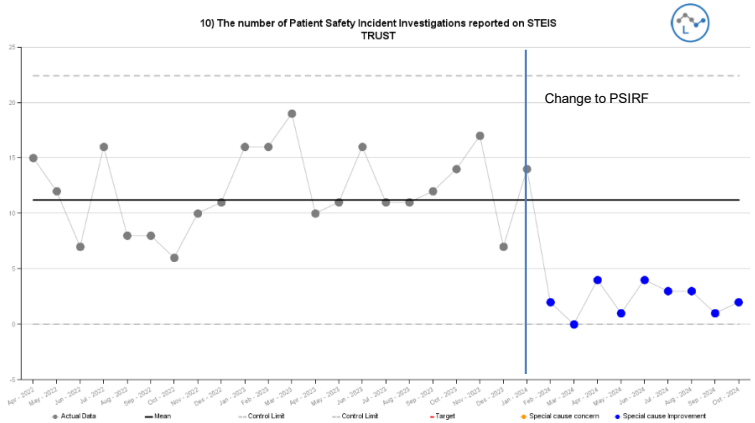
What does the chart show/context:
2 patient Safety Incident Investigations (PSII) were reported on the Strategic Executive Information System (STEIS) during September.

There is special cause improvement at Trust and Care Group level in the reporting period and for most services. *This is not necessarily an actual improvement, as there was a change in process late January 2024, when we Trust transitioned to the National Patient Safety Incident Framework (PSIRF). This new framework advocates a more proportionate approach to investigations.*

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.



11) The number of Incidents of moderate or severe harm

Tees, Esk and Wear Valleys NHS Foundation Trust

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

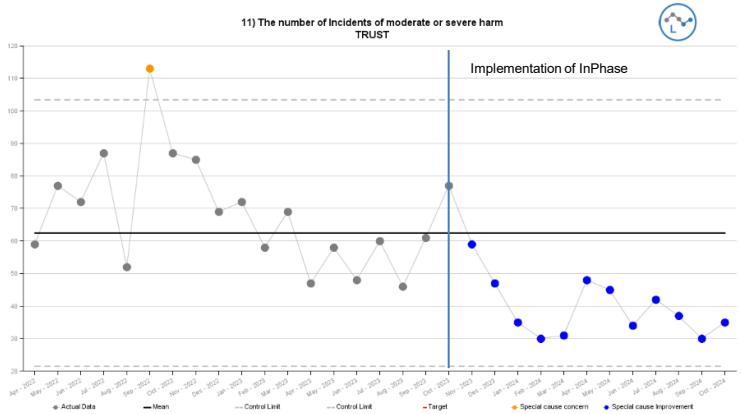
There is a reduction (not necessarily an improvement as indicated in the SPC chart) at Trust and Care Group level in the reporting period, as this change looks to align to the new system implementation. This is mirrored for Adult Learning Disabilities, Adult Mental Health and Children & Young Peoples Services within Durham, Tees Valley & Forensic Care Group and Adult Learning Disabilities within North Yorkshire, York & Selby Care Group.

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

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.



12) The number of Restrictive Intervention Used

Tees, Esk and Wear Valleys NHS Foundation Trust

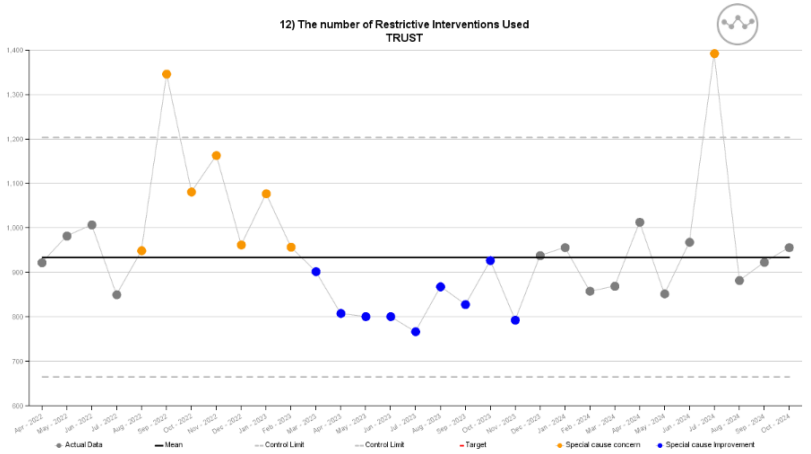
What does the chart show/context:
956 types of Restrictive Interventions were used during October.

There is no significant change at Trust and Care Group in the reporting period. There is special cause concern in Adult Mental Health Services within Durham, Tees Valley & Forensic Care Group. Whilst there is special cause improvement indicated for Adult Learning Disabilities in both Care Groups, there are significant concerns within DTVFCG (*see underlying issues below*). There is also special cause improvement in Children & Young Peoples Services in Durham, Tees Valley & Forensic Care Group.

Update:
Following identification of an issue that resulted in a number of duplicate interventions being counted, work has been undertaken to correct historic data.

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

Actions
- There are several actions to support improvement in AMH services, which include:
  - Specialist Practitioner for Positive & Safe continues to work with Overdale Ward, to review the use of restrictive interventions and to provide education.
  - Trust-wide Autism Team providing an Autism-Informed Care Project into Overdale Ward and providing support into Stockdale Ward.
  - Clinical Psychologist undertaking a piece of work on Tunstall Ward to reduce the number of headbanging incidents for a small number of patients.
  - Positive & Safe Team are providing support into Tunstall Ward to ensure that the least restrictive interventions are used.
  - DTVFCG ALD services continue to monitor the use of restrictive interventions, seeking support from the Specialist Practitioner for Positive & Safe where appropriate.



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

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

Tees, Esk and Wear Valleys NHS Foundation Trust

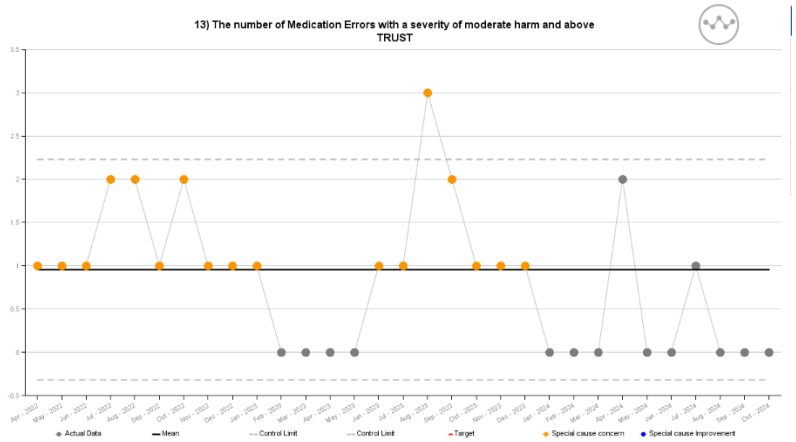
What does the chart show/context:
0 medication errors were recorded with a severity of moderate harm, severe or death during October.

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

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

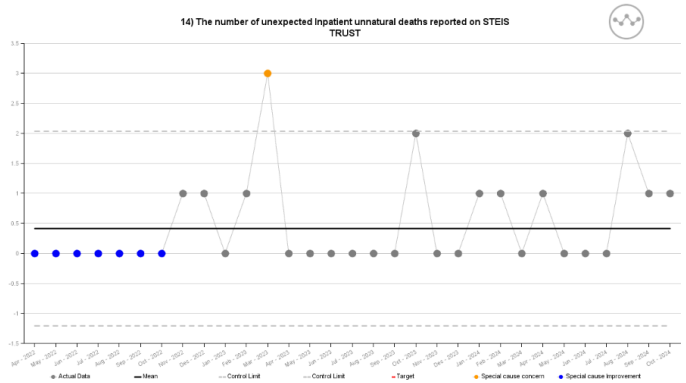
What does the chart show/context:
1 unexpected inpatient unnatural death on an inpatient ward was reported on the Strategic Executive Information System (STEIS) during October.

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

Underlying issues:
There are no underlying issues to report

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

DQ ✓✓ 87%



15) The number of uses of the Mental Health Act

Tees, Esk and Wear Valleys NHS Foundation Trust

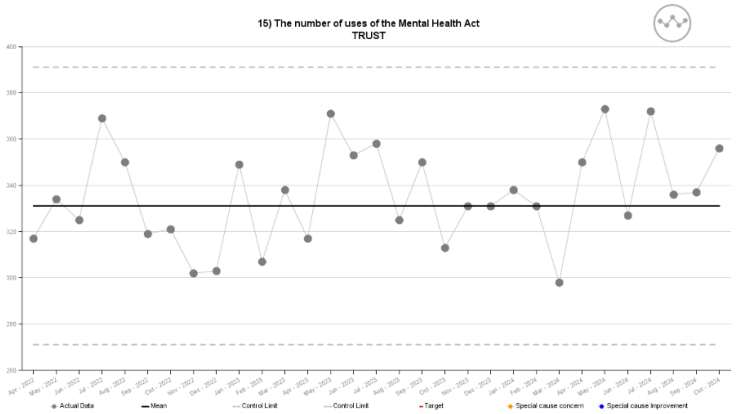
What does the chart show/context:
There were **356** uses of the Mental Health Act during October .

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

DQ ✓✓ 87%



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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

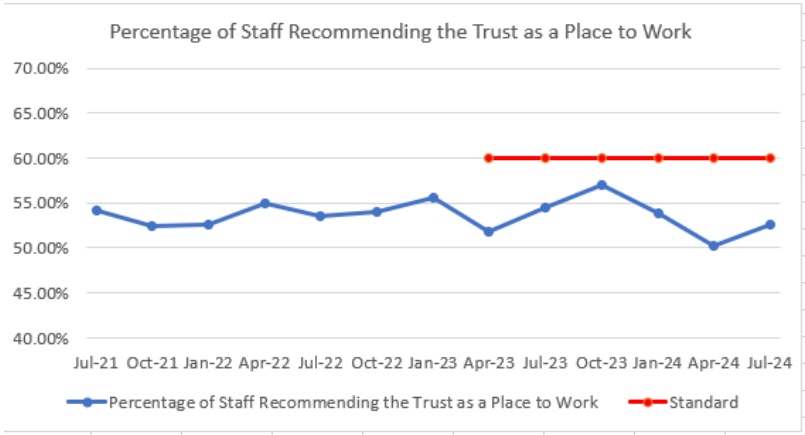
What does the chart show/context:
1,244 staff responded to the July 2024 Pulse Survey. In relation to the question "I would recommend my organisation as a place to work", **655 (52.65%)** responded either "Strongly Agree" or "Agree".

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

NB: *We previously identified that the number of responses being used in the calculation was not consistent. Whilst we have resolved the quarterly Pulse Survey data, we are still progressing the Annual Staff Survey data.*

Underlying issues:
We are not capturing the views of all our staff (approximately 15% in July); therefore, this is not a comprehensive picture.

Actions:
The Organisational Development Team and People Partners to provide advice and guidance to support the Services to develop targeted action plans over the next 6 months and report into Executive People Culture and Diversity and People Culture & Diversity Committee. Originally to be completed by the end of September 2024, action plans will now be completed by the end of October 2024. (**Not completed)** These will now be completed by the end of December 2024.



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

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
1,244 staff responded to the July 2024 Pulse Survey. In relation to the question "I am able to make improvements happen in my area of work", **780 (62.70%)** responded either "Strongly Agree" or "Agree".

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

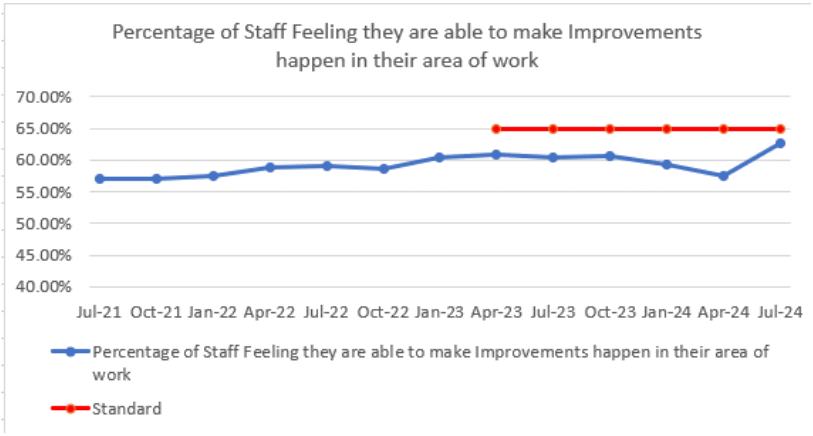
NB: *We previously identified that the number of responses being used in the calculation was not consistent. Whilst we have resolved the quarterly Pulse Survey data, we are still progressing the Annual Staff Survey data.*

Underlying issues:
We are not capturing the views of all our staff (approximately 15% in July); therefore, this is not a comprehensive picture.

Actions:
The Organisational Development Team and People Partners to provide advice and guidance to support the Services to develop targeted action plans over the next 6 months and report into Executive People Culture and Diversity and People Culture & Diversity Committee. Originally to be completed by the end of September 2024, action plans will now be completed by the end of October 2024. (**Not completed)** These will now be completed by the end of December 2024.

DQ

80%



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

18) Staff Leaver Rate

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

What does the chart show/context:
From a total of **7,306.74** staff in post, **784.37 (10.73%)** had left the Trust in the 12-month period ending October 2024.

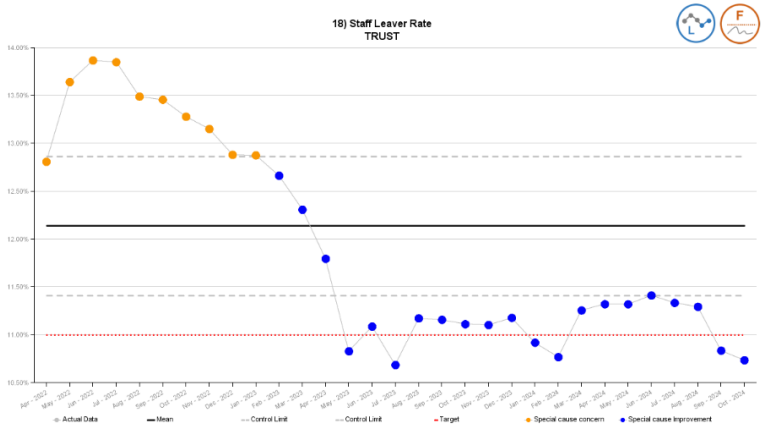
There is special cause improvement at Trust level and for Company Secretary, Corporate Affairs & Involvement, Digital & Data Services, Durham Tees Valley & Forensic Care Group, Medical, North Yorkshire, York & Selby Care Group and Therapies in the reporting period. However, there is special cause concern for the Assistant Chief Executive Directorate, People & Culture, and Health & Justice and Mental Health Services for Older People within Durham Tees Valley & Forensic Care Group (the directorates have confirmed there are no underlying issues).

The latest (August 2024) National Benchmarking for NHS Staff Leaver Rate published on NHS England NHS Oversight Framework Dashboard shows we were ranked **32** (previously ranked 28) of 71 Trusts Mental Health & Learning Disability Trusts (1 being the best with the lowest leaver rate) and are placed in the interquartile range.

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

Actions:
- The revised PIP for e-Roster effectiveness focused on having 80% of rotas published in line with the Trust target and 80% of teams achieving target for annual leave level loading by the 1st July 2024. We have achieved 83% of rotas published, better than Trust target. The action on annual leave level loading was extended to the 31st October 2024. (**Not completed)** Trajectory to be discussed and agreed at the December Safer Staffing Group.

DQ ✓✓ 87%



19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

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

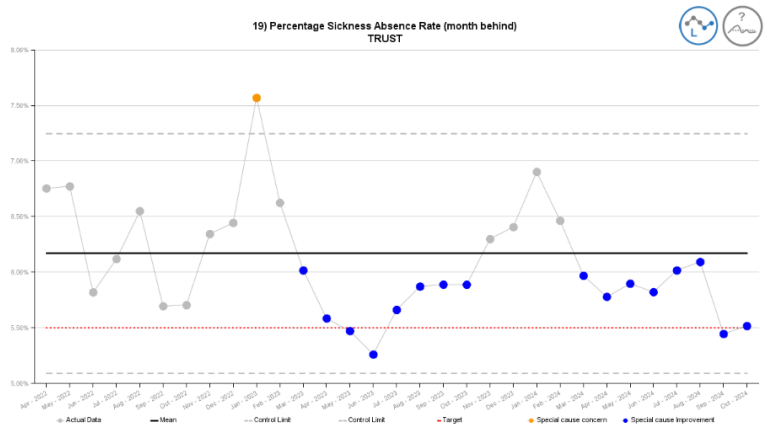
What does the chart show/context:
There were **223,464.53** working days available for all staff during September (reported month behind); of those, **12,328.91 (5.52%)** days were lost due to sickness.

There is special cause improvement at Trust and Care Group level in the reporting period. There is special cause concern for Assistant Chief Executive and Corporate Affairs & Involvement and Management within Durham, Tees Valley & Forensic Care Group.

National Benchmarking for NHS Sickness Absence Rates published 24th October 2024 (data ending June 2024) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is 5.54**%** compared to the Trust mean of **6.10%**, with the Trust ranked 37 of 48 Mental Health Trusts (1 being the best with the lowest sickness rate).

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

Actions:
- ACE and CA&I Directorate sickness is being managed through appropriate processes, with mitigating actions established. Most sickness is non-work related. In CA&I, staff are returning to work and report a further reduced absence rate for October; in ACE all staff will have returned to work by the end of November 2024.
- DTVFCG People Partners to link in with all services rated poor or very poor in the sickness audits by the end of October 2024 to share the outcome of the audit and the actions required. **(Completed)** a summary report on action progress will be presented to the November Care Group Board.
- NYYSCG Principal People Partner to present a report on the findings of the sickness audits, including recommendations, to the North Yorkshire York & Selby Care Group by the end of December 2024.
- Principal People Partners have reviewed causes of long-term sickness to identify the impact of organisational processes. The findings from this were to be presented to the Care Group Governance Meetings by the end of October 2024 (initially August 2024) **(Not completed)** The DTVFCG report was presented at the November meeting; the NYYSCG report will be presented in December.



20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
178,046 training courses were due to be completed for all staff in post by the end of October. Of those, **154,641 (86.69%)** were completed.

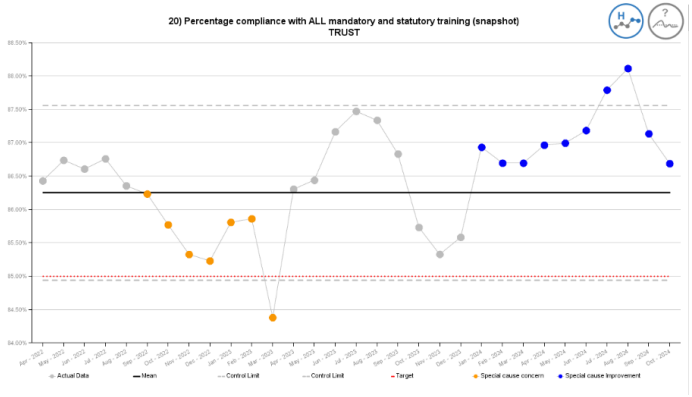
There is special cause improvement at Trust level and for most areas in the reporting period. There is special cause concern for Estates & Facilities Management but above standard.

As at the 31st October 2024, by exception compliance levels below 85% are shown in the bottom right-hand table. We are currently focusing on the lowest 5 compliance levels, plus the lowest core compliance.

	Number Complaint	Total Number	% Compliant
1) TRUST FINANCING	386	638	60.50%
2) COMPANY SECRETARY	120	145	82.76%
3) THERAPIES	2422	2901	83.49%
4) NURSING AND GOVERNANCE	1611	1919	83.95%

Underlying issues:
- This measure has been updated to incorporate the requirement for all staff including Bank to complete Information Governance Data Security training. Bank staff are aligned to Trust Financing, which has impacted compliance.

Actions:
- Head of Performance to liaise with the Head of Information Governance and Data Protection and Temporary Staffing Manager to better understand the issue and identify improvement actions.
- There is a significant program of work following the QI Event which includes several workstreams, one of which is to review all Mandatory Training requirements. Originally planned for the end of September 2024, action plans will now be completed by the end of October 2024. **(Not completed)**. EDG have a session on the 6th January 2025 with all their subject matter experts to review and reduce the Training Needs Analysis.



20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

Lowest 5 plus Lowest Core Compliance

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

What does the table show/context:
We have **19** courses that are currently below the standard. We are currently focusing on the lowest 5 compliance levels, plus the lowest core compliance.

Underlying issues:
- Staff unable to be released to attend training (high DNA rate)
- Reduced capacity for Positive & Safe training courses to manage the backlog
- Lack of suitable training rooms within Durham and North Yorkshire
- Lack of available courses for Incident Reporting Level 1

Actions:
- Training Department are actively following up all staff who do not attend their training sessions.
- The training portfolio for Positive & Safe is to be reviewed in line with the addition of courses for Trust Welcome. Originally planned for the end of September 2024 this will be implemented from January 2025.
- Care Groups were to develop trajectories for achieving compliance for the lowest 5 training courses and Fire Safety 2 training and present these to the September EDG for a focused discussion. **(Completed)**
- The trajectory for Resuscitation – Level 3 – Adult Immediate Life Support – 1 Year has not been achieved and we are now expecting to achieve 84% compliance by the end of March 2025, pending the release of new training dates in April.
- Extra dates have been added to support Incident Level 1 training and E-Learning is expected to be available by the end of November 2024.

	Number Complaint	Total Number	% Compliant
1) Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year*	525	867	60.55%
2) Resuscitation - Level 1 - 1 Year*	1563	2534	61.68%
3) Positive and Safe Care Level 2 Update*	1032	1630	63.31%
4) Rapid Tranquilisation 1	198	300	66.00%
5) Incident Reporting Level 1	5077	7618	66.64%
6) Resuscitation - Level 2 - Adult Basic Life Support - 1 Year*	1353	1982	68.26%
7) Positive & Safe Care Level 1*	2972	4276	69.50%
8) Face to Face Medication Assessment	1604	2252	71.23%
9) Moving and Handling - Level 2 - 2 Years*	724	916	79.04%
10) Safe Prescribing	227	279	81.36%
11) Annual Medicines Optimisation Module	1761	2149	81.95%
12) Mental Health Act Level 2	3140	3830	81.98%
13) Infection Prevention and Control - Level 2 - 1 Year	4944	6018	82.15%
14) MCA - MCA and Young People Aged 16/17	727	881	82.52%
15) MCA - Relationship Between MCA and MHA	3334	4022	82.89%
16) MCA - Restraint	3334	4022	82.89%
17) MCA - Deprivation of Liberty	3364	4015	83.79%
18) Fire Safety - 2 Years**	6662	7898	84.35%
19) Patient Safety Level 2	4785	5672	84.36%

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

21) Percentage of staff in post with a current appraisal

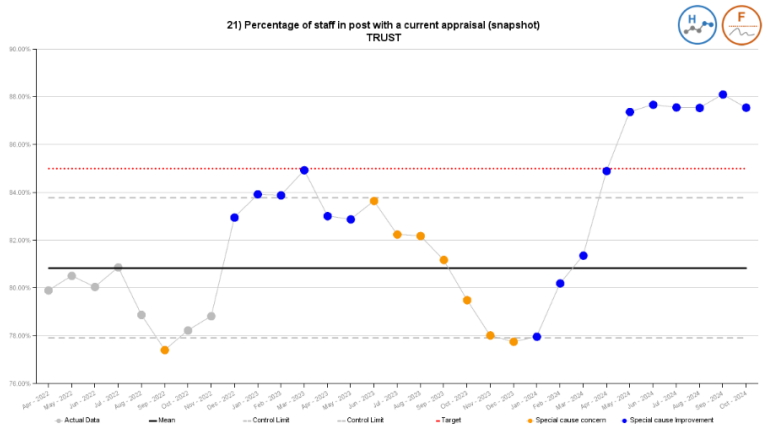
Background / standard description:
We are aiming for 85% of staff in post with a current appraisal

What does the chart show/context:
Of the **6858** eligible staff in post at the end of October; **6004 (87.55%)** had an up-to-date appraisal.

There is special cause improvement at Trust level and for most areas in the reporting period.

As at the 31st October 2024, by exception compliance levels below 85% are as follows:

	Number Complaint	Total Number	% Compliant
1) COMPANY SECRETARY	6	12	50.00%
2) CORPORATE AFFAIRS AND INVOLVEMENT	27	37	72.97%
3) ESTATES AND FACILITIES MANAGEMENT	327	390	83.85%
4) NORTH YORKSHIRE, YORK AND SELBY	1363	1610	84.66%



Underlying issues:
- We have a small number of directorates not achieving standard (*see above*).
- A number of NYYSCG staff are aligned to an incorrect service on ESR.

Actions:
- The Company Secretariat has been impacted by staff absence on which EDG are fully cited. Efforts are being taken to undertake the outstanding appraisals as quickly as possible.
- Outstanding appraisals will be undertaken in Corporate Affairs & Involvement by the end of December 2024.
- Outstanding appraisals will be undertaken in Estates & Facilities Management by the end of November 2024. Heads of Service have established processes to monitor all staff who move to an amber status for upcoming appraisals.
- NYYSCG were taking action to complete outstanding appraisals to achieve standard by the end of October 2024. (**Partially completed**) It has now been identified that a group of staff are incorrectly aligned on ESR. (*See below action*)
- Managing Director, Finance and People & Culture to follow up progress on the work being undertaken to realign staff to the correct teams on ESR. Timescale to be confirmed.

Actions continued:
- Organisational Development to lead the development of a new immersive and interactive training package for appraisals by the end of March 2025.

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

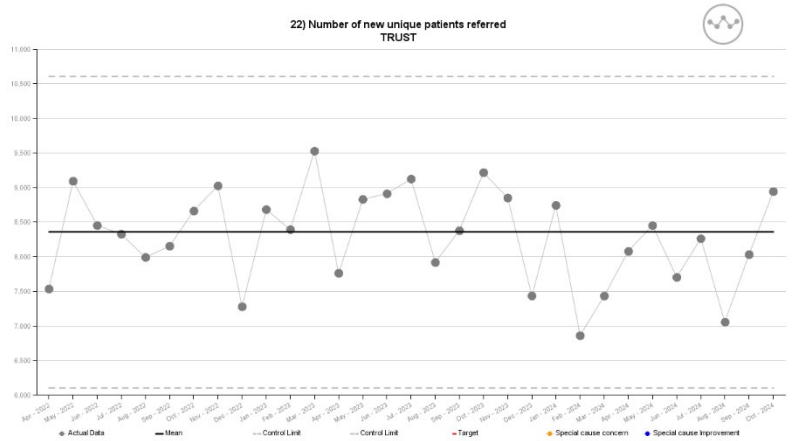
What does the chart show/context:
8943 patients referred in October that are not currently open to an existing Trust service.

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required

DQ ★ 93%



23) Unique Caseload (snapshot)

Tees, Esk and Wear Valleys NHS Foundation Trust

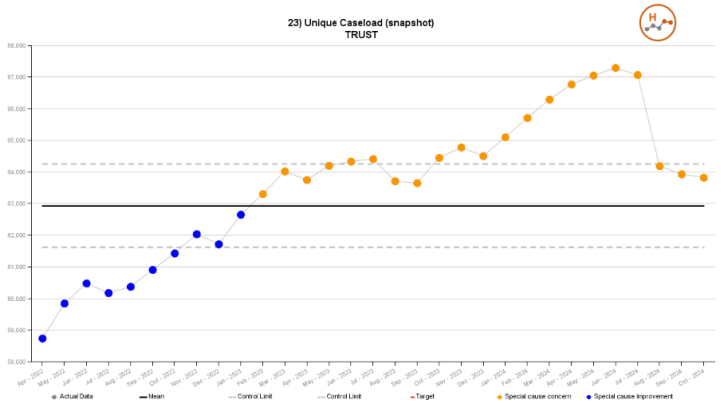
What does the chart show/context:
67,291 cases were open, including those waiting to be seen, as at the end of October 2024.

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

Whilst there is special cause concern indicated in the SPC charts noted above, this is not necessarily an actual concern as we know from the detailed analysis previously undertaken, unique caseload is impacted by the increase in patients **waiting** for a first contact.

Underlying issues:
- This measure currently includes patients waiting for a first contact, which does not provide a true reflection of active caseload.
- Concern remains for the significant number of neuro-diverse patients waiting for assessment (approximately 21k patients which equates to **31**% of the caseload).
    - We have had an 91% increase in the number of children and young people waiting between May 2022 and October 2024.
    - We have had a 134% increase in the number of adults waiting within DTVFCG between October 2023 and October 2024.

Actions:
- Corporate Performance and Business Intelligence teams to work collaboratively to develop a supporting measure for active caseload. Timescale to be confirmed.
- DTVFCG CYPS have developed a Recovery Plan to address the long waiting times within CYPS Neurodevelopmental teams.
- Findings of the caseload deep dive on CYP services have been shared with the Care Groups who will now collectively agree next steps by the end of January 2025 and present back to EDG.
- A focused deep dive on DTVFCG AMH active caseload has been stood down and new actions added to the PIP, which support the Durham Community Services Restructure. These are the creation of a neurodevelopmental team and streamlining of community teams by the end of March 2025.



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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

P — Our system is hitting the target/expectation

DQ ★ — 93%

What does the data show/context:

The financial position to 31st October 2024 against which Trust performance is assessed is a deficit of **£1.026m which amounts to a £1.708m favourable variance against plan**. The Trust submitted a breakeven plan for 2024/25 which assumes delivery of challenging 4.5% or £21.78m Cash Releasing Efficiency Scheme (CRES) Plans.

- **Agency expenditure** for the year to date is £6.68m, which is £0.81m below plan. In month costs were £1.02m which is an increase of £0.16m from prior month, and slightly above average year to date run rates. There was a 36% increase in medical shifts, 15% increase in nursing and 10% increase in AHP. Plans for 2024/25 assumed agency costs remain below the national cap of 3.2% of paybill. Performance in month was 2.42% including pay award arears, 2.88% on a consistent basis and 3.07% including 1/7 of the actual pay award. YTD performance is 2.79%, 2.87% and 2.77% respectively. The Trust has achieved significant agency WTE and expenditure reductions since April 2023 (though minor recent increases in August and October 2024). This reflects sustained impacts from actions to exit non-clinical agency assignments, reducing costs relating to complex care packages for a small number of adults with a learning disability, and reducing inpatient agency headcount. Ongoing albeit reducing usage includes high premia rate locum costs for cover of Health and Justice vacancies and, until October, for medical vacancy cover. The Temporary Staffing Service is now supporting incremental rate reductions in the former. The trust continues to have **no off-framework agency assignments**.
- **Independent sector beds** - the Trust used 90 non-Trust bed days in month (111 in September) which represented a decrease of 21 bed days from the previous month. Year to date costs were £0.68m, which includes estimates for unvalidated periods of occupancy and average observation levels pending billing and is £0.50m below plan. This remains a key area of volatility, and consequently clinical and management focus including through the Urgent Care Programme Board (chaired by the Managing Director for DTVF) is required. Bed pressures, including from elevated numbers of those who are clinically ready for discharge, mean that sustaining low (and delivering nil targeted) independent sector bed utilisation remains very challenging.
- **Taxis and Secure Patient Transport** costs were £1.45m (£207k average run rate) to 31st October compared to a plan, based on exit run rates, of £178k per month (or £1.246m for 7 months), and a £200k adverse variance to plan. Annual costs for 2023/24 were £2.675m, which was £1.0m higher than plan, and equated to a monthly average run rate of £223k. A quality improvement event was held in 2023 which recommended grip and control actions and development of a new policy. Due to limited sustained impact an improvement workshop is taking place on 20th November including both Care Groups and corporate teams. Procurements for both taxis and secure transport are expected to reduce unit costs / improve oversight during the later stages of 2024/25.
- 2024/25 plans assume delivery of 4.5% £21.78m **Cash Releasing Efficiency Savings (CRES)** for the year, with £15.7m planned schemes being recurrent and £6.055m non–recurrent. £2.055m unidentified non-recurrent CRES assumed at plan has now been fully identified from corporate, estates/facilities and central directorates and has been transacted in October 2024. Year to date CRES are £0.286m behind plan, but with recurrent schemes delivering £0.446m behind plan and non-recurrent schemes delivering £0.732m ahead of plan.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Underlying issues:

- We need to reduce bed occupancy including through reduced lengths of stay to reduce reliance on independent sector beds. This will require support from local authority system partners, including due to rising and sustained high levels of patients who are clinically ready for discharge.
- We recognise that agency expenditure and safe staffing levels are significantly impacting our financial plan due to numbers of staffing above funded levels and including agency premia rates (including 42% of agency shifts being above price cap), and in part reflecting over occupancy linked to the above.
- We need to deliver CRES schemes to achieve our financial plan and deliver recurrent programmes to address our underlying financial pressures.

Actions:

- Please see actions within measures 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider.
- The revised PIP for e-Roster effectiveness focuses on having 80% of rotas published in line with the Trust target and 80% of teams achieving target for annual leave level loading by the 1st July 2024. We achieved 83% of rotas published which is marginally better than the Trust target of 80%. However, the action on annual leave level loading was not completed and EDG have approved an extension to the end of October 2024. **(Not completed)** timescales to be confirmed.
- The Agency Reduction PIP is progressing. Three actions have been completed and have had the desired impact: an increased number of bank workers to reduce Health Care Assistant Agency usage in DTVFCG, a review of the outsourcing timeframes within DTVFCG, and an increased number of bank workers to reduce Health Care Assistant Agency usage in NYYSCG. In DTVFCG work to reduce the number of shifts filled by agency has been completed and whilst the desired 23% reduction has not been achieved, there has been a 15% reduction. The cessation of accommodation costs has been extended to the end of November. An additional action to re-negotiate rates of pay with framework agencies for Health & Justice registered nurses and all new Health & Justice registered nurses to be within price caps will be completed in a phased approach, by the 31st January 2025. Phase 1 of the reduction of agency cap rates has been completed with the desired impact.
- An Efficiency Hub has been set up to oversee delivery of CRES and provide support to Care Groups / Directorates.
- In addition to delivery of identified in-year CRES, the Efficiency Hub will provide support to enable focus on key strategic financial recovery actions including to manage and reduce over-establishments, track benefits from International Recruitment, ensure the efficient rostering of inpatient staffing and linked to inpatient occupancy, flow and Out of Area Placements. It will also support the transformation programmes to identify and realise associated benefit. Progress will be supported by recruitment to a recently approved additional Finance post.
- Information on workforce spend (both financial and WTE) has been enhanced and will be available for all relevant managers to view and analyse in terms of driving efficiency.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

Year to date agency costs of £6.68m at Month 7 are £0.81m below plan. In-month expenditure of £1.02m is £0.04m higher than plan and £0.16m higher than month 6. Spend in month was 2.42% including pay award arears, 2.88% on a consistent basis and 3.07% including 1/7 of the actual in year pay award.

NHS planning guidance for 2023/24 introduced system agency cost caps of 3.70% pay bill, reducing to 3.2% pay bill for the 2024/25 financial year. YTD spend is 2.79% including pay award arears, 2.87% on a consistent basis and 2.77% of the in year pay award, having reduced from around 4.5% on average through 2023/24 and 6% on average through 2022/23.

Reducing agency shifts and medical / health and justice shifts paid above national price caps remains a key focus. Agency shifts have reduced equivalent to 134 worked Whole Time Equivalent (WTE) from April 2023 (240 WTE) to October 2024 (106 WTE), and related annualised premia reduced from £4.0m in April 2023 to £3.5m in October 2024 (£0.5m reduction). Whilst the trend for medical WTE and price cap breaches was broadly positive between April 2023 and September 2024, assignments increased in October, going against that trend and having a significant impact on annualised premia. With that exception, run rates demonstrate positive impacts from actions taken to date and the benefit from sustained focus, including through framework compliance to reduce numbers of shifts breaching price caps.

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

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

Underlying issues:

We need to continue to ensure a sustainable permanent workforce, including in key shortage professions including medical and nursing (the latter notably to tackle price cap breaches in Health and Justice), to tackle high occupancy levels including driven by delayed transfers in inpatient wards (including with system collaboration) and to use temporary staffing more optimally including through improved rostering and regularly reviewing our safer staffing levels relative to clinical need.

Actions:

The Executive Directors Group (formerly Executive Workforce and Resources Group) will oversee the following actions to improve rostering:

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

25b) Agency price cap compliance

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:

2,133 agency shifts were worked in October 2024, with **1,236 shifts compliant** (58%) and **897 non-compliant** (42%) (prior month 1,226 shifts compliant or 64% and 678 non-compliant or 36%) **with national price caps**.

Most price cap breaches during 2024/25 have related to medical or prison nursing cover for hard to fill vacancies. In month 75% of non-compliant shifts (93% of value of breaches) are medical and 23% of non-compliant shifts (7% of value of breaches) are nursing. Of the nursing agency shifts, and 20% of shifts (primarily nursing) relate to prisons (8% of value of breaches). Breaches in medical shifts increased from 494 shifts in September to 674 in October 2024 (100% of medical shifts breach price cap).

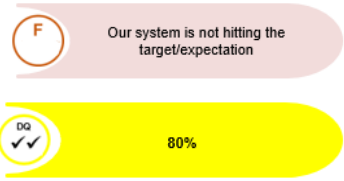
229 more overall shifts were worked this month compared to last, with shifts worked being equivalent to **approximately 69 shifts per day** (63 in September and 66 in August). The increase in month is due to 180 additional medical agency shifts (36% increase), 105 additional nursing agency shifts (15% increase) and 6 additional AHP agency shifts (10% increase), partly offset by a 62 shift reduction in HCA agency shifts (9% reduction). Actions are in train to review the implications for the medical staffing forecast.

Whilst an increase in month, this reflects a reduction in total shifts worked of 1,209 over the 12 months from 3,342 shifts worked in October 2023 and **a reduction of 64% or 340 shifts breaching price cap since September 2023** (1,237 shifts breached).

- The Trust's ability to reduce price cap breaches now almost entirely stems from recruitment challenges for medical and health and justice vacancies, but with both on downward trajectories currently.
- Further refinement of shift data relating to the above takes place up to the point that NHSE Temporary Staffing data is submitted mid-month, which may result in minor differences between reported data.
- We recognise that volume pressures and particularly price cap breaches and rate premia associated with agency expenditure significantly impact our financial plan. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance (Please see measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit).

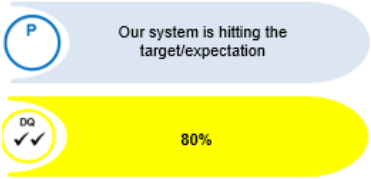
Underlying issues:
Particularly persistent challenges relate to levels of medical staffing and prison mental health nursing vacancies requiring cover from premia rate locum assignments which have consistently breached price caps during 2024/25.

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



26) Use of Resources Rating - overall score

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



What does the data show/context:

The overall rating for the trust is a **3** for the period ending 31st October.
The **Use of Resources Rating** (UoRR) was impacted by Covid-19 with national monitoring suspended. The Trust has continued to assess the UoRR based on plan submissions compared to actual performance.

- The **capital service capacity metric** assesses the level of operating surplus generated, to ensure Trusts can cover all debt repayments due in the reporting period. The Trust has a capital service capacity rating of **4**.
- The **liquidity metric** assesses the number of days' operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric is rated as **1.**
- The Income and Expenditure **(I&E) margin metric** assesses the level of surplus or deficit against turnover. The Trust has an I&E margin of -0.40% which is a **rating of 3**.
- The Income and Expenditure **(I&E)** margin distance from plan is 0.79% which is a **rating of 1.**
- **The agency expenditure metric** assesses agency expenditure against a 3.2% cap (set by NHSE) on agency spend as a proportion of pay. Costs of £6.68m are below plan and would therefore be **rated as a 1.** The Trust's year to date agency costs were 3.09% of pay bill.

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

The Trust's financial performance results is an **overall UoRR** of **3** for the period ending 31st October compared to a planned UoRR of 3.

Underlying issues:
The Trust's forward liquidity position is of concern, including as cash balances are deployed to progress capital programmes. As recovery actions are identified to support delivery of the Trust's planned breakeven position and improved agency compliance are targeted and progressed these will support achievement of the associated individual UoRR metrics and overall UoRR rating.

Actions:
There are no specific improvement actions required albeit that the Trust's wider financial strategy and medium term financial plan are subject to continued review.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Update:

Recurrent CRES performance for the period ending 31st October was £8.81m which was below plan by £0.45m. Month 6 recurrent CRES was £1.03m behind plan, the £0.58m in month improvement against plan includes the confirmed over-delivery of agency reduction CRES in Adult Mental Health within DTV.

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

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

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

- Schemes that are underperforming include International Nurse recruitment (behind by £0.46m), LED lighting (behind by £0.21m), Over Establishment (behind by £0.18m) and EFM non-pay (behind by £0.15m).

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

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

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Update:
Non Recurrent CRES performance was ahead of plan by £0.73m for the period ending 31st October, with £2.00m having being achieved.

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

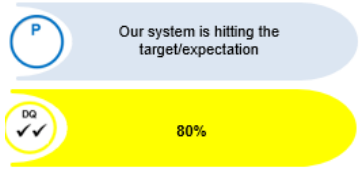
The Trust planned to deliver **£6.055m or 1.25% of non-recurrent** Cash-Releasing Efficiency Savings (CRES) for the year.

£4.0m of non-recurrent CRES had been identified in the plan, which left £2.055m to be identified. This has now been fully identified from corporate, estates/facilities and central directorates and has been transacted in October 2024. Work is ongoing to assess whether any of the additional schemes are recurrent schemes, potentially offering some mitigation to recurrent under performance.

Of the £0.73m overachievement year to date, £0.626m reflects non-recurrent mitigation of the Over Establishment Target, with an additional £0.073m reflecting a negotiated water rebate.

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

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



29) Capital Expenditure (Capital Allocation)

Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:

Capital expenditure was **£3.27m** at the end of October and **less than allocated by £1.47m**.

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

The Trust secured £2.14m of additional cash-backed central funding in 2024/25 to improve Information systems and assist creating our Mental Health hub in North Yorkshire. This is not included in performance measurement against the £8.93m capital allocated to the Trust through North East and North Cumbria ICB.

This means the Trust's **aggregate capital programme for 2024/25 is £11.43m** (including £0.37m PFI life-cycle).

The underspending for the year to date is linked to slippage against schemes and will be managed, including with Integrated Care System Partners, within this financial year.

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

Actions:
A key focus is on the milestone tracking of Programmes, including for sensor door installation and the final design of works to be completed at Jesmond House. Any anticipated delays to planned inpatient environment schemes are communicated to the Environmental Risk Group to manage any associated risks.

30) Cash balances (actual compared to plan)

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

The Trust had cash balances of **£57.65m** at the end of October 2024 which exceeded planned cash balances of **£53.64m** by **£4.01m** (favourable variance).

- This is mainly linked to the slippage in the capital programme and the favourable revenue plan variance, offset by central funding not yet received for capital projects. Cash is expected outturn in line with plan for 2024/25.
- The Trust has achieved a combined Better Payment Practice Code (BPPC) compliance of 95.0% to date for the prompt payment suppliers, which is in line with the 95% target. We continue to support the use of Cardea to make processes as efficient as possible, and to ensure suppliers are paid promptly.
- The value of debt outstanding at 31 October 2024 was £1.72m, with debts exceeding 90 days amounting to £0.35m (excluding amounts being paid via instalments and PIPS loan repayments). Progress continues to be made to receive payment for older debts. No outstanding debts have been formally challenged.

Underlying issues:

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

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

Actions:

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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

National Quality Standards and Mental Health Priorities Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines*

- **72 hour follow up** Whilst our system data reports we have failed target in County Durham, this is subject to manual validation as this measure has been impacted by Cito. The manual validation of April to October 2024 data confirms achievement of standard in all areas.
- **EIP waiting times** We have failed target in Vale of York and there is no significant change; however, we have achieved target in all other areas.
- **Talking Therapies waiting times (6 and 18 weeks)** Achieved target in all areas.
- **Child Eating Disorders waiting times:** Whilst we have failed target in all areas for **routine** referrals, there is special cause improvement indicated in the SPC charts. We have failed target in all areas for **urgent** referrals and there is cause for concern in North Yorkshire and Vale of York; however, there is no significant change in County Durham and improvement in Tees Valley. These are not areas of concern as the reasons were patient choice, patients required hospital admission, data quality and CITO issues; the latter of which have been addressed.
- **Talking Therapies: 1st to 2nd treatment waits** – We have failed target in all areas except for North Yorkshire. There is no significant change for Vale of York and cause for concern in County Durham and Tees Valley. **Reliable Recovery** We have failed targets in County Durham and Tees Valley and there is no significant change in both areas. **Reliable Improvement** failed targets in County Durham and Tees Valley and there is no significant change.
- **Children: 1 contact** We have failed target and there is special cause concern in all areas. **Paired Outcomes** failed target and no significant change in all areas, except for County Durham where there is special cause concern.
- **Access to transformed community services** We have failed target in County Durham, however achieved target in Tees Valley; there is special cause improvement for both areas as an increased number of PCNs (all in Tees Valley) have now completed transformation. We have failed target and there is no significant change in North Yorkshire and special cause concern in Vale of York.
- **Active OAP (inappropriate)** We have achieved plan in both ICB areas; however, there were 3 active OAPs as at the end of October.
- **Specialist Community Perinatal Mental Health (PMH) services** We have achieved target in County Durham and Tees Valley. We have failed target in North Yorkshire and Vale of York; however, there is special cause improvement in both areas.

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

National Quality Standards and Mental Health Priorities Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

- Talking Therapies waiting times (6 and 18 weeks)

Risks & Issues

- EIP Waiting Times (Vale of York)
- Talking Therapies 1st to 2nd treatment (County Durham, Tees Valley, Vale of York)
- Talking Therapies Reliable Recovery & Improvement (County Durham & Tees Valley)
- CYP 1 contact
- Childrens Paired Outcomes
- Access to transformed community services
- Specialist Community PMH services (North Yorkshire & Vale of York)

Mitigations

EIP Waiting Times (Vale of York)
Staffing capacity has returned to normal; it is anticipated the backlog of patients waiting will be addressed by the middle of December and from the end of December new patients will start treatment within 2 weeks.

Talking Therapies 1st to 2nd treatment (County Durham, Tees Valley, Vale of York)
DTVFCG have developed a PIP that will be submitted to the November Care Board for approval. Actions include using PWP capacity to increase treatment capacity; a review of patient pathways; the provision of rapid access through online wellbeing groups and cCBT (by the end of December); an increase in the number of Step 2 workshops; and improved Single Point of Access referral management processes (by the end of January 2025). NYYSCG have a PIP with an action to temporarily use assessment capacity to support treatment appointments. It had been anticipated that the full impact will be visible by the end of November (December report) but this is not on track for delivery. Next steps are being considered and will be confirmed by the end of December 2024.

Talking Therapies Reliable Recovery (County Durham & Tees Valley)
A process has been established to review every patient as they approach discharge and contacting those not achieving reliable recovery to consider the provision of additional intervention or attendance at the keeping well clinic. Team Managers to review/audit the records for every person who completes treatment without achieving reliable recovery to share learning.

Talking Therapies Reliable Improvement (County Durham & Tees Valley)
A PIP has been developed and will be submitted to the November Care Board for approval. Actions include a review of patient pathways, the provision of rapid access through online wellbeing groups and cCBT by the end of December 2024, and an increase in the number of Step 2 workshops and improved Single Point of Access referral management processes by the end of January 2025.

Whilst there are several mitigations described for Talking Therapies, we are concerned about Durham service's reported performance in relation to these key quality standards. The Deputy Chief Executive is to meet with Talking Therapies and Care Group leads (Trust-wide) to understand and agree a more robust position describing the associated issues and actions we are going to take.

National Quality Standards and Mental Health Priorities Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Risks/Issues and Mitigations

CYP 1 contact

The 2023/24 baseline data used to develop the 2024/25 plans was influenced by the short-term realignment of staff and overtime, particularly to address screening backlogs in neurodevelopmental services. This has now ended, resulting in expected 5% lower activity levels. The General Manager is to work with Finance to confirm the 5% drop in access is attributable to the return of staff to their substantive posts and the cessation of overtime. A business continuity plan is in place for the North Yorkshire and York and Selby SPA teams. To improve staffing capacity the service have recruited to all but 1 vacancy, with interviews planned in November. Ad hoc support from SPA staff through overtime and community teams remains in place however uptake is minimal. No further actions have been agreed at this stage.

Childrens Paired Outcomes

The first Trust-wide Outcomes & Safety Summit took place on the 6th November 2024, which was well attended by a range of clinical and operational staff across the specialties. Presentations were given on the importance of understanding our outcomes by our Clinical Lead for Community Transformation and the NHS England Senior Project Manager – Outcomes and Experience, as well as local examples of good practice by our CYP and Talking Therapies services. There were a number of group exercises undertaken to better understand the local challenges and what more can be done to improve outcome collection. The outputs of the event will be considered by the Clinical Outcomes Steering Group. The Trust-wide outcomes improvement plan was approved by EDG in December and oversight will be maintained through monthly reports into EDG.

Access to transformed community services (County Durham, North Yorkshire & Vale of York)

Three PCNs are still to transform in County Durham; they will be transformed by the end of March 2025. A refresh of historic data to realigned following the move of 14 GPs from Vale of York to North Yorkshire from the 1st April 2024 has now been completed and analysis will be undertaken by the end of November 2024 to identify any underlying areas of concern. Ripon Community team is in business continuity with a recovery plan in place. Recruitment of staff is underway and in the interim, posts have been back filled through 2 agency staffs. York & Selby EIP team is in business continuity with a recovery plan in place to address vacancies and sick leave.

Specialist Community PMH services (North Yorkshire & Vale of York)

Due to ongoing capacity issues, the Perinatal teams are currently being supported through a service recovery plan in line with business continuity processes. Short term sickness and vacancy is currently being mitigated by support from the wider Multi-Disciplinary team for care co-ordination and implementation of a Band 5-6 run through-post to mitigate against the difficulties in recruiting to a B6 care-coordination post. The Service Manager is working with the Planning Team to undertake a capacity and demand exercise by the end of December 2024, which will inform the ongoing actions for the recovery of the longer term structural and capacity pressures, and a Rapid Process Improvement Workshop is planned for January 2025 to identify and remedy any inefficiencies in process and structure and to further inform the service recovery plan.

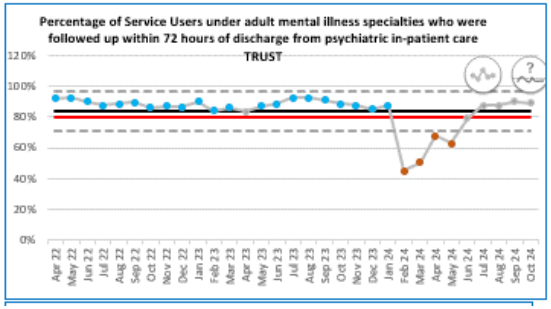
National Quality Standards and Mental Health Priorities Dashboard

Tees, Esk and Wear Valleys NHS Foundation Trust

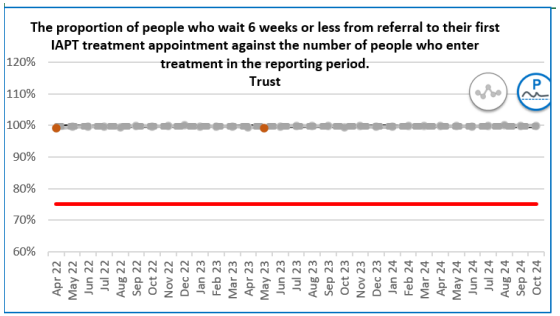
National Quality Requirements	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care		?	80%	80.61%	80%
Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care		?	60%	61.22%	60%
Percentage of Service Users referred to an NHS Talking Therapies programme who wait six weeks or less from referral to entering a course of NHS Talking Therapies treatment		P	75%	99.80%	75%
Percentage of Service Users referred to an NHS Talking Therapies programme who wait 18 weeks or less from referral to entering a course of NHS Talking Therapies treatment	H	P	95%	100%	95%
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks (rolling 12 months)	H	F	95%	90.79%	95%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week (rolling 12 months)		F	95%	73.68%	95%
Local Quality Requirements	**Variation**	**Assurance**	**Standard (FYTD)**	**Actual (FYTD)**	**Annual Standard**
Talking Therapies:Percentage of people who have waited more than 90 days between first and second appointments	H	?	<10%	29.52%	<10%
Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting caseness		?	48%	48.51%	48%
Talking Therapies: Reliable improvement rate for those completing a course of treatment		?	67%	66.97%	67%
Number of CYP aged 0-17 supported through NHS funded mental health with at least one contact (rolling 12 months)	L	?	29797	28112	29797
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period		F	40%	20.86%	40%
Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses (rolling 12 months)	H	F	22955	21470	22955
Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)		P	4	3	0
Number of women accessing specialist community PMH services in the reporting period (rolling 12 months)	H	F	1467	1461	1427

National Quality Requirements

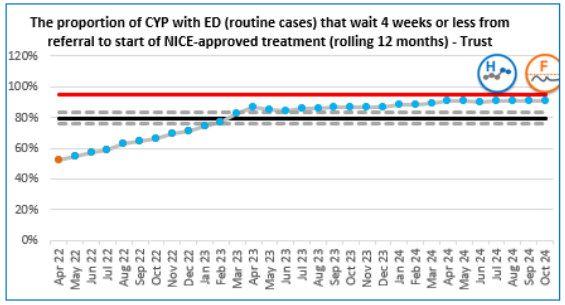
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



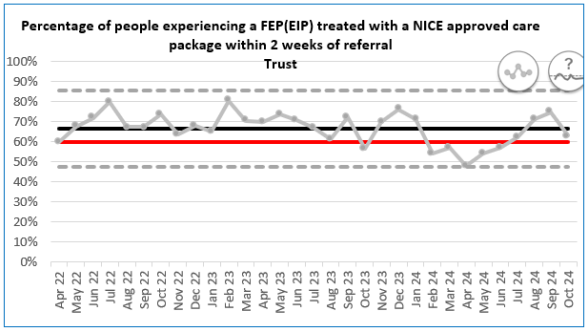
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	80%	80.61%			
County Durham	80%	78.42%			
Tees Valley	80%	80.23%			
North Yorkshire	80%	83.19%			
Vale of York	80%	84.18%			



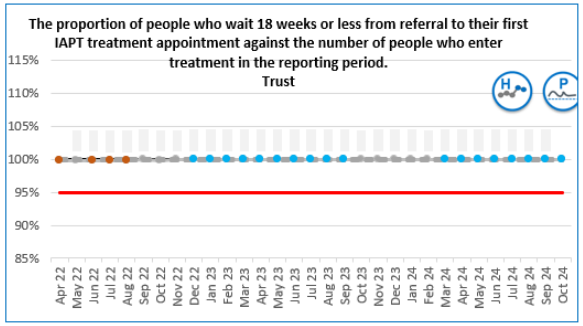
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	75%	99.80%			
County Durham	75%	99.89%			
Tees Valley	75%	99.79%			
North Yorkshire	75%	99.63%			
Vale of York	75%	99.85%			



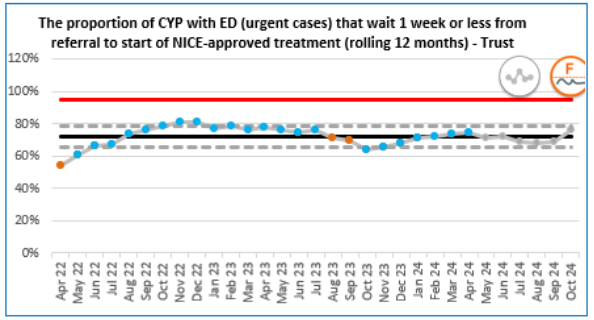
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	95%	90.79%			
County Durham	95%	86.76%			
Tees Valley	95%	94.05%			
North Yorkshire	95%	90.20%			
Vale of York	95%	91.43%			



Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	60%	61.22%			
County Durham	60%	60.26%			
Tees Valley	60%	66.90%			
North Yorkshire	60%	64.47%			
Vale of York	60%	39.02%			



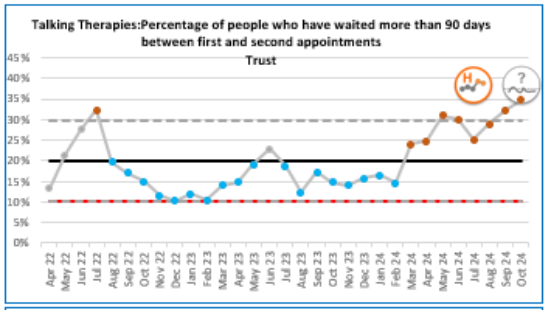
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	95%	99.99%			
County Durham	95%	100%			
Tees Valley	95%	100%			
North Yorkshire	95%	100%			
Vale of York	95%	99.96%			



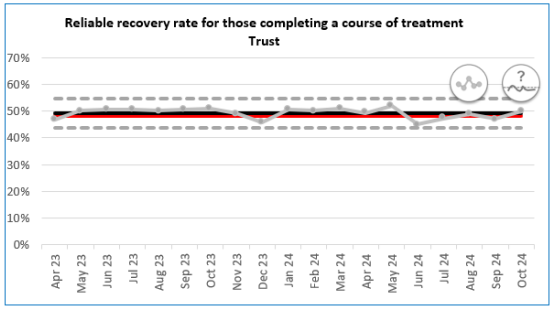
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	95%	73.68%			
County Durham	95%	78.79%			
Tees Valley	95%	90.91%			
North Yorkshire	95%	63.64%			
Vale of York	95%	33.33%			

Local Quality Requirements

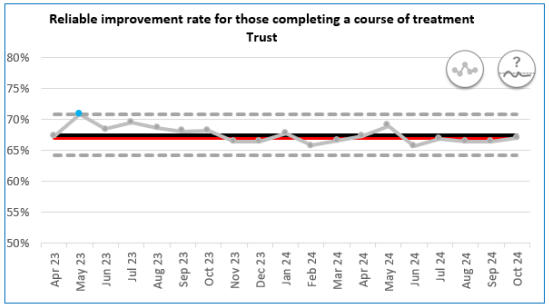
Tees, Esk and Wear Valleys NHS Foundation Trust



Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	<10%	29.52%			
County Durham	<10%	41.56%			
Tees Valley	<10%	48.59%			
North Yorkshire	<10%	8.78%			
Vale of York	<10%	35.23%			



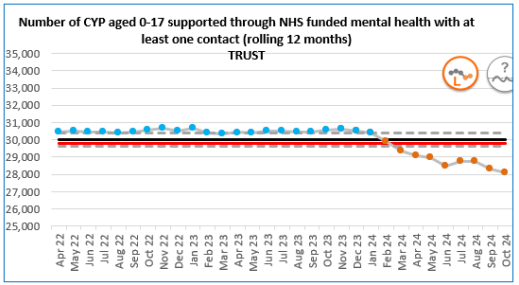
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	48%	48.51%			
County Durham	48%	46.13%			
Tees Valley	48%	46.72%			
North Yorkshire	48%	49.78%			
Vale of York	48%	52.33%			



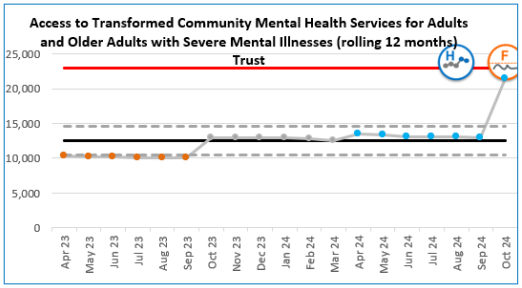
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	67%	66.97%			
County Durham	67%	63.80%			
Tees Valley	67%	62.08%			
North Yorkshire	67%	68.75%			
Vale of York	67%	73.01%			

Local Quality Requirements

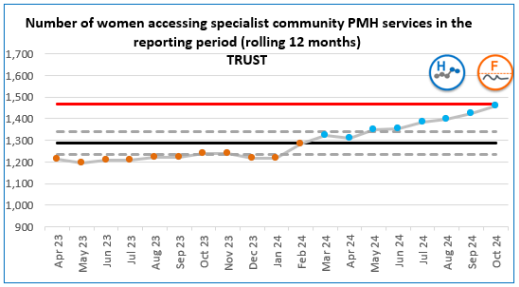
Tees, Esk and Wear Valleys NHS Foundation Trust



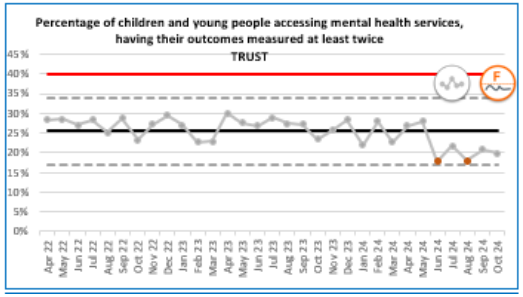
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	29797	28112			
County Durham	10012	9685			
Tees Valley	11218	10976			
North Yorkshire	4062	4648			
Vale of York	4505	2803			



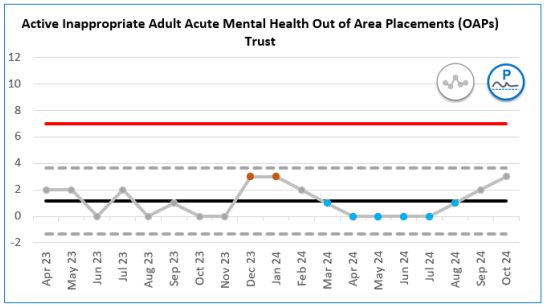
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	22955	21470			
County Durham	8240	6329			
Tees Valley	7535	8604			
North Yorkshire	4853	4444			
Vale of York	2327	2093			



Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	1427	1461			
County Durham	456	572			
Tees Valley	447	482			
North Yorkshire	368	280			
Vale of York	156	127			



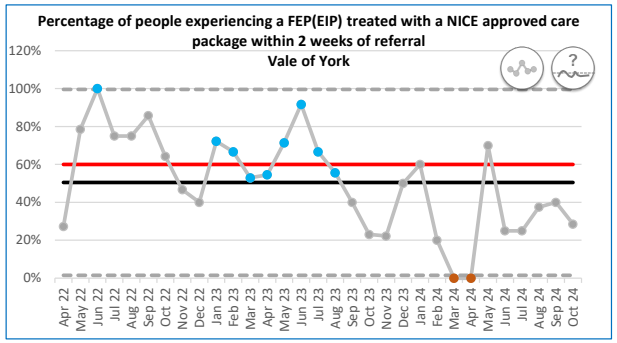
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	40%	20.86%			
County Durham	40%	17.24%			
Tees Valley	40%	24.69%			
North Yorkshire	40%	25.99%			
Vale of York	40%	15.58%			



Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	7	3			
County Durham	3	0			
Tees Valley		2			
North Yorkshire	1	1			
Vale of York		0			

Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust



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

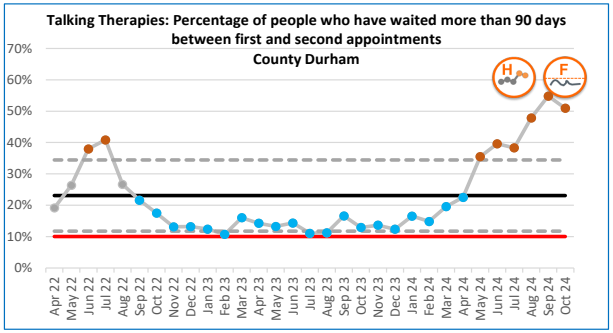
What does the chart show/context:
During October, **7** patients were placed on Early Intervention of Psychosis (EIP) pathway; of these, **2 (28.57%)** commenced a NICE approved treatment within 2 weeks within **Vale of York**.

Underlying issues:
Staffing capacity has been impacted by a number of vacancies, maternity leave and long-term sickness.

Update:
Staffing capacity has returned to normal, and the team have started offering 5 routine assessments and 1 urgent assessment each week. It is anticipated the backlog of patients waiting will be addressed by the middle of December and from the end of December new patients will start treatment within 2 weeks.

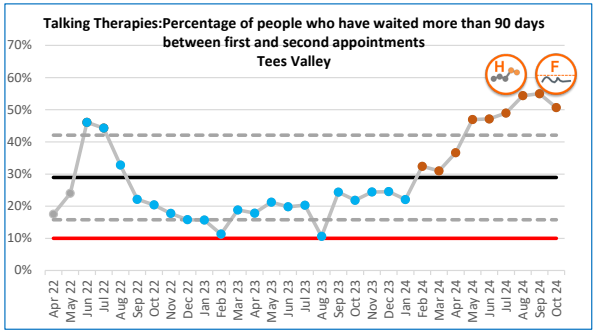
Talking Therapies: Percentage of people who have waited more than 90 days between first and second appointments – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust



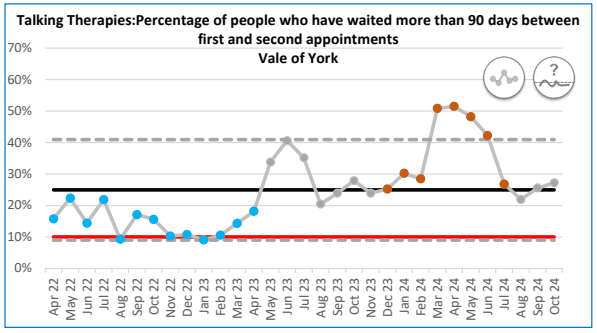
Background / standard description:
We are aiming to have less than 10% of people waiting more than 90 days between their first and second Talking Therapies appointment.

What does the chart show/context:
During October **807** had a second appointment with our services, of those **411 (50.93%)** people waited over 90 days between their 1st and 2nd appointment within **County Durham**.



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

What does the chart show/context:
During October **150** had a second appointment with our services, of those **76 (50.67%)** people waited over 90 days between their 1st and 2nd appointment within **Tees Valley**.



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

What does the chart show/context:
During October **261** had a second appointment with our services, of those **71 (27.20%)** people waited over 90 days between their 1st and 2nd appointment within **Vale of York**.

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

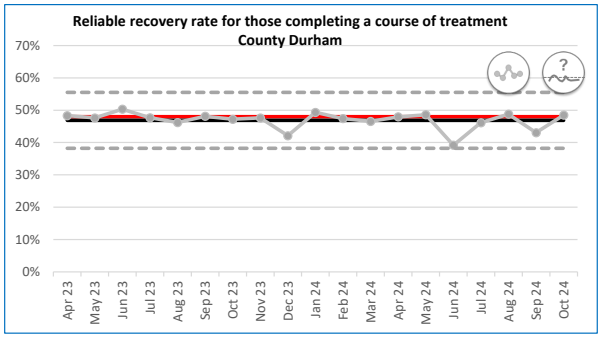
Actions:
- DTVFCG have developed a PIP that will be submitted to the November Care Board for approval. Actions include using PWP capacity to increase treatment capacity; a review of patient pathways; the provision of rapid access through online wellbeing groups and cCBT (by the end of December); an increase in the number of Step 2 workshops; and improved Single Point of Access referral management processes (by the end of January 2025).
- The Deputy Chief Executive is meeting with Talking Therapies and Care Group leads (Trust-wide) in December to understand and agree a more robust position describing the associated issues and actions we are going to take.

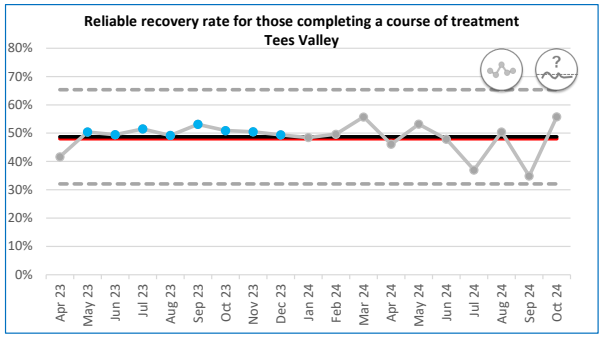
Underlying issues:
Underfunding within Step 2 and Step 3

Actions:
A performance improvement plan is in place; it had been anticipated that the full impact will be visible by the end of November (December report); however, this is not on track for delivery. Next steps are being considered and will be confirmed by the end of December 2024.

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

Tees, Esk and Wear Valleys NHS Foundation Trust





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

What does the chart show/context:
During October **559** patients completed a course of treatment, of which **271** demonstrated reliable improvement **(48.48**%) within **County Durham**.

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

What does the chart show/context:
During October **138** patients completed a course of treatment, of which **77** demonstrated reliable improvement **(55.80**%) within **Tees Valley**.

Underlying issues:

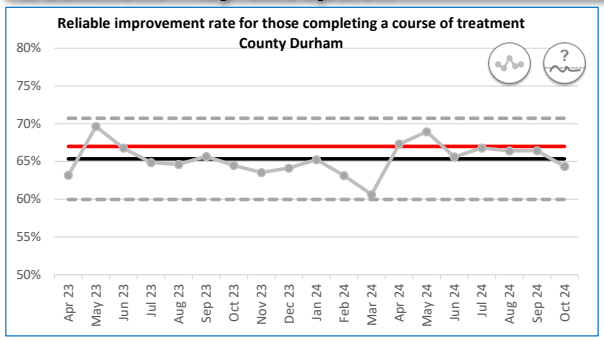
- Increase in complexity and severity of patient's presentation, which makes it more challenging to see a 6-point (Patient health questionnaire - PHQ9) or a 4-point (Generalised anxiety disorder - GAD) shift.
- A high number of patients do not attend appointments and, therefore, are not attending enough appointments to enable reliable recovery to be achieved.

Actions:

- A process has been established to review every patient as they approach discharge and contacting those not achieving reliable recovery to consider the provision of additional intervention or attendance at the keeping well clinic.
- Team Managers to review/audit the records for every person who completes treatment without achieving reliable recovery to share learning.
- The Deputy Chief Executive is meeting with Talking Therapies and Care Group leads (Trust-wide) in December to understand and agree a more robust position describing the associated issues and actions we are going to take.

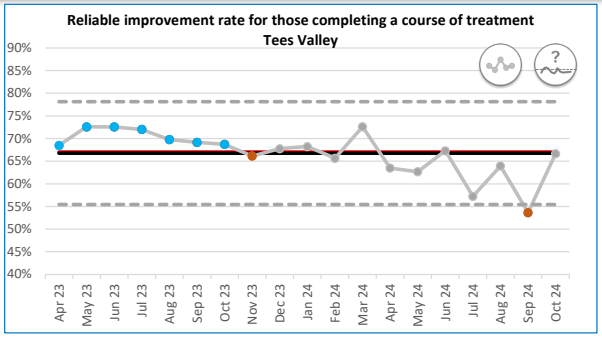
Talking Therapies: Reliable improvement rate for those completing a course of treatment – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust



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

What does the chart show/context:
During October **620** patients completed a course of treatment, of which **399** demonstrated reliable improvement **(64.35**%) within **County Durham**.



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

What does the chart show/context:
During October **150** patients completed a course of treatment, of which **100** demonstrated reliable improvement **(66.67**%) within **Tees Valley**.

Underlying issues:

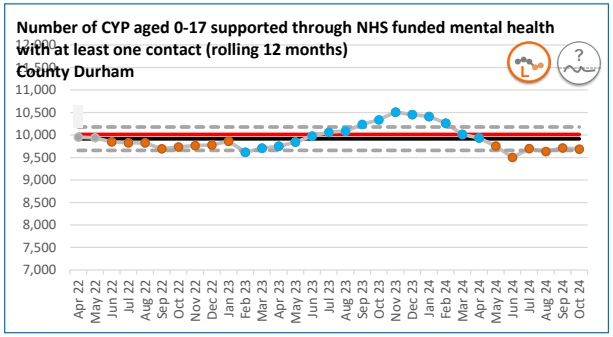
- High levels of complex patients are seeing a reliable improvement on two outcome measures (Patient health questionnaire - PHQ9 and Generalised anxiety disorder - GAD7); however, if an Anxiety Disorder Specific Measures (ADSM) is also undertaken and does not report an improvement, that supersedes the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

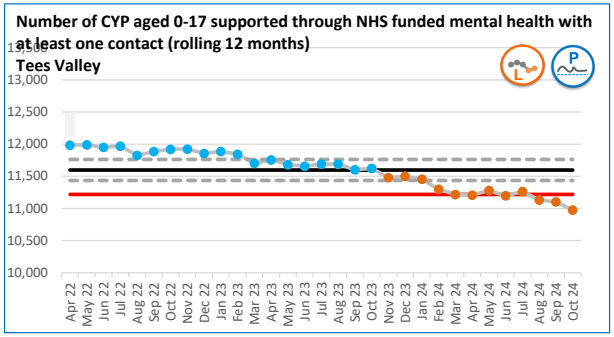
Actions:

- A PIP was to be developed by the end of August 2024; however, this was not completed. The PIP will now be submitted to the November Care Board for approval. Actions include a review of patient pathways, the provision of rapid access through online wellbeing groups and cCBT by the end of December 2024, and an increase in the number of Step 2 workshops and improved Single Point of Access referral management processes by the end of January 2025.
- The Deputy Chief Executive is meeting with Talking Therapies and Care Group leads (Trust-wide) in December to understand and agree a more robust position describing the associated issues and actions we are going to take.

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

Tees, Esk and Wear Valleys NHS Foundation Trust





Background / standard description:
We are aiming for **10,012** children or young people to be supported through NHS funded mental health with at least one contact in a 12-month rolling period.

What does the chart show/context:
In the 12-month period ending October 2024, **9685** children and young people aged between 0-17 were supported through NHS funded mental health with at least one contact within **County Durham**.

Background / standard description:
We are aiming for **11,218** children or young people to be supported through NHS funded mental health with at least one contact in a 12-month rolling period.

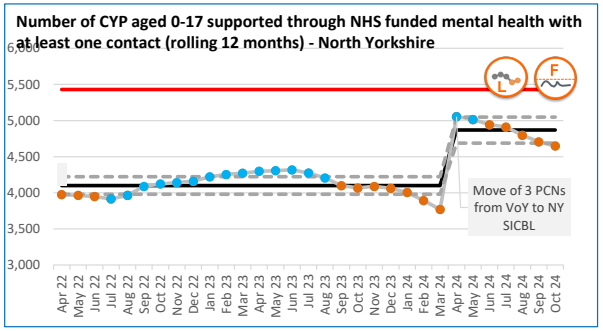
What does the chart show/context:
In the 12-month period ending October 2024, **10,976** children and young people aged between 0-17 were supported through NHS funded mental health with at least one contact within **Tees Valley**.

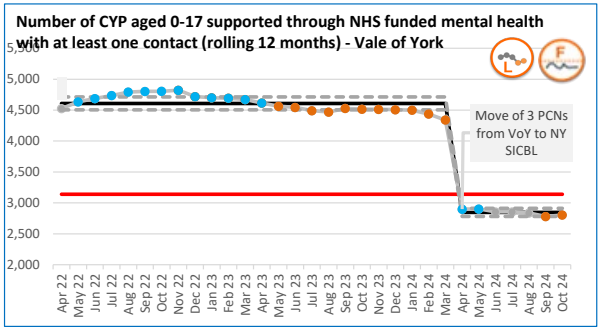
Underlying issues:
- The implementation of the Cito roll out is having an impact on performance due to issues with activity recording and lack of understanding around document sign off procedures.
- 2023/24 baseline data used to develop the 2024/25 plans was influenced by the short-term realignment of staff and overtime, particularly to address screening backlogs in neurodevelopmental services. This has now ended, resulting in expected 5% lower activity levels.
- Vacancies, sickness and maternity leave are impacting capacity

Actions:
- General Manager to work with Finance to confirm the 5% drop in access is attributable to the return of staff to their substantive posts and the cessation of overtime. This work will be completed by the end of November 2024.
- The service are recruiting to the vacant nursing posts in the neuro pathway and Tees Getting More Help Team, in addition to 2 clinical nurse specialists in South Durham.

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

Tees, Esk and Wear Valleys NHS Foundation Trust





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

What does the chart show/context:
In the 12-month period ending October 2024, **4648** children and young people aged between 0-17 were supported through NHS funded mental health with at least one contact within **North Yorkshire**.

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

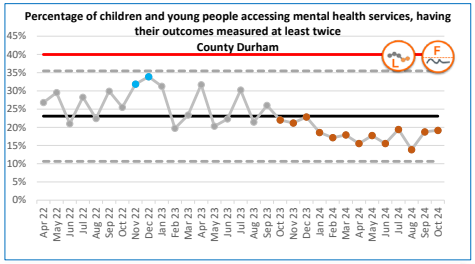
What does the chart show/context:
In the 12-month period ending October 2024, **2803** children and young people aged between 0-17 were supported through NHS funded mental health with at least one contact within **Vale of York**.

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

Actions:
A business continuity plan is in place for the North Yorkshire and York and Selby SPA teams. To improve staffing capacity the service have recruited to all but 1 vacancy, with interviews planned in November. Ad hoc support from SPA staff through overtime and community teams remains in place however uptake is minimal. No further actions have been agreed at this stage.

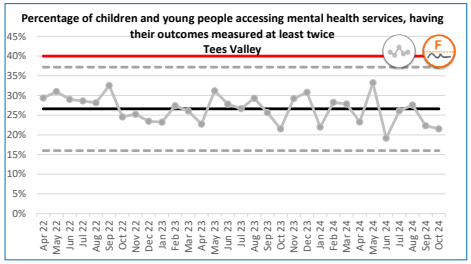
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust



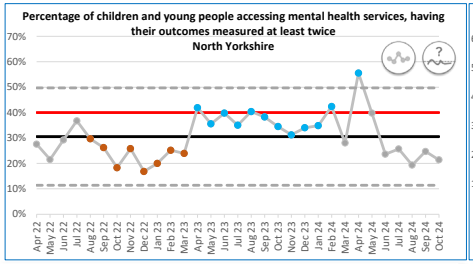
Background / standard description:
We are aiming for **40%** of closed referrals that have at least two contacts with a paired outcome measure completed.

What does the chart show/context:
During October **485** patients were discharged with at least two contacts; **93 (19.18%)** of these had a paired outcome measure within **County Durham**.



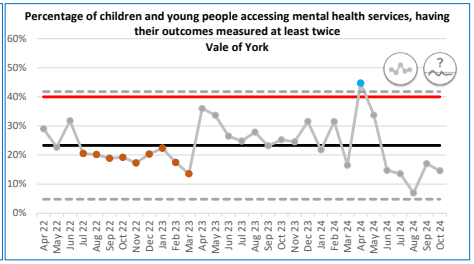
Background / standard description:
We are aiming for **40%** of closed referrals that have at least two contacts with a paired outcome measure completed.

What does the chart show/context:
During October **460** patients were discharged with at least two contacts; **99 (21.52%)** of these had a paired outcome measure within **Tees Valley**.



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

What does the chart show/context:
During October **215** patients were discharged with at least two contacts; **46 (21.40%)** of these had a paired outcome measure within **North Yorkshire**.



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

What does the chart show/context:
During October **130** patients were discharged with at least two contacts; **19 (14.62%)** of these had a paired outcome measure within **Vale of York**.

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

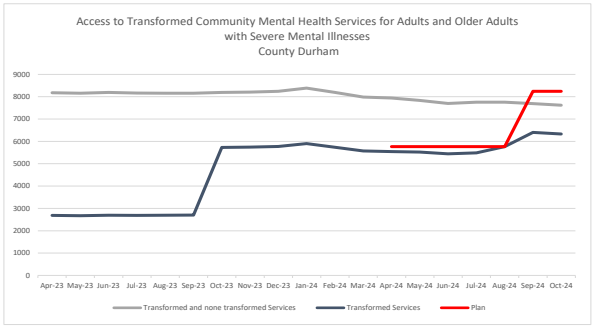
Actions:
DTVFCG have developed a PIP, which will be presented to the November Care Group Board for approval. Actions include establishing ROMs links in every team and a Task & Finish Group to support the new access standards by the end of December 2024, embedding reporting through governance and quality and performance discussions by the end of January 2025, reviewing the CAMHS core pathway guidance and undertaking targeted work to embed ROMs within the neuro teams by the end of March 2025.

Underlying issues (specific to North Yorkshire & York):
- Community, Autism and ADHD teams are not recording clinical outcome consistently during patients' journeys.

Actions:
- Specialist Practitioner in Children and Young People Clinical Outcomes Development to provide support and guidance to all NYYSCG teams on the appropriate use of outcome measures, ensuring they are paired, by the end of December 2024.
- Clinical Outcome Champions to be established for all NYYSCG teams by the end of December 2024.

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

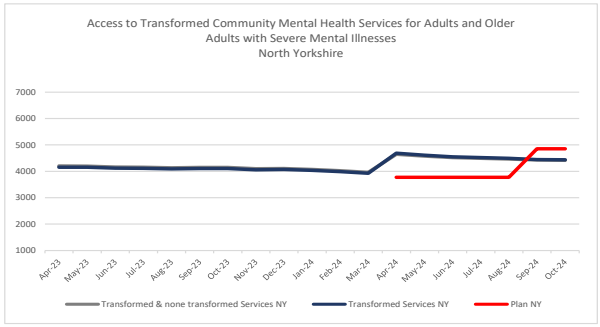


Background / standard description:
We aim to have **8240** adults and older people with severe mental illness accessing transformed community mental health services in a 12-month rolling period.

What does the chart show/context:
In the 12-month period ending October 2024 **6329** adults and older people were accessing Transformed Community Mental health services within **County Durham**.

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

Actions:
The remaining three PCNs will be transformed by the end of March 2025.

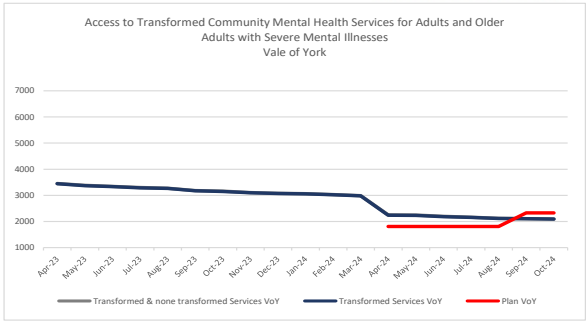


Background / standard description:
We aim to have **4853** adults and older people with severe mental illness accessing transformed community mental health services in a 12-month rolling period.

What does the chart show/context:
In the 12-month period ending October 2024 **4444** adults and older people were accessing Transformed Community Mental health services within **North Yorkshire**.

Underlying issues:
- Ripon Community is impacted by vacancies and long-term sickness absence.

Actions:
- Ripon Community team is in business continuity with a recovery plan in place. Recruitment of staff is underway, several commenced in September and October however 3 posts remain out to advert. In the interim, posts have been back filled through 2 agency staffs.



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

What does the chart show/context:
In the 12-month period ending October 2024 **2093** adults and older people were accessing Transformed Community Mental health services within **Vale of York**.

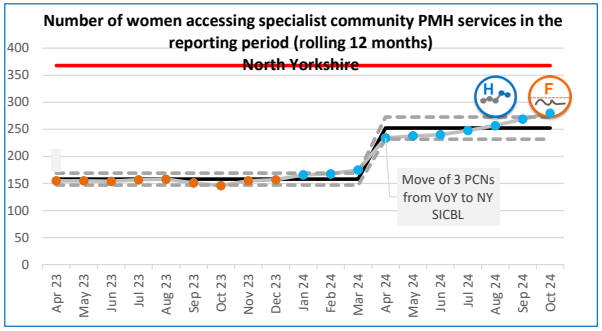
Underlying issues:
York and Selby Early Intervention team is impacted by vacancies, maternity leave and long-term sick leave.

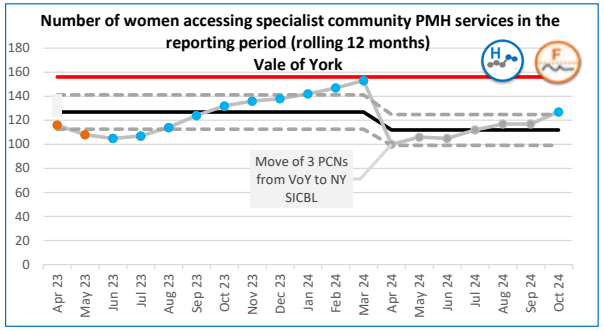
Actions:
York & Selby EIP team is in business continuity with a recovery plan in place to address vacancies and sick leave.

A refresh of historic data following the move of 14 GPs from Vale of York to North Yorkshire from the 1st April 2024 has now been completed and analysis will be undertaken by the end of November 2024 to identify any additional underlying areas of concern.

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

Tees, Esk and Wear Valleys NHS Foundation Trust





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

What does the chart show/context:
In the 12-month period ending October 2024 there were **280** women accessing a specialist community Perinatal Mental health services.

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

What does the chart show/context:
In the 12-month period ending October 2024 there were **127** women accessing a specialist community Perinatal Mental health services.

Underlying issues:

- Capacity issues within the Perinatal services, including short term sickness and vacancies.
- Longer-term funding and structural issues affecting the service, which are impacting on the ability to meet demand.

Actions:

The Perinatal teams are currently being supported through a service recovery plan in line with business continuity processes. Mitigating actions are:

- Short term sickness and vacancy is currently being mitigated by support from the wider Multi-Disciplinary Team for care co-ordination and implementation of a Band 5-6 run-through post to mitigate against the difficulties to recruit to a B6 care-coordination post.
- The Service Manager is working with the Planning Team to undertake a capacity and demand exercise by the end of December 2024 to inform the ongoing actions for the recovery of the longer term structural and capacity pressures.
- A Rapid Process Improvement Workshop is planned for January 2025 with the whole PMH service to identify and remedy inefficiencies in process and structure, which will further inform the service recovery plan.

Waiting Times Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

Children & Young People Services

- There is no significant change in the number **waiting for an assessment**. Our longest wait time is currently 955 days (DTVFCG).
- There is special cause improvement (a reduction) in the number **waiting for treatment (excluding Neuro)**. Our longest wait time is currently 2223 days (DTVFCG).
- There is no significant change in the number waiting from an **urgent referral within our Eating Disorder Service**. Our longest genuine wait time is 19 days (NYYS); this is attributable to patient choice (the longest wait time shown is 216 days; however, this is a data quality issue). There is special cause improvement (a reduction) in the number waiting from a **routine referral within our Eating Disorder Service.** Our longest genuine wait time is 38 days (DTVF); this is attributable to the patient not attending their offered appointment (the longest wait time shown is 269 days; however, this is a data quality issue).
- There is special cause concern (an increase) in the number **waiting for a neurological assessment** (autism assessment, ADHD assessment and both or not yet categorised). Our longest wait for an **autism** assessment is 1295 days (DTVFCG). Our longest genuine wait time for an **ADHD** assessment is 1552 days (DTVF) (the longest wait time shown is 1623 days; however, this is a data quality issue). Our longest wait for **both/not yet categorised** is 1285 days (DTVFCG).

Adult Mental Health Services

- There is special cause improvement (a reduction) in the number of adults **waiting for an assessment**. Our longest genuine wait time is 592 days (NYYS) (the longest wait time shown is 595 days; however, this is a data quality issue).
- There is no significant change in the number of Adults **waiting for EIP Treatment**. Our longest wait time is currently 262 days (NYYSCG).
- There is special cause concern (an increase) in the number of adults waiting **for their second contact with Talking Therapies**. Our longest wait time is currently 406 days (NYYSCG).
- There is special cause concern (an increase) in the number of **Adults waiting for an Autism Assessment**. Our longest genuine wait time is 1742 days (DTVF) (the longest wait time shown is 1908 days; however, this is a data quality issue).

Adult Learning Disability Services

There is special cause improvement (a reduction) in the number waiting for an assessment. Our longest genuine wait time is 138 days (DTVF) (the longest wait time shown is 266 days; however, this is a data quality issue).

Adults in Health & Justice Services

There is special cause concern (an increase) in the number waiting for an assessment. Our genuine longest wait time is 47 days (DTVF) (the longest wait time shown is 201 days; however, this is a data quality issue.

Older People waiting for an assessment

There is special cause improvement (a reduction) in the number waiting for an assessment. Our longest wait time is currently 648 days (NYYSCG).

Waiting Times Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

Not applicable

Risks & Issues

- Children and Young People waiting for neurological assessments
- Adults waiting for an autism assessment
- Adults waiting for their second contact with Talking Therapies

Mitigations

Waiting for neurodevelopmental assessments (Children & Young People and Adults)
The Mental Health, Learning Disability and Autism Subcommittee for NENC have agreed to put in place an all-age neurodiversity group. The group's scope will encompass ADHD and / or Autism services for children, young people, transitions, and adults and collaboration primarily within NHS structures but also with local authority partners across the ICB's geographical footprint. The group will develop a clear exposition of the current state, covering existing pathways; demand modelling; capacity modelling and quality impacts due to pathway deficiencies. The group will then develop a proposed future state, including revised pathways for needs-led approaches and pre-diagnostic support; screening and triage for diagnostic assessment; comprehensive diagnostic assessment; and post-diagnostic support, including both pharmacological and non-pharmacological interventions for ADHD. In addition to demand projections and required capacity, including workforce; strategies and potential trajectories for reducing waiting list backlogs; differentiation between NHS and non-NHS services, such as NHS diagnostic services focusing on high-acuity cases and Non-NHS services addressing lower-acuity cases.

DTVFCG CYPS have developed a Recovery Plan to address the long waiting times within CYPS Neurodevelopmental teams, which is being managed through the Care Board. The initial testing of the new clinical protocol within the neuro teams has completed with some success being seen in Tees and phase 2 testing is now underway; however, there has been less impact in Durham due to the way that service operates, and further progression of the pilot has been stood down pending review in January 2025. In Durham the team is using the patient tracker lists to level load cases. In Teesside additional recurrent funding has been agreed to provide a band 6 nurse which support level loading of cases. Patient progress through the pathways is being closely monitored.

In NYYSCG CYPS ongoing challenges include long term absences, vacancies, high levels of demand relative to capacity and wider workforce shortages. All vacant posts within the York Autism and ADHD teams commended in October, with the exception of two Psychologists (one starting December). In York ADHD, all except the Psychologist have been recruited and started in October; post-reconfiguration plans for that post have been submitted to Finance for review. There are particular pressures in the Scarborough, Whitby & Ryedale area and a proposal has been submitted to the Integrated Care System to address aspects of high levels of demand relative to capacity. Within the service alternatives approaches and skills mix are being considered; a consolidated list of the actions has been shared with Executive Directors for oversight and assurance.

Adults waiting for their second contact with Talking Therapies
Please see Talking Therapies 1st to 2nd treatment (County Durham, Tees Valley, Vale of York) within the National Quality Standards and Mental Health Priorities (page 52)

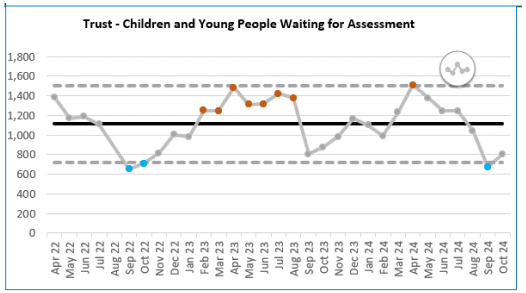
Waiting Times Dashboard

Tees, Esk and Wear Valleys
NHS Foundation Trust

Waiting Times Dashboard	Variation	Actual Number Waiting (Snapshot)	Average Wait (days)	Longest Wait (days)
Children and Young People Waiting for an Assessment		997	49	955
Children and Young People Waiting for Treatment (excluding Neuro)	L	1769	240	2223
Children & Young People Waiting for Eating Disorders Services - Urgent Referral (1 week standard)		5	51	216
Children & Young People Waiting for Eating Disorders Services - Routine Referral (4 week standard)	L	37	45	269
Children and young people waiting for an Autism Assessment	H	5811	472	1295
Children and young people waiting for an ADHD Assessment	H	4313	424	1623
Children and young people waiting for both Autism/ADHD Assessment or Not Categorised	H	2098	529	1285
Adults Waiting for an Assessment	L	3193	76	595
Adults Waiting for EIP Treatment (2 week standard)		95	28	262
Adults waiting for their second treatment contact in Talking Therapies	H	4873	81	406
Adults waiting for an Autism Assessment	H	3831	631	1908
Adults with a learning disability Waiting for an Assessment		89	38	266
Adults in Health and Justice services Waiting for an Assessment	H	82	83	201
Older People Waiting for Assessment	L	2534	82	446

Patients Waiting

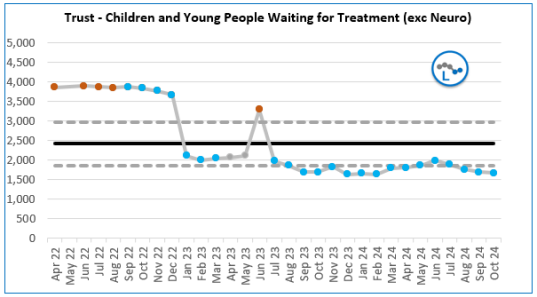
Tees, Esk and Wear Valleys NHS Foundation Trust



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	997	49	955	
DTVF Care Group	573	57	955	
NYY&S Care Group	424	39	332	

Commentary on Longest waits

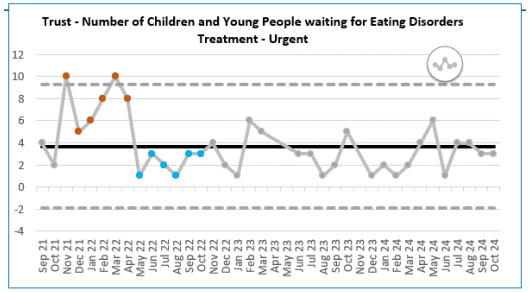
DTVF: Genuine wait - Assessment Booked
NYY&S: Data Quality - Assessment Complete (longest genuine wait - 145 days - Assessment required)



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	1769	240	2223	
DTVF Care Group	1074	228	2223	
NYY&S Care Group	695	258	1734	

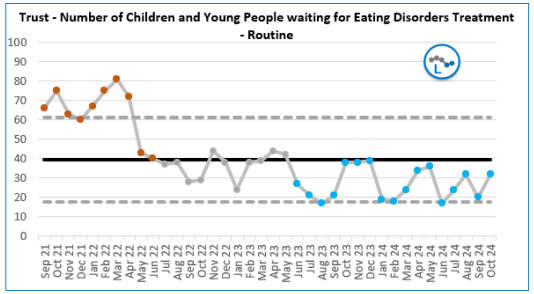
Commentary on Longest waits

DTVF: Genuine Wait - Treatment not yet commenced
NYY&S: Genuine Wait - Treatment not yet commenced



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	5	51	216	
DTVF Care Group	4	59	216	
NYY&S Care Group	1	19	19	

DTVF: Data Quality - Assessment Complete and treatment commenced (longest genuine wait - 5 days - treatment not yet commenced)
NYY&S: Genuine Wait - Treatment not yet commenced

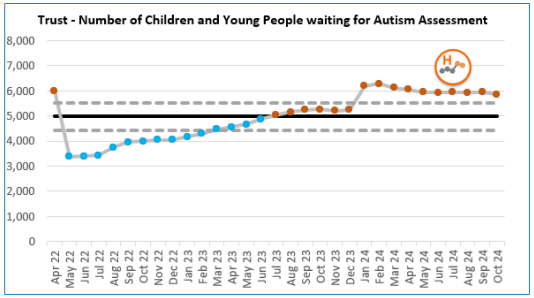


Organisation	Actual	Average wait	Longest wait	Assurance
Trust	37	45	269	
DTVF Care Group	20	39	154	
NYY&S Care Group	17	57	269	

DTVF: Data Quality - Assessment complete and treatment commenced (longest genuine wait - 38 days - treatment not yest commenced)
NYY&S: Data Quality - Not a genuine longer waiter (longest genuine wait - 19 days - treatment not yet commenced)

Patients Waiting

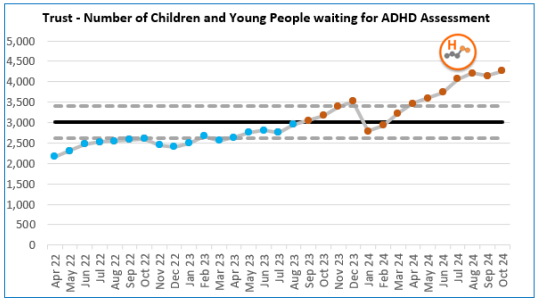
Tees, Esk and Wear Valleys NHS Foundation Trust



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	5811	472	1295	
DTVF Care Group	5013	503	1295	
NYY&S Care Group	798	276	759	

Commentary on Longest waits

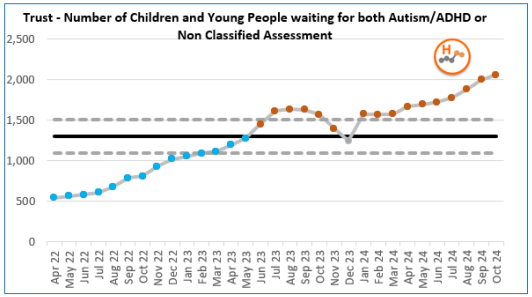
DTVF: Genuine Wait - Specialist Assessment Required
NYY&S: Genuine wait - Specialist Assessment Required



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4313	424	1623	
DTVF Care Group	3481	460	1623	
NYY&S Care Group	832	274	670	

Commentary on Longest waits

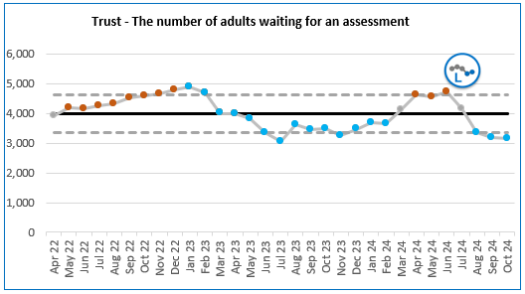
DTVF: Data Quality - Specialist Assessment Commenced (longest genuine wait - 1552 days - specialist assessment required)
NYY&S: Data Quality - Specialist Assessment commenced (longest genuine wait - 658 days - specialist assessment required)



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	2098	529	1285	
DTVF Care Group	1728	620	1285	
NYY&S Care Group	370	103	797	

Commentary on Longest waits

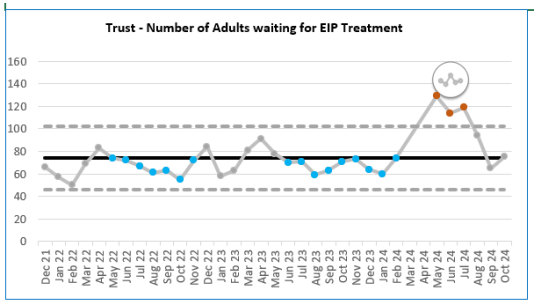
DTVF: Genuine wait - Specialist Assessment Required
NYY&S: Genuine Wait - Specialist Assessment Complete



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	3193	76	595	
DTVF Care Group	1744	59	595	
NYY&S Care Group	1449	96	592	

Commentary on Longest waits

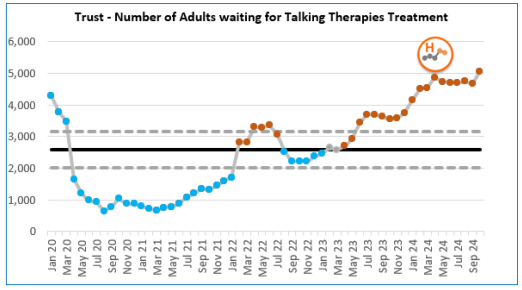
DTVF: Data Quality - Assessment complete (longest genuine wait - 328 days - assessment booked)
NYY&S: Genuine Wait - Assessment required



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	95	28	262	
DTVF Care Group	52	18	151	
NYY&S Care Group	43	42	262	

Commentary on Longest waits

DTVF: Data Quality - Assessment Complete (longest genuine wait - 40 days - treatment not yet commenced)
NYY&S: Genuine Wait - Treatment not yet commenced



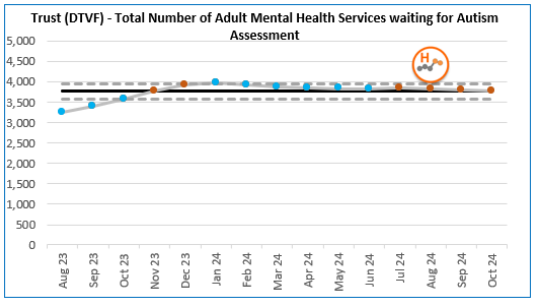
Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4873	81	406	
DTVF Care Group	3317	78	299	
NYY&S Care Group	1556	89	406	

Commentary on Longest waits

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

Patients Waiting

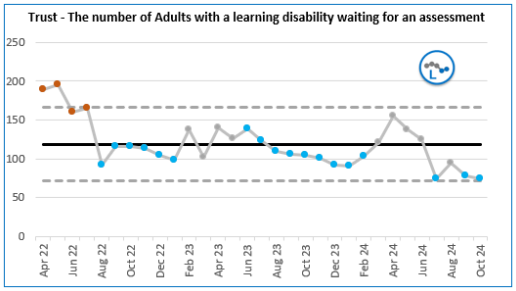
Tees, Esk and Wear Valleys NHS Foundation Trust



Organisation	Actual	Average wait	Longest wait	Assurance
Trust (DTVF Care Group)	3831	631	1908	

Commentary on Longest waits

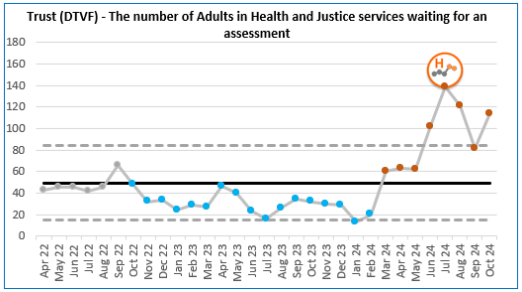
DTVF: Data Quality - Assessment complete (longest genuine wait - 1742 days - specialist assessment booked



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	89	38	266	
DTVF Care Group	44	34	138	
NYY&S Care Group	45	42	266	

Commentary on Longest waits

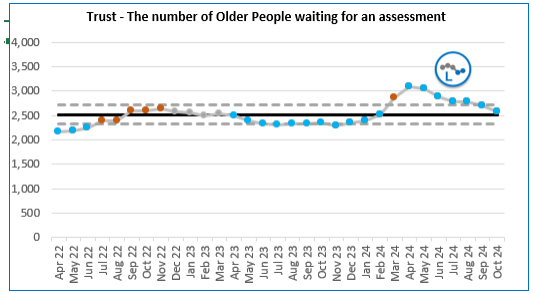
DTVF: Genuine Wait - Assessment required
NYY&S: Data Quality - Assessment complete (longest genuine wait - 119 days - assessment required



Organisation	Actual	Average wait	Longest wait	Assurance
Trust (DTVF Care Group)	82	83	201	

Commentary on Longest waits

DTVF: Data Quality - Assessment Complete (longest genuine wait - 47 days - assessment booked)



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	2534	84	648	
DTVF Care Group	1025	48	271	
NYY&S Care Group	1509	108	648	

Commentary on Longest waits

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

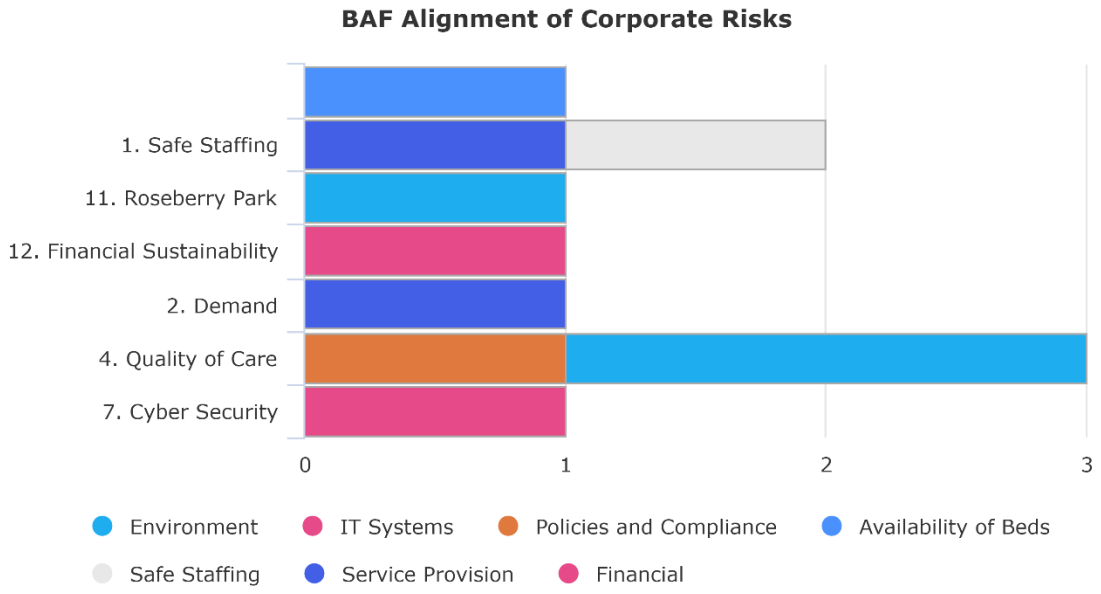
Meeting of:	**Board of Directors**
Date:	**12 December 2024**
Title:	**Corporate Risk Register**
Executive Sponsor(s):	**Beverley Murphy, Chief Nurse**
Author(s):	**Kendra Marley, Head of Risk Management**

Report for:				
	Assurance	✓	Decision	
	Consultation		Information	

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

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

Strategic Risks relating to this report:



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

Executive Summary:

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

Overview: This paper presents to the Board the risks that are rated ≥15 on the Corporate Risk Register as of 4th December 2024, reflecting any movement and changes since July 2024.

There are currently 10 risks on the Corporate Risk Register, a reduction of 5. This reflects removal of 7 risks which were reduced below 15 and 2 new risks which have been added.

The 7 removals include:
Aligned to Strategy and Resource

- Risk 1134, DTVF LD - Patients who are clinically ready for discharge and those who are a Green light admission do not have an appropriate placement to move on to. Reduced from 20 to 9.
- Risk 1327, DTVF SIS - Establishment of additional ECAs within existing environment and resource. Reduced from 16 to 12.

Aligned to Quality Assurance

- risk 1311, Risk that the NY & Y Crisis team are not always able to cover the rota (12).
- Risk 1495, N&G - Risk of increased public interest and FOI's. Reduced from 15 to 6.

Aligned to People and Culture

- risk 1361, NYY crisis teams may be unable to answer calls timely (12),
- Risk 998, DTVF H&J - HMP Northumberland below minimum staffing levels. Reduced from 15 to 12.
- Risk 1464, Sustained provision of Occupational Health services (12).

1 risk remains on the register below the threshold as the group asked for further reflection in the risk that the gaps had been addressed. This will be reviewed at the next executive Risk group Meeting in January.

Aligned to Quality Assurance

- Risk 1131, Limited Trust wide medical devise service. Reduced from 16 to 12

2 new risks have been added to the register:

Aligned to Strategy and Resource:

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

Aligned to Quality Assurance

- Risk 1529, DTVF Management, Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards. Currently 16.

Detailed review of all static risks at 15 or above at the Executive Risk Group is now included in the workplan, with a 6 monthly cycle to review all

of these. The first iteration of this, covering 10 static risks was undertaken in September, including 5 of those on the Corporate Risk Register (DTVF 1219, 998, 1137 and Estates 219 and 811). The second review at the December meeting covered 13 risks, all of North Yorkshire and York and those in Nursing & Governance, including 3 from the Corporate Risk Register, 909, 1131 and 1044. This was viewed positively by all, providing assurance that risks were being managed and enabling good discussion around blockages or potential mitigations that could be explored. Some further risks were reduced as a result of the detailed review by leads.

At the Executive Risk Group in December we discussed the low number of risks now on the Corporate Risk Register and the fact that some strategic BAF risks did not have sub risks on the register aligned to them. A review to consider the risks underlying the strategic BAF risks is to be undertaken and a plan for this will be discussed in January Executive Risk Group.

This Risk review compliance for corporate risks had dipped slightly to 90%, after being at 100% for 3 consecutive months, as one owner is on annual leave.

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

There is work to do to embed our improved processes for controls and actions and as such reasonable assurance is provided as we progress this.

Prior Consideration and Feedback

All risks are considered at service level governance.

All risks are considered by the Care Group Risk Group/ Directorate.

The Trust Executive Risk Group consider all risks rated as ≥15.

Implications:

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

Recommendations:

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

Further Information

1. Introduction and Purpose

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

2. Background Information and Context

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

3. Purpose of the Corporate Risk Register

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

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

4. Current Reporting Period

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

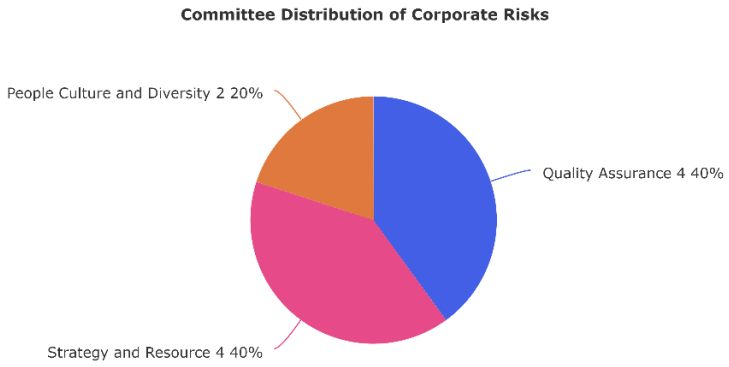
5. Corporate Risk Register

There are currently 10 risks on the Corporate Risk Register, a reduction of 5. This reflects removal of 7 risks which were reduced below 15 and 2 new risks which have been added.

1 risk remains on the register below the threshold as the group asked for further reflection in the risk that the gaps had been addressed. This will be reviewed at the next Executive Risk Group Meeting in January.

5.1 Committee & Care Group Alignment

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

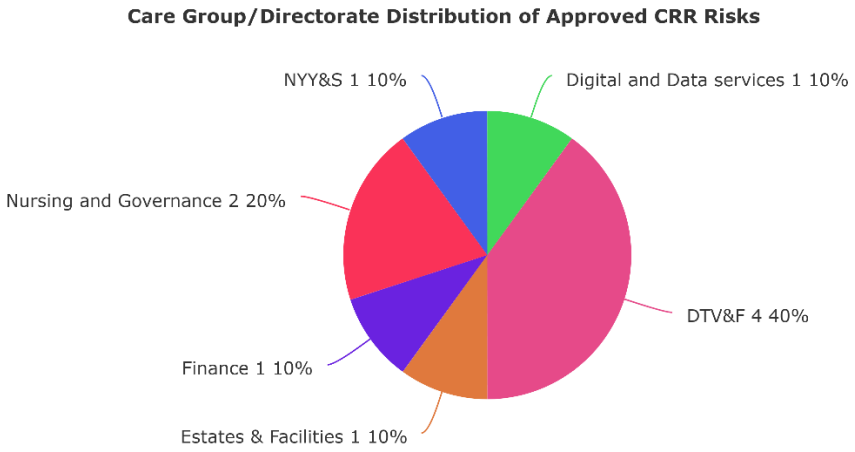


This shows that there are now

- 4 risks aligning to the Quality Assurance Committee
- 4 risks aligning to the Strategy and Resource Committee
- 2 risks aligning to the People, Culture and Diversity Committee

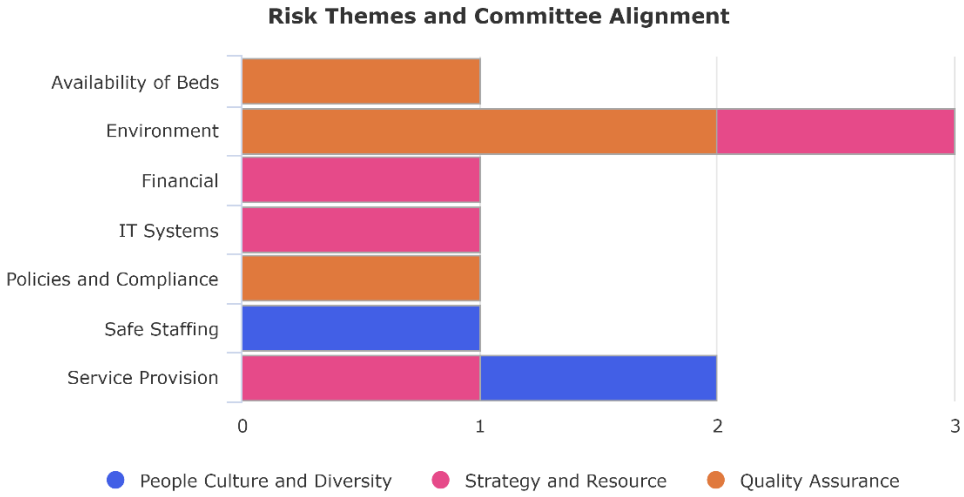
There are currently no risks aligning to the Mental Health Legislation Committee.

Focussing on the Care Group and Directorate breakdown of the Corporate Risk Register shows us that 40% of the current Corporate Risk Register is made up of risks from Durham Tees Valley and Forensics Care Group, with North Yorkshire, York Care Group with 10%, Nursing and Governance at 20%, Estates and Facilities, Digital and Data and Finance also at 10%.



5.2 Risk Themes

The 10 risks fall under the following themes within the Committee Alignment, with higher numbers of risks relating to Environment and Service Provision.



5.3 Risk Movements

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

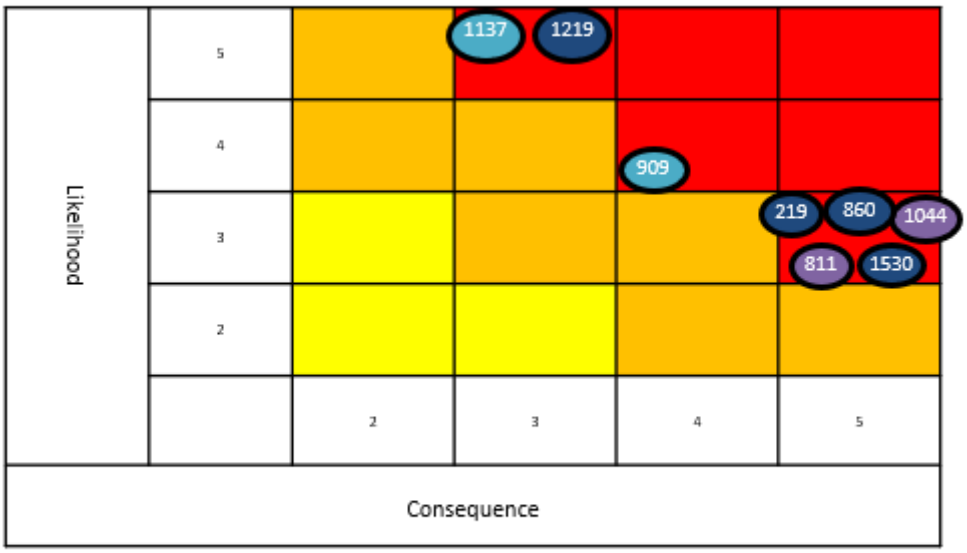
Outline – movement in period
- Black – static
- Green – reduced
- Red – increased

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

Risks with no movement in the period

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

Corporate risks at ≥15 remaining static in period

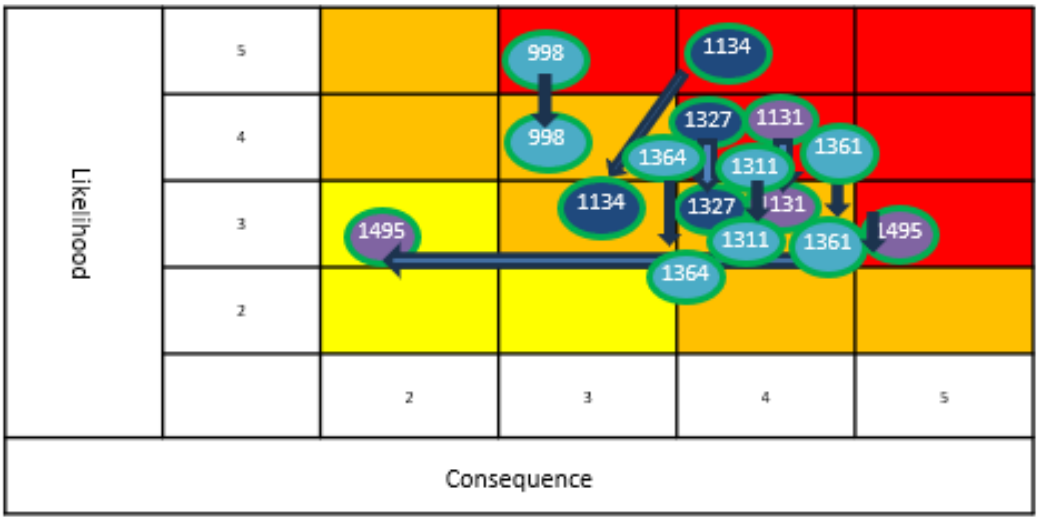


Risks are shown based on current risk rating

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

Risk Reductions and Removals

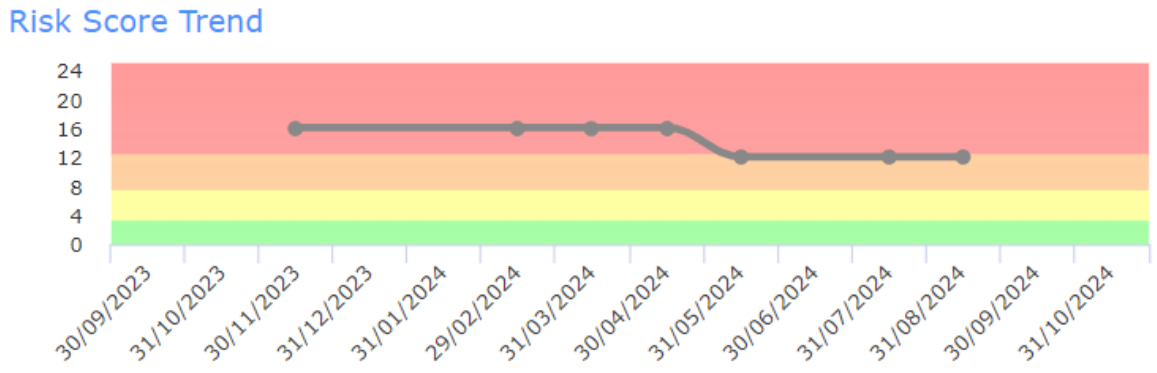
Risks reduced in the period



The following risks were considered and removed in July 2024.

Aligned to Quality Assurance

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

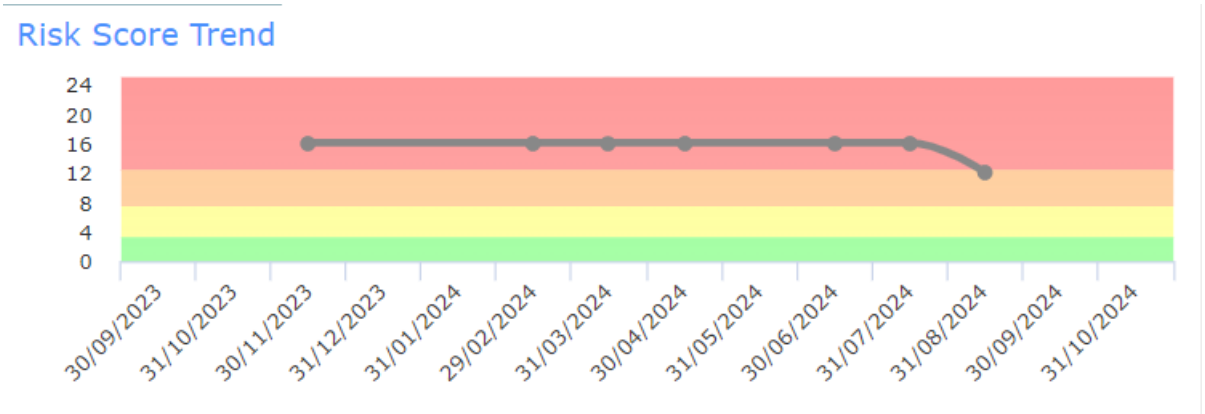


Rationale for change - agreed to reduce as a result of recent improvements in recruitment.

Executive risk group decision – agreed to remove, improvements in team workforce demonstrated.

Aligned to People, Culture and Diversity

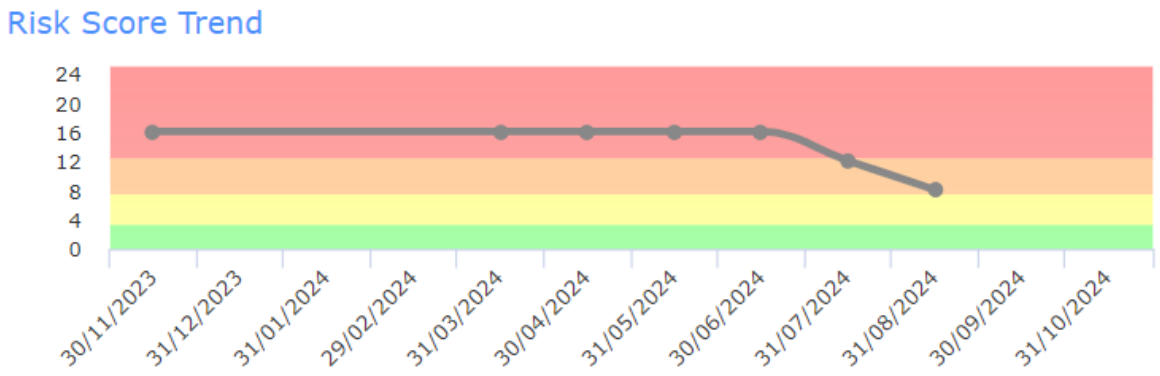
- Risk 1361 – NYY AMH - There is a risk of delayed access to telephone crisis triage, very urgent assessments (crisis 4hour response) and limited support through home based treatment across the NYYS AMH crisis response home based treatment teams due to the inability to recruit into vacant posts or secure temp staffing for the teams, resulting in the inability to mitigate against risk presentations and support alternative to admissions that supports treatment and promote patient safety and family/carer wellbeing. (reduced from 16 to 12)



Rationale for change - Improved regular oversight of rotas and immediate response to issues has had a demonstrable improvement in call handling. Risk likelihood reduced to reflect this.

Executive risk group decision – agreed to remove, improvements in team management reflected.

- Risk 1464 – PCD Health & Wellbeing - There is a risk that OH / physiotherapy services would be suspended due to current contract disputes, resulting in wider impact on staff, their availability and capability to work, their overall health & wellbeing, timely clearance for new staff to commence work, and impact on small number of staff applying for ill health retirement. (Reduced from 16 to 12).



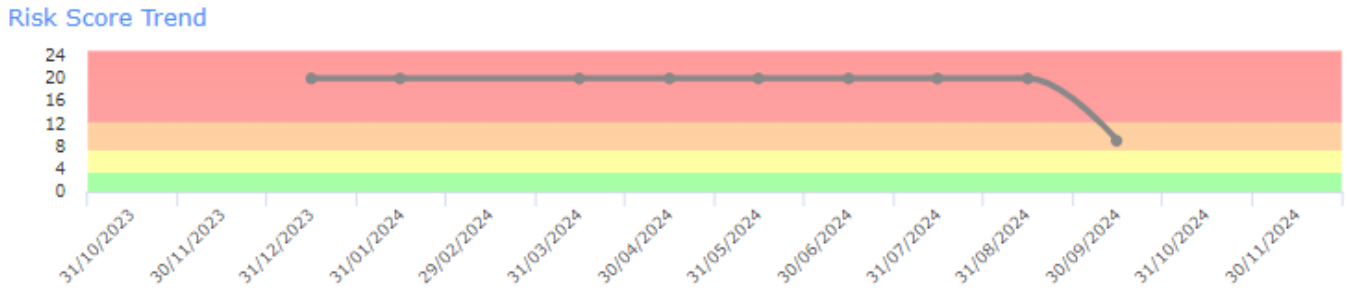
Rationale for change – most outstanding invoices have been agreed and paid, and meeting to agree forward costs are progressing satisfactorily. This has removed the threat of service suspension.

Executive risk group decision – agreed to remove as risk mitigated.

Following reduction of 5 risks were reviewed by the Executive Risk Group in December 2024 to consider removal from the register. There was agreement to remove 4 of these as mitigation was clear and the group agreed these reductions were appropriate. While a challenge to risk 1134 was raised, due to the potentially conflicting view from other sources, this was explained to be specific to this service and it was agreed that the risk description did not fully capture this. Based on the discussion it was agreed that the risk reduction was appropriate and removal from the register agreed, although a refresh of the risk description was requested.

Aligned to Strategy & Resource

Risk 1134 – DTVF ALD - There is a risk that some patients - particularly those who are CRFD - do not have an appropriate placement to move on to. This may result in patients not being placed in the best environment to support their care due to a lack of providers and resilience to facilitate discharge, resulting in complex patients being cared for within temporary ward environments/ inappropriate beds, and potential adverse patient safety and quality outcomes. This may impact on Green Light admissions to AMH and MHSOP beds, including to PICU. This may also impact on the admission of new patients to the service. (Reduced from 20 to 9)

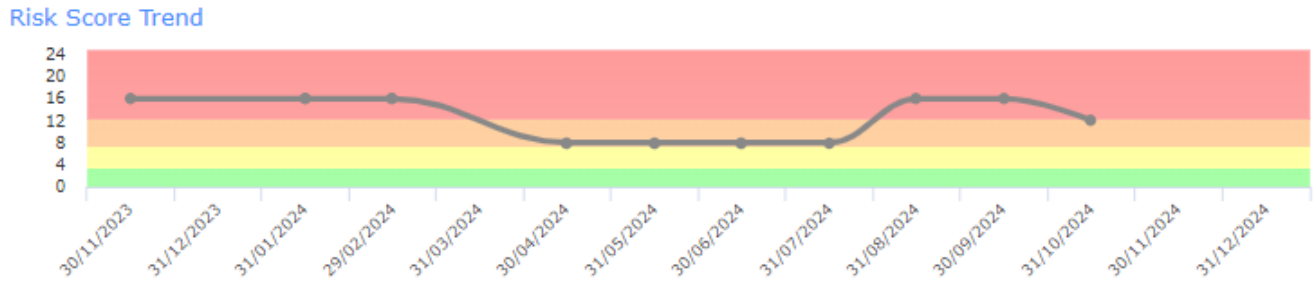


Rationale for reduction - Risk reviewed and description amended to reflect the updated position following the discharge of the patient to an MSU bed and the phased development of the IST. Score also reduced to reflect the reduction in level of risk.

Executive Group Decision – The group agreed removal. This followed a detailed discussion which challenged the reduction given similar risks and concerns triangulated from meetings. The Managing Director discussed the risk and the action taken describing how this was specific to the service and their

confidence in the improving position. The group agreed removal but requested that the risk description be updated to fully reflect the current risk as described.

Risk 1327, Establishment of additional ECAs within existing environment and resource. Reduced from 16 to 12.



Rationale for reduction - Reviewed at the Ridgeway Specialty Level Group meeting on 9/10/24.

The likelihood of additional ECAs has been reduced from likely (4) to possible (3) due to:

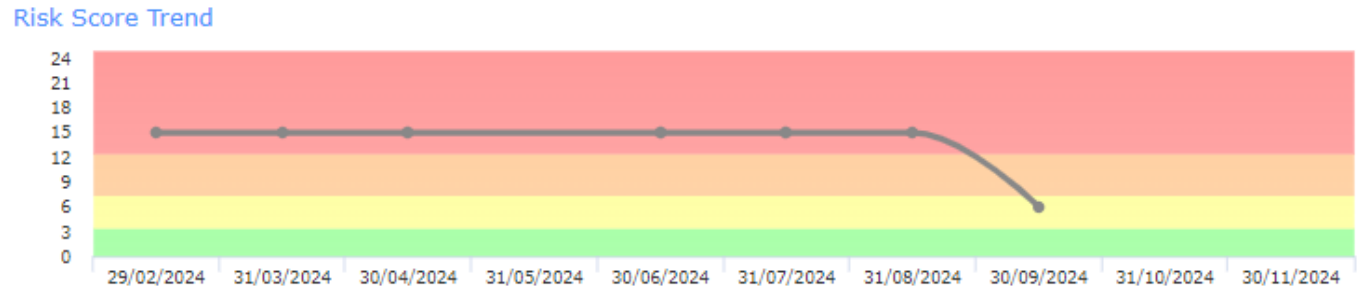
- There have been no recent referrals requiring ECAs.
- Discharge plans progressing for service users in segregation currently using ECAs in Ridgeway.
- HOPE models are now being used where appropriate within the service.
- Recent long term seclusion patient was transferred to high secure service in August 24.

Update November 2024 - Risk likelihood should reduce further when the ECAs become available in the Cedar development at CNTW through the NENC Provider Collaborative. This was originally scheduled to be by April 2024 but there has been slippage at CNTW. CNTW are currently stating these will be available by the end of January 2025.

Executive Group Decision – The group agreed removal as the mitigations taken and rationale for reduction were clearly documented and supported by the Managing Director.

Aligned to Quality Assurance

Risk 1495, Nursing & Governance - There is a risk of increased public interest, and FOIs, as a result of a new public facing dashboard potentially resulting in adverse publicity and increased FOI's. (Reduced from 15 to 6)



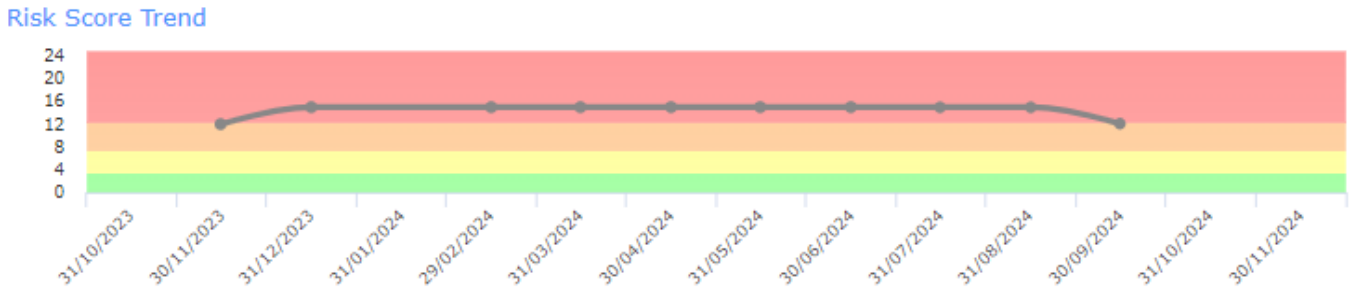
Rationale for reduction - NHS E have now informed trusts that the dashboard produced will only be accessible to trusts (and not public) in the first instance to enable full data validation. As a result of this, combined with the work undertaken to ensure fatalities (where not related to a patient safety incident) and safeguarding referrals are recorded as outcomes, additional quality work and strengthening of daily processes the consequence has been reduced to minor as we now expect that the data produced will be validated and correct, and while this may still generate additional public interest the data will be factual and not highlight us incorrectly as an outlier. Media coverage is more likely to be

local with a short term reduction in public confidence we will be able to explain our activity and answer any questions posed.

Executive Group Decision – The group agreed removal. Both the change in what NHSE will be initially publishing and the opportunity for data validation and internal improvements significantly mitigate the risk.

Aligned to People, Culture and Diversity

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



Rationale for reduction - Risk updated with further controls and assurances. Agreed to reduce risk score from 15 to 12. H&J are represented at the RCNI recruitment fair and HMP Northumberland will be included in future events. Also working in partnership with Northumbria University to build the profile at the University with Health and Social Care students. Training being provided to agency nurses to support their working in the TEWV/H&J environment/service. Continue to have additional leadership presence including Nurse Consultant, ADON, Matron. Communications Lead is proactive in geographically targeted advertising vacant posts including use of billboards, in process of creating videos specific to Northumberland area and using current team members. Interactions on Facebook are reviewed. Communications undertaken have resulted in an increase in applicants.

Update - On 6th of November it was discussed within the BCP meeting that the service no longer remained within BCP. Measures remain in place for oversight of clinical documentation and management of clinical caseloads which are up to date. Availability and staffing levels relating to the clinical lead vacancies have improved, staff are competent within their roles and there is regular agency staff in place as mitigation for managing the risk. There is no identified shifts in which there is less than minimum staffing levels and if we were to experience unexpected sickness, this would not impact the delivery of the service or safety of patients given the current measures in place.

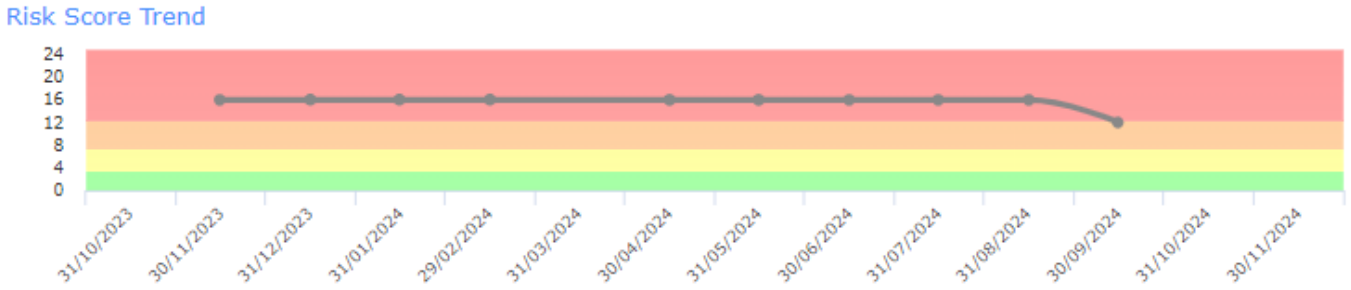
Executive Group Decision – The group agreed removal. There is significant improvement reflected.

Remaining risk below 15

1 reduced risk remains on the Corporate Risk Register as additional update to the record has been requested by the Executive Risk Group to seek further assurance that gaps have been addressed to mitigate the risk. This will be reviewed again at the January meeting for removal.

Aligned to Quality Assurance

Risk 1131 – Nursing & Governance - There is a risk that medical devices may not be available/ or safe to use due to the potential for devices being obsolete, out of date, poor working condition etc. when needed most i.e. emergency situation, resulting in patient harm. (reduced from 16 to 12)



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

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

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

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

Executive Group Decision – The group did not agree removal at this point. While it was recognised that significant changes have been made in the team, it was felt the risk does not fully reflect that gaps have been addressed. The lead is requested to update and the risk will be reviewed in January.

New risks

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

1 risk was approved and added in August 2024. This is a finance risk that replaces the one removed earlier in the year.

Aligned to Strategy and Resource:

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

1 risk was approved and added in December 2024.

Aligned to Quality Assurance

- Risk 1529, DTVF Management, Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards. Currently 16.

  The update reflects that work continues to progress with local authorities and ICB colleagues in relation to patients clinically ready for discharge and transformation of the AMH discharge pathway with a group being established with partners to support this work.

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

Static Risk Review

Additional detailed review of all static risks at 15 or above at the Executive Risk Group has been included in the workplan, with a 6 monthly cycle to review all of these. The first iteration of this, covering 10 static risks was undertaken in September, including 5 of those on the Corporate Risk Register (DTVF 1219, 998, 1137 and Estates 219 and 811). The second review at the December meeting covered 13 risks, including 3 from the Corporate Risk Register, 909, 1131 and 1044.This was viewed positively by all, providing assurance that risks were being managed and enabling good discussion around blockages or potential mitigations that could be explored. Some risks were reduced as a result of the detailed review by leads.

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

Corporate Risk Register Review and Additions

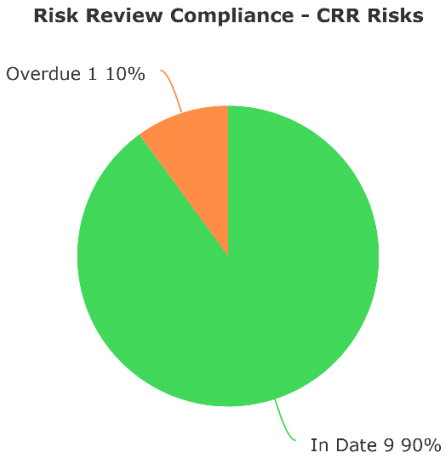
The Executive Risk Group discussed the low number of risks now on the Corporate Risk Register and the fact that some strategic BAF risks did not have sub risks on the register aligned to them. A review to consider the risks underlying the strategic BAF risks is to be undertaken and a plan for this will be discussed in January Executive Risk Group.

5.4 Risk Review Compliance

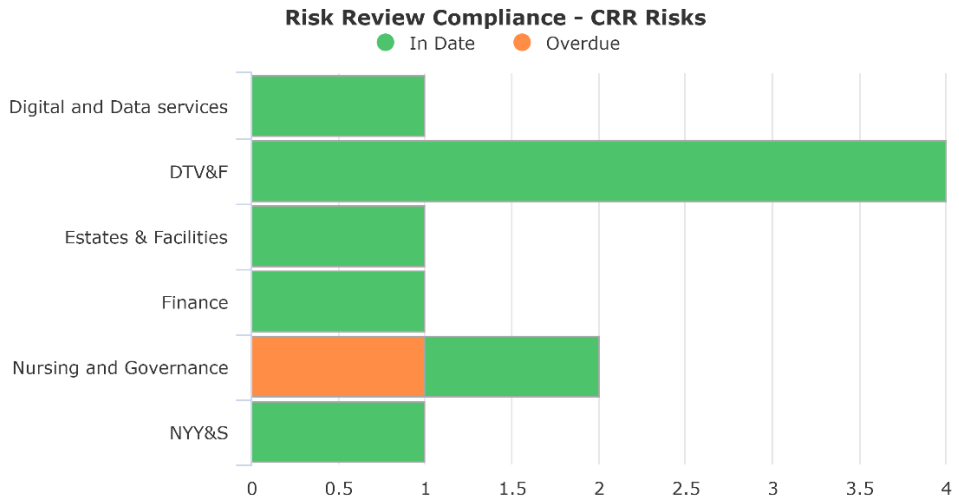
The policy includes appendices that outline the process in more detail, including the timing of risk review. This is shown below:

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

At the time of writing the paper the compliance of timely risk review for the Corporate Risk Register is 90% (previously 100%). This is due to one owner being on annual leave over the review due period.



The breakdown by directorate is shown below.



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

6. Conclusions

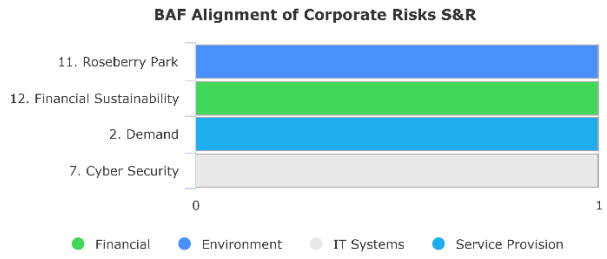
Governance meetings are being undertaken in line with policy and risks reviewed. We have some static risks that may take time to mitigate, however progress is being made. A review to consider the risks underlying the strategic BAF risks is to be undertaken and a plan for this will be discussed in January Executive Risk Group.

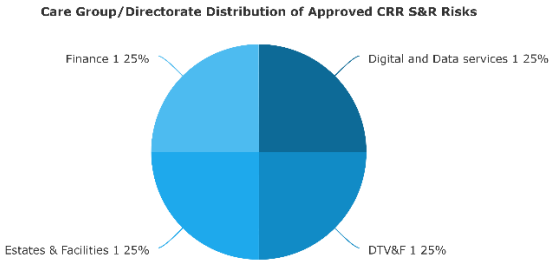
Compliance with review this month dips slightly to 90% as a result of annual leave, this is expected to rectify as the lead returns. This follows 3 consecutive months at 100%. All leads are engaging with the new control and action process.

7. Recommendations

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

Strategy & Resources Aligned Risks





The current summary of the register is shown below

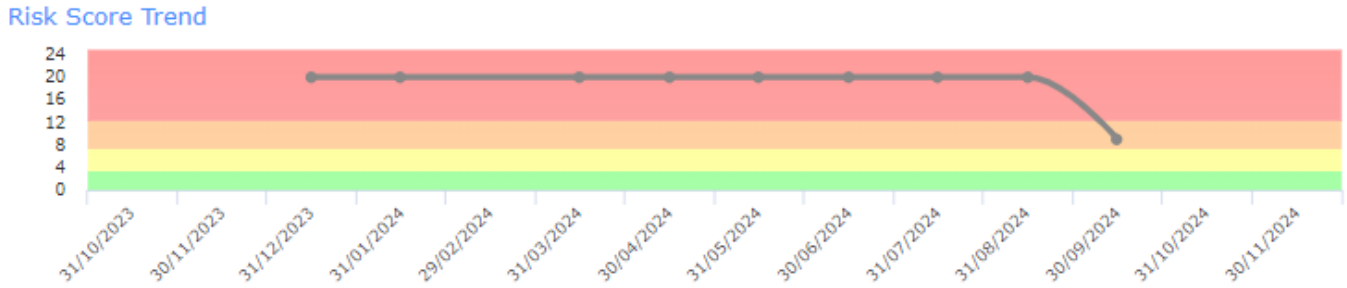
Risk CRR summary

Id	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	31 Dec 2024			
								Control Effectiveness		RM03 Risk Rating	
								Actual	Target	Actual	Target
Risk 00000219	There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.	08 Sep 2016	06/11/2024	Simon Adamson	15		▪ R295 - Achieve contract resolution to the satisfaction of the Trust ▪ Phase 2 rectification works			15	10
Risk 00000860	There is a risk of a successful cyber attack on the Trust, due to IT Staff having insufficient cyber security resources, and enforced cyber security policies and procedures, along with technical controls, audit and assurance, resulting in the Trust not being able to identify, isolate and rectify the source of attack to prevent loss of data and or access to trust systems.	10 Jun 2020	08/11/2024	Nick Black	25		R952 - Hire staff			15	5
Risk 00001219	There is a risk that children and young people may experience deterioration in their presentation which is likely to impact on their mental health and wellbeing, resulting in an increase in demand for mental health support, specialist secondary services and urgent care. As a consequence, children, young people and their families are likely to have unsatisfactory patient experience due to the unacceptable waits for neurodevelopmental assessments. This in turn causes delay to ADHD treatment which is exacerbated by national medication supply issues. This may result in Dissatisfactory experience for families Complaints Knock on effect of long waits for diagnosis-specific support Reputational damage YP open to the service for a significant period of time with no completed care documentation and/or risk assessments (non compliance with Harm Minimisation Policy) The pathways currently are unlikely to meet standards in relation to new National Access Standards.	01 Apr 2021	02/12/2024	Jamie Todd	16	▪ Activity levels and outputs ▪ Capacity and demand ▪ Capacity and demand work ▪ Clinical prioritisation ▪ Closely monitoring the changing picture nationally re ADHD meds supply. ▪ KiT processes ▪ PTLs ▪ Support whilst waiting and signposting	Undertake impact assessment to prioritise cases for assessment within core GMH teams.			15	6
Risk 00001530	There is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory breaches / interventions and / or adversely impact quality of services.	30 May 2024	21/11/2024	Liz Romaniak	15		▪ Deliver 2024/25 Recurrent and Non Recurrent CRES plans, with monthly monitoring at FSB ▪ Report on financial performance vs plan ▪ Report detailed position to Board and escalate additional reporting as required ▪ Develop 2024/25 Control Totals and agree with CGB / Directorates ▪ Improve level loading of headroom and all rosters to be approved on time ▪ EDG to approve all new investments £10k+ ▪ Vacancy panel to approve all posts ▪ Care Group Boards to approve workforce roadmaps			15	8

The following risks were removed following approval by the Executive Risk Group.

Risk 1134 – DTVF ALD - There is a risk that some patients - particularly those who are CRFD - do not have an appropriate placement to move on to. This may result in patients not being placed in the best

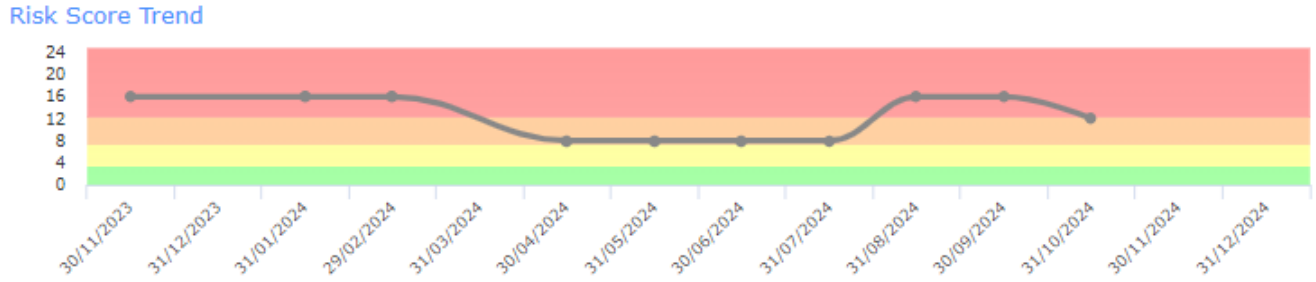
environment to support their care due to a lack of providers and resilience to facilitate discharge, resulting in complex patients being cared for within temporary ward environments/ inappropriate beds, and potential adverse patient safety and quality outcomes. This may impact on Green Light admissions to AMH and MHSOP beds, including to PICU. This may also impact on the admission of new patients to the service. (Reduced from 20 to 9)



Rationale for reduction - Risk reviewed and description amended to reflect the updated position following the discharge of the patient to an MSU bed and the phased development of the IST. Score also reduced to reflect the reduction in level of risk.

Executive Group Decision – The group agreed removal. This followed a detailed discussion which challenged the reduction given similar risks and concerns triangulated from meetings. The Managing Director discussed the risk and the action taken describing how this was specific to the service and their confidence in the improving position. The group agreed removal but requested that the risk description be updated to fully reflect the current risk as described.

Risk 1327, Establishment of additional ECAs within existing environment and resource. Reduced from 16 to 12.



Rationale for reduction - Reviewed at the Ridgeway Specialty Level Group meeting on 9/10/24.

The likelihood of additional ECAs has been reduced from likely (4) to possible (3) due to:

- There have been no recent referrals requiring ECAs.
- Discharge plans progressing for service users in segregation currently using ECAs in Ridgeway.
- HOPE models are now being used where appropriate within the service.
- Recent long term seclusion patient was transferred to high secure service in August 24.

Update November 2024 - Risk likelihood should reduce further when the ECAs become available in the Cedar development at CNTW through the NENC Provider Collaborative. This was originally scheduled to be by April 2024 but there has been slippage at CNTW. CNTW are currently stating these will be available by the end of January 2025.

Executive Group Decision – The group agreed removal as the mitigations taken and rationale for reduction were clearly documented and supported by the Managing Director.

Current Risk Rating Movements

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

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

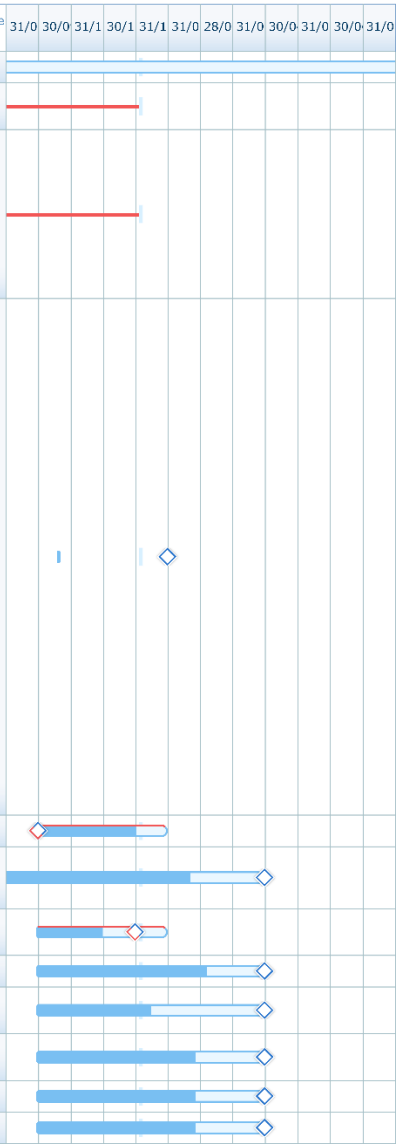
CRR risks - monthly current rating

	Risk Number	Risk Title	Current Risk Rating	31 Dec 2023	31 Jan 2024	29 Feb 2024	31 Mar 2024	30 Apr 2024	31 May 2024	30 Jun 2024	31 Jul 2024	31 Aug 2024	30 Sep 2024	31 Oct 2024	30 Nov 2024	31 Dec 2024
Strategy and Resource	Risk 00000219	Risk of a H&S incident at Roseberry park Hospital	Actual		15		15	15	15		15	15	15	15		
	Risk 00000860	Cyber attack on Trust	Actual		20	20	20	20	15		15	15	15	15	15	
	Risk 00001219	CAMHS Neurodevelopmental assessment and treatment pathways.	Actual	15		15	15	15		15	15	15	9	15		
	Risk 00001530	Delivery of financial plan	Actual	n/r	n/r	n/r	n/r	n/r	15		15	15	15	15		

The following table shows all current actions related to these risks. 2 are showing overdue.

Current Actions

Risk ID	Risk Description	Action Name	Due Date	Planned Completic Date	Owner	Percentage Complete
Risk 00000219	There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.	Phase 2 rectification works	01 Sep 2025	01 Sep 2025	Simon Adamson	5%
		R295 - Achieve contract resolution to the satisfaction of the Trust	28 Jun 2024	28 Jun 2024	Simon Adamson	75%
Risk 00000860	There is a risk of a successful cyber attack on the Trust, due to IT Staff having insufficient cyber security resources, and enforced cyber security policies and procedures, along with technical controls, audit and assurance, resulting in the Trust not being able to identify, isolate and rectify the source of attack to prevent loss of data and or access to trust systems.	R952 - Hire staff	31 Mar 2024	31 Mar 2024	Steven Forster	50%
Risk 00001219	▪ There is a risk that children and young people may experience deterioration in their presentation which is likely to impact on their mental health and wellbeing, resulting in an increase in demand for mental health support, specialist secondary services and urgent care. As a consequence, children, young people and their families are likely to have unsatisfactory patient experience due to the unacceptable waits for neurodevelopmental assessments. This in turn causes delay to ADHD treatment which is exacerbated by national medication supply issues. This may result in Dissatisfactory experience for families ▪ Complaints ▪ Knock on effect of long waits for diagnosis-specific support ▪ Reputational damage ▪ YP open to the service for a significant period of time with no completed care documentation and/or risk assessments (non compliance with Harm Minimisation Policy) ▪ The pathways currently are unlikely to meet standards in relation to new National Access Standards.	Undertake impact assessment to prioritise cases for assessment within core GMH teams.	31 Dec 2024	19 Sep 2024	Mita Saha	25%
Risk 00001530	There is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory breaches / interventions and / or adversely impact quality of services.	Care Group Boards to approve workforce roadmaps	31 Aug 2024	31 Dec 2024	Mathew Norman	75%
		Deliver 2024/25 Recurrent and Non Recurrent CRES plans, with monthly monitoring at FSB	31 Mar 2025	31 Mar 2025	Mathew Norman	75%
		Develop 2024/25 Control Totals and agree with CGB / Directorates	30 Nov 2024	31 Dec 2024	Mathew Norman	50%
		EDG to approve all new investments £10k+	31 Mar 2025	31 Mar 2025	Mathew Norman	75%
		Improve level loading of headroom and all rosters to be approved on time	31 Mar 2025	31 Mar 2025	Mathew Norman	50%
		Report detailed position to Board and escalate additional reporting as required	31 Mar 2025	31 Mar 2025	Mathew Norman	70%
		Report on financial performance vs plan	31 Mar 2025	31 Mar 2025	Mathew Norman	70%
		Vacancy panel to approve all posts	31 Mar 2025	31 Mar 2025	Mathew Norman	70%



Summary of risks

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

Owner – Simon Adamson

Initial rating 15 (C5, L3), Current Rating 15 (C5, L3), Target Rating 4 (C5, L2), Date to reduce risk 6 January 2032.

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

Assurance – Reasonable Assurance – This risk was subject to the new static risk review at the Executive Risk Group in September. As a result a recommendation made to change this risk to reflect a sub set of risks which are contained within this instead of a broad H&S risk. This work is underway and will enable clear controls and actions to be more specific, resulting in the ability to more effectively demonstrate risk reduction in each risk.

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

Owner – Nick Black

Initial rating 25 (C5, L5), Current Rating 15 (C5, L3), Target Rating 4 (C5, L1), Date to reduce risk 31 April 2025.

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

Assurance – Reasonable Assurance – the risk has been updated and further work is taking place to fully reflect controls.

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

Owner – Jamie Todd

Initial rating 20 (C4, L5), Current Rating 15 (C3, L5), Target Rating 8 (C2, L4), Date to reduce risk 31 March 2025.

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

Assurance – Reasonable Assurance – the risk has been fully reviewed and controls are not reflected in the risk, as well as actions previously completed being added to the risk to reflect the full progress made. New actions currently underway and completed have also been added.

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

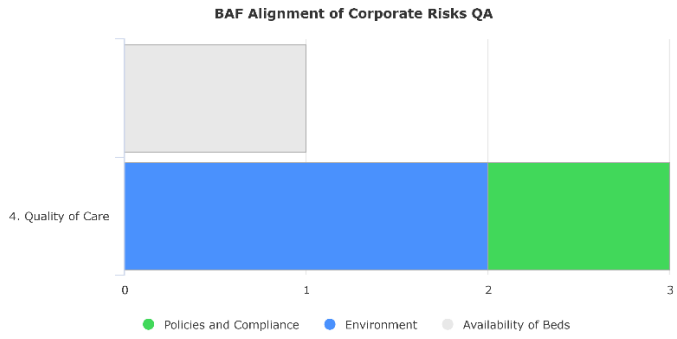
Owner – Liz Romaniak

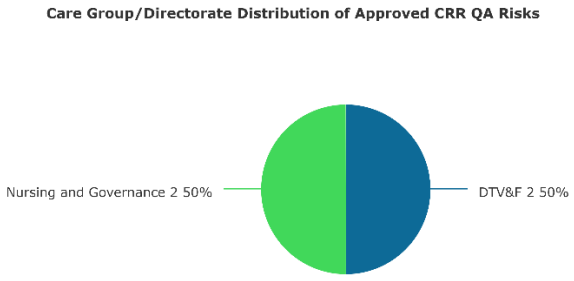
Initial rating 15 (C5, L3), Current Rating 15 (C5, L3), Target Rating 4 (C4, L2), Date to reduce risk 31 March 2025.

Risk Review – in date, Action Delivery – 8 actions ongoing – in date.

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

Quality Assurance Aligned Risks





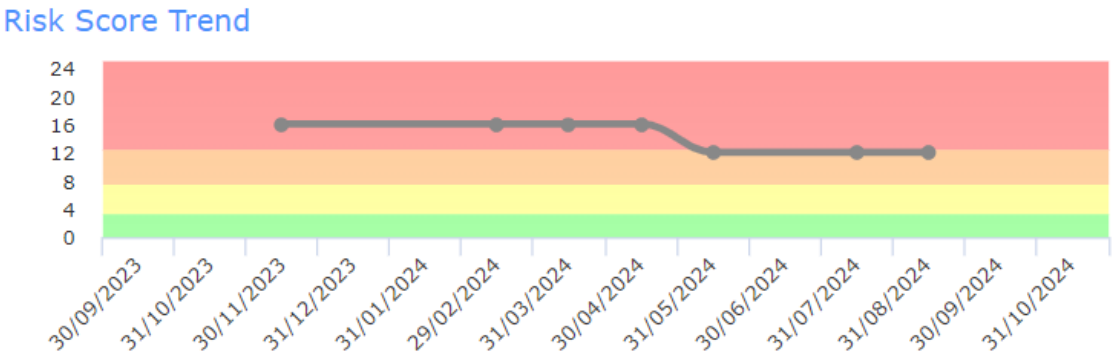
The current summary of the register is shown below

Risk CRR summary

Id	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	31 Dec 2024			
								Control Effectiveness		RM03 Risk Rating	
								Actual	Target	Actual	Target
Risk 00000811	There is a risk that patients may attempt suicide using potential ligature points within clinical areas across the organisation, due to the presence of potential ligature points and access to these, resulting in severe harm/death to patients and significant distress to families and staff, and impact on organisational reputation.	01 Jun 2020	04/12/2024	Naomi Lonergan	20		▪ R903 - Implement phase 2 of the ligature reduction programme ▪ R903 - Phase 3 delivery			15	10
Risk 00001044	There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the lack of a timely initial review resulting in failure to quickly identify learning, and mitigate patient safety and quality risks, affecting regulator confidence in services and trust reputation.	08 Aug 2022	04/12/2024	Rachel Weddle	20	▪ INC - Patient Safety Huddle Daily - reviews moderate and above incidents ▪ Staff understand the initial review process and timelines	R1044 - QI work on operational management and governance of incidents from ward to board	Amber	Green	15	10
Risk 00001131	There is a risk that medical devices may not be available/ or safe to use due to the potential for devices being obsolete, out of date, poor working condition etc. when needed most i.e. emergency situation, resulting in patient harm.	16 Feb 2022	01/05/2024	Carole Rutter	16	▪ 1131 Direct telephone and email reporting system ▪ 1131 Equip system in place ▪ Medical Devices Group ▪ Medical Devices Team	R1223 - Undertake a baseline assessment of medical devices stored within operational services to asc	Amber	Amber	12	6
Risk 00001529	Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards.	29 May 2024	30/11/2024	Shaun McKenna	20	Patient Flow Work	Patient Flow Oversight Group			16	9

2 risks were removed following approval by Executive Risk Group.

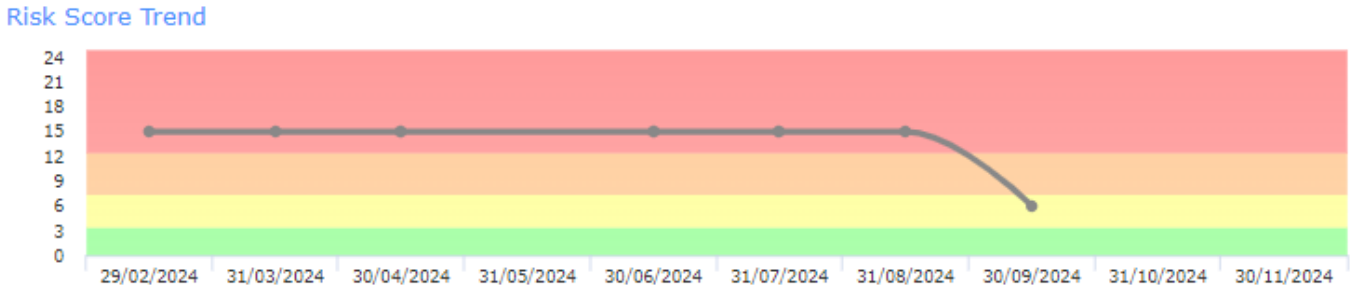
Risk 1311 – NYYS CAMHS - Risk that the NY & Y Crisis team are not always able to cover the rota with enough staff 24/7 (especially at night) to ensure good cover across the whole NYYS geography due to low staffing (as a result of vacancies) (Reduced from 16 to 12).



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

Executive risk group decision – agreed to remove, improvements in team workforce demonstrated.

Risk 1495, Nursing & Governance - There is a risk of increased public interest, and FOIs, as a result of a new public facing dashboard potentially resulting in adverse publicity and increased FOI's. (Reduced from 15 to 6)



Rationale for reduction - NHS E have now informed trusts that the dashboard produced will only be accessible to trusts (and not public) in the first instance to enable full data validation. As a result of this, combined with the work undertaken to ensure fatalities (where not related to a patient safety incident) and safeguarding referrals are recorded as outcomes, additional quality work and strengthening of daily processes the consequence has been reduced to minor as we now expect that the data produced will be validated and correct, and while this may still generate additional public interest the data will be factual and not highlight us incorrectly as an outlier. Media coverage is more likely to be local with a short term reduction in public confidence we will be able to explain our activity and answer any questions posed.

Executive Group Decision – The group agreed removal. Both the change in what NHSE will be initially publishing and the opportunity for data validation and internal improvements significantly mitigate the risk.

Current Risk Rating Movements

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

Risk 811, potential ligatures, requires review and split to separate out the estates and clinical elements to ensure the risk owner(s) are able to manage and mitigate the elements of the risk.

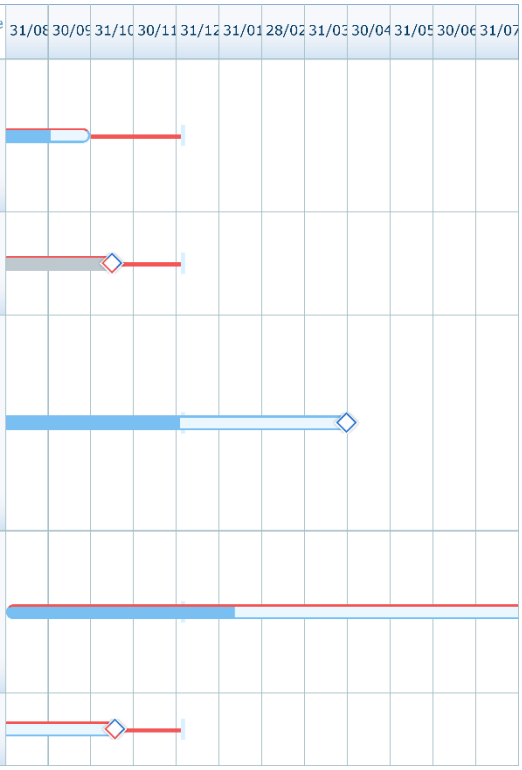
CRR risks - monthly current rating

	Risk Number	Risk Title	Current Risk Rating	31 Dec 2023	31 Jan 2024	29 Feb 2024	31 Mar 2024	30 Apr 2024	31 May 2024	30 Jun 2024	31 Jul 2024	31 Aug 2024	30 Sep 2024	31 Oct 2024	30 Nov 2024	31 Dec 2024
Quality Assurance	Risk 00000811	Patients may attempt suicide using potential ligature points within clinical areas	Actual	15	15			15	15	15	15	15	15	15		15
	Risk 00001044	Incidents that are more serious than initially reported are not identified within appropriate timescales	Actual	15	15	15		15		15	15	15	15		15	
	Risk 00001131	Limited trust wide medical devices service	Actual	16	16	16		16	16	16	16	16	12			
	Risk 00001529	Risk if increased length of stay across AMH acute wards	Actual	n/r	n/r	n/r	n/r	n/r	16	16	16	16	16	16	16	16

The below table show the actions ongoing in relation to the risks, 3 are showing overdue.

Current Actions

Risk ID	Risk Description	Action Name	Due Date	Planned Completio Date	Owner	Percentage Complete
Risk 00000811	▪ There is a risk that patients may attempt suicide using potential ligature points within clinical areas across the organisation, due to the presence of potential ligature points and access to these, resulting in severe harm/death to patients and significant distress to families and staff, and impact on organisational reputation. ▪	R903 - Implement phase 2 of the ligature reduction programme	30 Jun 2024	30 Sep 2024	Simon Adamson	95%
		R903 - Phase 3 delivery	16 Oct 2024	16 Oct 2024	Simon Adamson	0%
Risk 00001044	There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the lack of a timely initial review resulting in failure to quickly identify learning, and mitigate patient safety and quality risks, affecting regulator confidence in services and trust reputation.	R1044 - QI work on operational management and governance of incidents from ward to board	31 Mar 2025	31 Mar 2025	Kendra Marley	60%
Risk 00001131	There is a risk that medical devices may not be available/ or safe to use due to the potential for devices being obsolete, out of date, poor working condition etc. when needed most i.e. emergency situation, resulting in patient harm.	R1223 - Undertake a baseline assessment of medical devices stored within operational services to asc	31 Mar 2026	29 Jul 2027	Carole Rutter	15%
Risk 00001529	Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards.	Patient Flow Oversight Group	18 Oct 2024	18 Oct 2024	Joanne Salvin	0%



Summary of risks

Risk 811 – EFM Estates - There is a risk that patients may attempt suicide using potential ligature points within clinical areas across the organisation, due to the presence of potential ligature points and access to these, resulting in severe harm/death to patients and significant distress to families and staff, and impact on organisational reputation.

Owner – Simon Adamson

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

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

Assurance – Reasonable Assurance – while it is clear that work on the ligature reduction programme progresses the risk action does not reflect progress and requires update. The current controls and management as well as actions are discussed regularly in the Environmental Risk Group.

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

Initial rating 20 (C5, L4), Current Rating 15 (C5, L3), Target Rating 10 (C5, L2), Date to reduce risk previously revised from 30 September 2024 to 31 March 2025.

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

Assurance – Good Assurance – the risk has been updated and includes detail of progress made. While central controls are effective, local review management needs strengthening, and numbers of unreviewed incident need to reduce to a 'routine' level. hence the risk remaining at 15 at present. The date to reduce the risk has been updated to reflect further QI work underway.

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

Owner – Carole Rutter

Initial rating 16 (C4, L4), Current Rating 12 (C4, L3), Target Rating 3 (C3, L1), Date to reduce risk 30 September 2025.

Risk Review – in date, Action Delivery – 1 actions ongoing, new planned date for delivery.

Assurance – Reasonable Assurance – the risk has been updated to fully reflect control in place and the actions undertaken to date and remains at 12. A review of gaps in controls and assurance has been requested by the Executive Risk Group to provide assurance that these have been addressed.

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

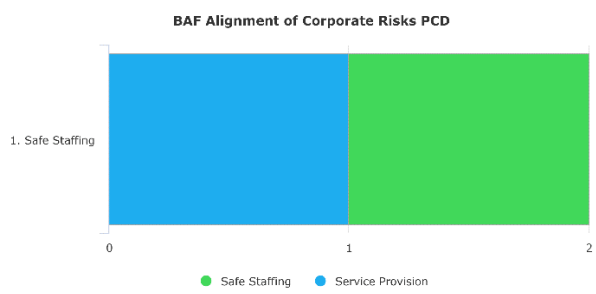
Owner – Jamie Todd

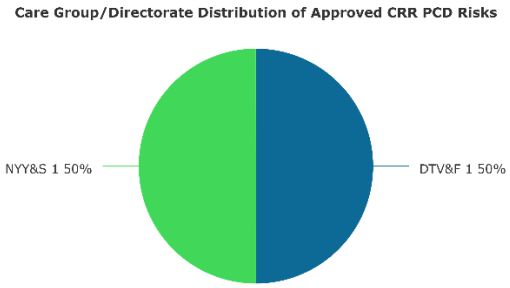
Initial rating 16 (C4, L4), Current Rating 16 (C4, L4), Target Rating 9 (C3, L3), Date to reduce risk - To be determined.

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

Assurance – Limited Assurance – the risk has limited information and may not reflect all of the work being undertaken. The current owner has just taken over this area and is yet to work through fully with General Managers and Business Managers. While there is a lot of work going on through the Transforming Mental Health Discharge Groups within the system, it would be difficult to determine when then target sore will be met at this point in time. The team have more work to do to quantify what scoring 9 would mean and how we would know we are at that point. Further review will be undertaken and a target date applied.

People, Culture & Diversity Aligned Risks





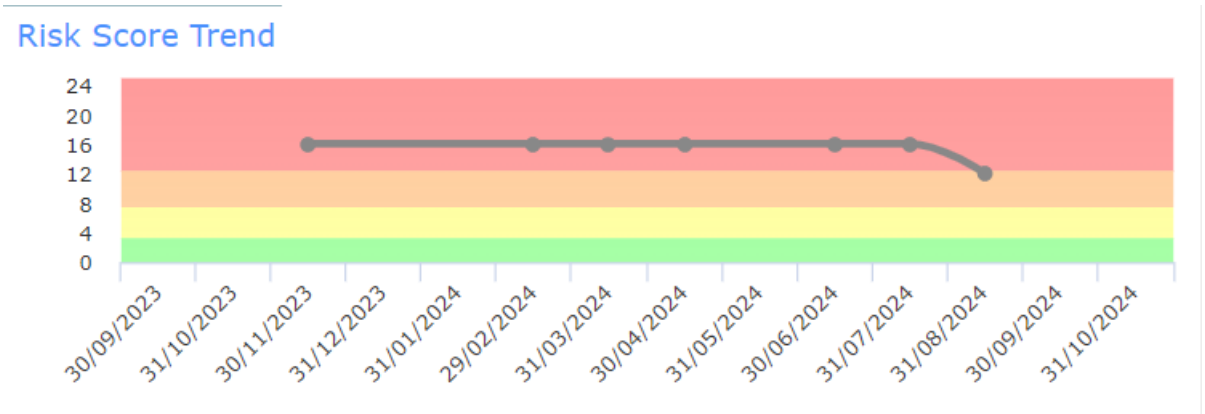
The current summary of the register is shown below

Risk CRR summary

Id	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	31 Dec 2024			
								Control Effectiveness		RM03 Risk Rating	
								Actual	Target	Actual	Target
Risk 00000909	There is a risk due to difficulties in recruitment to vacant posts in the consultant workforce across NYYS due to local and national shortages, resulting in the potential impact on; safe care delivery, teaching and training of junior staff and students, OOH on call rota, research, existing staff morale and wellbeing, finances.	20 Oct 2020	13/11/2024	Tolulope Olusoga	20	▪ Mind the Gap arrangement ▪ Retention of Existing Consultant workforce	▪ R1001 - Develop non-medic colleague skills to ensure consistent service delivery ▪ R1001 - Explore and encourage group job planning to increase flexibility of the workforce supporting	Amber	Green	16	9
Risk 00001137	Due to vacancies, staff absence and clinical activity compliance with the clinical supervision of Registered and unregistered nursing staff is below the desired compliance. Current system unable to provide assurance. The lack of opportunity to discuss clinical cases and reflect on the care delivered reduces opportunities for staff development and support of their wellbeing and in turn potentially impacts on the quality and effectiveness of care delivered.	22 Mar 2022	04/12/2024	Jo Nadkarni	15		▪ R1229 - All ward team managers to be using the same clinical supervision recording system ▪ Q&P meeting to be provided with a monthly specialty position in relation to clinical supervision ▪ Routine performance monitoring of clinical supervision compliance to take place within all specialti			15	9

3 risks have been removed from the register.

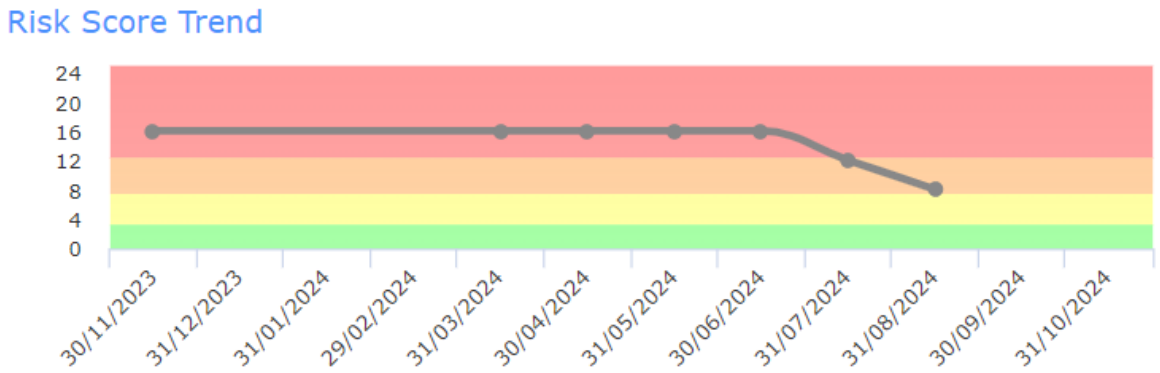
Risk 1361 – NYY AMH - There is a risk of delayed access to telephone crisis triage, very urgent assessments (crisis 4hour response) and limited support through home based treatment across the NYYS AMH crisis response home based treatment teams due to the inability to recruit into vacant posts or secure temp staffing for the teams, resulting in the inability to mitigate against risk presentations and support alternative to admissions that supports treatment and promote patient safety and family/carer wellbeing. (reduced from 16 to 12)



Rationale for change - Improved regular oversight of rotas and immediate response to issues has had a demonstrable improvement in call handling. Risk likelihood reduced to reflect this.

Executive risk group decision – agreed to remove, improvements in team management reflected.

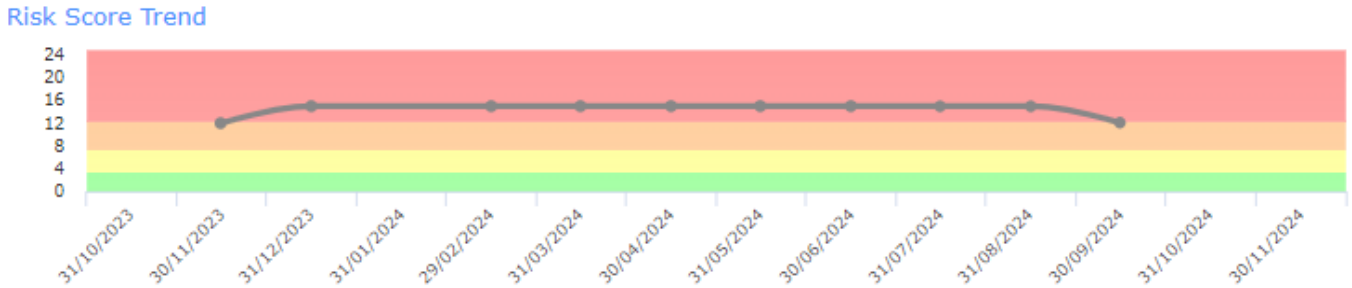
Risk 1464 – PCD Health & Wellbeing - There is a risk that OH / physiotherapy services would be suspended due to current contract disputes, resulting in wider impact on staff, their availability and capability to work, their overall health & wellbeing, timely clearance for new staff to commence work, and impact on small number of staff applying for ill health retirement. (Reduced from 16 to 12).



Rationale for change – most outstanding invoices have been agreed and paid, and meeting to agree forward costs are progressing satisfactorily. This has removed the threat of service suspension.

Executive risk group decision – agreed to remove as risk mitigated.

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



Rationale for reduction - Risk updated with further controls and assurances. Agreed to reduce risk score from 15 to 12. H&J are represented at the RCNI recruitment fair and HMP Northumberland will be included in future events. Also working in partnership with Northumbria University to build the profile at the University with Health and Social Care students. Training being provided to agency nurses to support their working in the TEWV/H&J environment/service. Continue to have additional leadership presence including Nurse Consultant, ADON, Matron. Communications Lead is proactive in geographically targeted advertising vacant posts including use of billboards, in process of creating videos specific to Northumberland area and using current team members. Interactions on Facebook are reviewed. Communications undertaken have resulted in an increase in applicants.

Update - On 6th of November it was discussed within the BCP meeting that the service no longer remained within BCP. Measures remain in place for oversight of clinical documentation and management of clinical caseloads which are up to date. Availability and staffing levels relating to the clinical lead vacancies have improved, staff are competent within their roles and there is regular agency staff in place as mitigation for managing the risk. There is no identified shifts in which there is less than

minimum staffing levels and if we were to experience unexpected sickness, this would not impact the delivery of the service or safety of patients given the current measures in place.

Executive Group Decision – The group agreed removal. There is significant improvement reflected.

Current Risk Rating Movements

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

Risk 909, recruiting to vacant consultant posts, has been an ongoing challenge, and there remain vacancies. While there has been improvement since 2020 when the risk was added, the existing vacancies are in high risk areas. There are plans to recruit to some of these in the next 12 months.

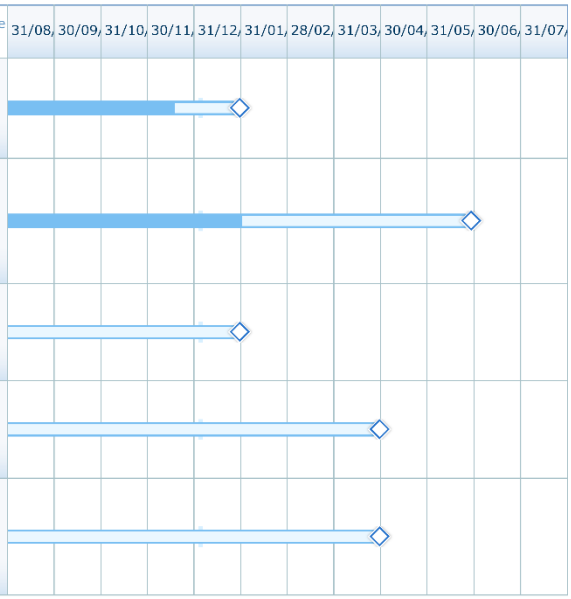
CRR risks - monthly current rating

	Risk Number	Risk Title	Current Risk Rating	31 Dec 2023	31 Jan 2024	29 Feb 2024	31 Mar 2024	30 Apr 2024	31 May 2024	30 Jun 2024	31 Jul 2024	31 Aug 2024	30 Sep 2024	31 Oct 2024	30 Nov 2024	31 Dec 2024
People Culture and Diversity	Risk 00000909	Inability to recruit to vacant consultant posts	Actual		16	16	16	16		16	16	16	16			
	Risk 00001137	Due to vacancies, staff absence and clinical activity compliance with the clinical supervision of Registered and unregistered nursing staff is below the desired compliance and the current system unable to provide assurance.	Actual				15	15		15	15	15	15	15	15	

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

Current Actions

Risk ID	Risk Description	Action Name	Due Date	Planned Completio Date	Owner	Percentage Complete
Risk 00000909	There is a risk due to difficulties in recruitment to vacant posts in the consultant workforce across NYYS due to local and national shortages, resulting in the potential impact on; safe care delivery, teaching and training of junior staff and students, OOH on call rota, research, existing staff morale and wellbeing, finances.	R1001 - Develop non-medic colleague skills to ensure consistent service delivery	31 Dec 2024	31 Dec 2024	Tolulope Olusoga	90%
		R1001 - Explore and encourage group job planning to increase flexibility of the workforce supporting	30 May 2025	30 May 2025	Tolulope Olusoga	65%
Risk 00001137	Due to vacancies, staff absence and clinical activity compliance with the clinical supervision of Registered and unregistered nursing staff is below the desired compliance. Current system unable to provide assurance. The lack of opportunity to discuss clinical cases and reflect on the care delivered reduces opportunities for staff development and support of their wellbeing and in turn potentially impacts on the quality and effectiveness of care delivered.	Q&P meeting to be provided with a monthly specialty position in relation to clinical supervision	31 Dec 2024	31 Dec 2024	Jo Nadkarni	0%
		R1229 - All ward team managers to be using the same clinical supervision recording system	31 Mar 2025	31 Mar 2025	Elspeth Devanney	50%
		Routine performance monitoring of clinical supervision compliance to take place within all specialti	31 Mar 2025	31 Mar 2025	Jo Nadkarni	50%



Summary of risks

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

Owner – Tolu Olusoga

Initial rating 20 (C4, L5), Current Rating 16 (C4, L4), Target Rating 9 (C3, L3), Date to reduce risk previoulsy changed from 30 November 2024 to 30 September 2025.

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

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

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

Owner - Jo Nadkarni

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

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

Assurance – Reasonable Assurance - there is some work to do on the risk entry to reflect controls, assurance sources, and assess effectiveness of current controls, however updates are being made and actions in date. This was discussed as part of the review by the Executive Risk Group and the challenges and barriers to addressing this considered.

Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	Board of Directors
Date:	12th December 2024
Title:	Delivery Plan quarter 2 (July – September 2024) update
Executive Sponsor(s):	Patrick Scott, Assistant Chief Executive
Author(s):	Strategy Team

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

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

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

Strategic Risks relating to this report:

The *Our Journey to Change Delivery Plan 2024/25* is informed by an understanding of all of the BAF risks and the differential levels of risk appetite for each of the risks within it.

Executive Summary:

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

There are a total of 135 deliverables to be achieved by the end of the financial year. This is an increase on the 61 deliverables (previously called projects) in the 23/24 delivery plan.

Proposal: Board of Directors are asked to note the updates on journey, priority and deliverable progress over the second quarter of 24/25. The report also provides a summary delivery position as a percentage at a deliverable and overall journey level.

Board of Directors are asked note the approval of extensions to deliverable timescales as outlined in this report (marked in **bold** font). These extensions were approved at Management Group on 15th October.

There are 4 requests for extension to timescales which go into 25/26, these are marked in **red.** ***The Board of Directors are asked to approve these revised timescales at their meeting on 12th December 2024.***

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

Complete	

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

This report includes:

- *Deliverable status per journey for Q1 & Q2* 2024/25
- *Deliverable status overall for Q1 & Q2* 2024/25
- *Journey updates as at Q2. Approved requests for timescale changes in* ***bold.*** *Requests for BoD approval in* **red.**

Prior Consideration and Feedback

Where appropriate, progress and issues have been discussed within Care Group or Executive Group meetings. This report has been approved at Management Group meeting on 15th October 2024. There are 4 requests for extension to timescales which go into 25/26. The Board of Directors are asked to approve these revised timescales at their meeting on 12th December 2024.

Implications:

There are a number of priorities which are at risk of not being delivered within agreed timescales. These have been flagged in **RED** within the OJTC delivery update tables. Extensions have been requested to the timescales of these priorities (mentioned above).

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

Table 1: % of Deliverables per Journey for Q1 & Q2

Completed deliverables per Journey for Q1 & Q2						
	Journey RAG status					
	Complete	On track	Delayed		Paused	Not reported
Clinical	54%	8%	0%	38%	0%	0%
Q&S	69%	0%	19%	13%	0%	0%
Co-Creation	78%	0%	0%	22%	0%	0%
People	50%	0%	0%	50%	0%	0%
Infrastructure	36%	7%	7%	50%	0%	0%

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

% of completed deliverables overall for Q1 & Q2					
Complete	On track	Delayed		Paused	Not reported
57%	**5%**	**6%**	**32%**	**0%**	**0%**

Recommendations: **Board of Directors are asked to:**

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

b) Approve the 4 timescale extensions into 25/26 where requested (marked in **red** on individual journey pages)

Clinical Journey – Quarter 2 24/25

Transforming Community Services: there are 27 deliverables within this piece of work, with 3 complete at Q1.
6 deliverables are due at Q2 all of which are red. These are:

- *NY&Y implementation of CYPs all age crisis hub* – (covering North Yorkshire & York so 2 deliverables) there are issues with recruitment and training . **It was agreed at Management Group on 15th October that the Board of Directors review the *request to extend the completion date of this milestone to June 2025***

- *Undertake service review of single Point of access* – (covering North Yorkshire & York) the main delays to the review have been recruitment but there are plans to go live on 4th November 2024**. Management Group agreed at the meeting on 15th October 2024 to extend the completion date of these milestones to December 2024**. There are no significant impacts as a result of the extension request.

- *AMH/MHSOP in Tees Valley: Physical healthcare model in place across all 5 Tees Valley localities* – There have been issues with staffing and recruitment. We are still in discussion with Healthcall to begin a pilot of the data transfer product although this is on hold until we have staff in post. **Management Group agreed at the meeting on 15th October 2024 *to extend* the completion date of these milestones to December 2024**

- *CYP ARRS roles evaluation:* ARRS roles expansion (Tees Valley only) – is ongoing and is being explored through the clinical transformation plan. **Management Group agreed at the meeting on 15th October 2024 to extend the completion date of this milestone to March 2025.**

Transforming Urgent Care: there are 5 deliverables within this piece of work, with 1 due at the end of Q1 which is complete. There are no milestones due at Q2.

NENC Secure Services Provider Collaborative Bed Model - there are 8 deliverables within this piece of work, with 2 due by September 2024. These deliverables are: Low secure male mental health and Medium Secure Male Mental Health TEWV these are red due to delays to sign off of overall bed model. These deliverables will be complete by Q3. **Management Group agreed at the meeting on 15th October 2024 *to extend the* completion date of these milestones to December 2024**

Expanding our Health & Justice services - there are 3 deliverables within this piece of work, with 1 due at the end of Q1 which is complete. There are no deliverables due at Q2. However, one is ongoing which is Review of individual opportunities using Trust business model to confirm rational prior to progressing. All opportunities are reviewed using the trust business model to inform Care Group Board and Trust of recommended way forward as and when appropriate.

Autism: there are 4 deliverables within this piece of work, with 1 complete at Q1 and 2 ongoing and on track.
1 deliverable which was due by July 24 is red. This is to *Develop an effective Autism communication strategy.* It is felt that this piece of work should be an ongoing deliverable throughout the year as there will be a number of things to address as the service offer is developed. **Management Group agreed at the meeting on 15th October 2024 to extend the completion date of this milestone to March 2025.**

Young Adult Services: there are 7 deliverables within this piece of work with 2 due at the end of Q1 which are complete. One milestone is due at Q2 which is to *Define, vision, purpose and scope.* This deliverable is complete. An event was held in July 2024 which set out the vision, purpose and scope for this work. The steering group continues to meet monthly.

Reducing health inequalities: there are 10 deliverables within this piece of work, with 2 due and completed at the end of Q1 which are both complete. 5 others are on track. One due by Q4 is amber - *Trial a model of closing the gap on did not attend/was not brought by.* There have been a number of challenges in implementation both in terms of capacity and available technology. The team are exploring alternative ways of delivery and learning and so this remains on track for end of year deadline but is under review.

Quality & Safety Journey – Quarter 2 24/25

Personalised Care Planning: there are 7 deliverables within this piece of work with 3 `due by the end of Q1 and which are complete. There are 2 deliverables are due at Q2:

- *Ensure there is a comprehensive communications plan to ensure all stakeholders are aware of developments and the related implications*. This deliverable is complete. However, it will be ongoing throughout as there will be iterative with the developments and changes in the policy implementation and the work around the role of the keyworker.

- The *ratification of the trust personalised care policy* this deliverable is red. This is now out for consultation and due to close on the 29th October, the feedback will then be reviewed the policy feedback, with a view to taking through governance for agreement. **Management Group agreed at the meeting on 15th October 2024 to extend the completion date of this milestone to January 2025.**

Physical Health: there are 4 deliverables within this piece of work which were due by the end of Q1.
3 are now complete and 1 is red. This is: *Communication plan developed by end April 2024 and engagement through to June 2024.* The engagement element is complete. A communications plan has been developed to share the physical health plan internally with our colleagues. However, there is also a longer-term communications campaign in development for patient safety, which will include key messages relating to physical health. **Management Group agreed at the meeting on 15th October 2024 to extend the completion date of this milestone to March 2025.**

Improved patient safety: there are 5 deliverables within this piece of work of which 3 were due by the end of Q1 and are complete. 2 further deliverables were due by Q2, one is complete: *Review of priorities and setting of further milestones and one is amber.* This is: *Implementation of further InPhase modules.* The majority of modules are now live, with 4 remaining. These modules are 80-95% complete and are expected to be live by the end of October.

Co-creation Journey – Quarter 2 24/25

Further develop our co-creation infrastructure: there are 5 deliverables within this piece of work of which 2 were due by the end of Q1 of which 1 was complete and 1 was red Both of these deliverables are now complete. One deliverable is due by Q2 - *Co-creation framework development complete and roll-out to commence,* this deliverable is red and will not be delivered until January 2025, **Management Group agreed at the meeting on 15th October 2024 to extend the completion date of this milestone to March 2025.**

Lived Experience/ Peer Roles: there are 6 deliverables within this piece of work of which 2 were due by the end of Q1. Both of these deliverables are complete. Another deliverable which was due by Q3 is also complete. One deliverable which was due at Q2 to hold a *celebration event* is red and will not be delivered until March 2025, **Management Group agreed at the meeting on 15th October 2024 to extend the completion date of this milestone to March 2025.**

Improve Patient Experience: there are 6 deliverables within this piece of work, 1 deliverable which was due by the end of July 2024 is already complete. The remaining 5 deliverables are not due until Q4 but are all on track.

People Journey – Quarter 2 24/25

Deliver our people plan: There are 4 deliverables within this piece of work, 1 of which was due at the end of quarter 1. This deliverable is to have the newly procured Occupational Health Service in place. This deliverable was red at the end of Q1 and Management Group agreed at the meeting on 16th July 2024 to extend the milestone to December 2024.

However, the new occupational health service will not be in place until May 25. This delay has been discussed through EDG and mitigations are in in place including an extended contract with the current provider. The delay is due to only one company bidding in the initial tender process. **It was agreed at Management Group on 15th October that the Board of Directors review the *request to extend the completion date of this milestone to June 2025.***

One other deliverable due at Q2 is '*Inclusive Engagement programme developed and in place with staff networks, allies and stakeholders'* this piece of work is complete.

Infrastructure Journey – Quarter 2 24/25

Estates: There are 10 deliverables within this piece of work, 1 of which was due at the end of Q1 and 2 due by the end of Q2

Due in Q1, the deliverable to *complete a detailed Design Sign Off and lease agreement for - Catterick Integrated Care Centre (CICC)* is red. The lease is currently being finalised and work commenced on site. However, equipment and commissioning provisions and affordability still yet to be agreed. **Management Group agreed at the meeting on 15th October 2024 to extend the completion date of this milestone to March 2025.**

Due at Q2: *Catering Infrastructure (Phased Approach):* this deliverable is red. Auckland Park, West Park and Cross Lane, hospitals are complete. Cross Lane - Phase 2 in progress. Foss Park – there is a delay with planning approval but permission now in place and tenders received. Currently liaising with manufacturer re. timescales. Lanchester Road - works commenced. ***It was agreed at Management Group on 15th October that the Board of Directors review the request to extend the completion date of this milestone to November 2025.***

Due at Q2: *Medical Education service operating from LRH* – this deliverable is red. Enabling works at Flatts Lane Centre are complete allowing the re-location of some training from LRH site & facilitation of Trust welcome meetings. Teesside University has recently confirmed a delay in the expansion of their medical school by at least two years. We expect this to reduce demand for placements but are uncertain on precise implications for this development. This is being urgently followed up. **Management Group agreed at the meeting on 15th October 2024 to extend the completion date of this milestone to March 2025.**

The deliverable: *Harrogate Community Hub (Jesmond House)* which is due at Q4 24/25 is currently red and **It was agreed at Management Group on 15th October that the Board of Directors review the request to extend the completion date of this milestone to September 2025**. Although the completion date has been delayed this is not considered an operational risk.

Digital and Data: There are 12 deliverables within this piece of work, 3 deliverables were due by July 2024. Two are complete. The third is *amber Move Business Intelligence system to cloud. deliver network bandwidth across 20 Trust sites experiencing performance issues and deliver MFA.* Project change of plan was agreed at Digital Programme Board. This is due to an identified issue requiring re-factoring work within the new environment. Testing is to be completed by 11th Oct, with parallel running of cloud and existing environments prior to users being moved to the new environment mid November 2024.

The Green Plan: There are 7 deliverables within this piece of work, 3 of which are due at Q2 and are red. These are: *Energy and Sustainability Manger to identify workstream leads and milestones for 2024-25, Pledge for Greener, Green Plan refresh and Catch up plan to establish quick wins and reduction in our carbon output for 2024/25.* **Management Group agreed at the meeting on 15th October 2024 to extend the completion date of this milestone to March 2025.**

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of: Board of Directors
Date: 12th December 2024
Title: Adoption of the Charitable Trust Fund Annual Report and Accounts for 2023/24
Executive Sponsor: Liz Romaniak, Director of Finance, Estates and Facilities
Author: John Chapman, Head of Accounting and Governance

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
12	Financial Sustainability	There is a risk that constraints in real terms funding growth caused by government budget constraints and underlying financial pressures could adversely impact on the sustainability of our services and/or our service quality/safety and financial, and regulatory standing.

Executive Summary:

Purpose: To support the submission of charitable Trust fund accounts and annual report in line with Charities Commission deadlines.

Proposal: The report includes the annual report and accounts for consideration, which have been subject to an independent review by Mazars.

Overview Appendix A contains the Charitable Trust Fund (CTF) annual report and accounts. In year the fund increased by £39k in net resources mainly due to grants received from NHS Charities Together to support wellbeing. The overall balance of the funds as at 31 March 2024 was £581k.

An independent review by Mazars LLP completed during November 2024, with an update being presented at the November Audit and Risk Committee confirming no changes were made to the draft annual report or accounts. The final independent review report will be signed following the December Board of Directors meeting.

Once the independent review is approved and signed it will be included in page 9 of the accounts prior to submission to the Charities Commission (a draft from last year is included for completeness).

Prior Consideration and Feedback: The independently reviewed annual report and accounts were received by Audit and Risk Committee members in November 2024, and the committee made the recommendation that the Board of Directors approves the submission of the Annual Report and Accounts of the Charitable Trust Fund, as shown in appendix A.

An independent review of the accounts and annual report is completed by Mazars LLP. An independent review provides a limited assurance report on the information included within the annual report and accounts. This is less intensive than an external audit but is appropriate for the size and value of transactions within the fund.

Implications:

If supported, the annual report will be uploaded to the charities commission by 31st January 2025.

Recommendations: The Board of Directors is recommended to approve the submission of the Annual Report and Accounts of the Charitable Trust Fund, as shown in appendix A to the charities commission.

The Board of Directors is recommended to ensure appropriate signatures are made on the following pages of the accounts:

- Page 1 – statement of trustee responsibilities
  - Chairman and Chief Executive
- Page 3 – balance sheet
  - Chief Executive

Tees, Esk and Wear Valleys
NHS Foundation Trust

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Tees, Esk and Wear Valleys
NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Foundation Trust

General Charitable Trust Fund

Annual Report 2023-24

1. Tees, Esk and Wear Valleys NHS Foundation Trust General Charitable Trust Fund

The Charity is administered by Tees, Esk and Wear Valleys NHS Foundation Trust and was formed as the "umbrella" Charity for the former Tees and North East Yorkshire NHS Trust and County Durham and Darlington Priority Services NHS Trust charitable funds.

2. Objectives of the Charity

The Tees, Esk and Wear Valleys NHS Foundation Trust Charitable Trust Fund Deed (which is the governing document for the charitable funds) states the Charity's principal objectives as being:

"... for any charitable purpose or purposes relating to the National Health Service".

The governing document does not place any specific restrictions on the use of the funds other than that implied by the Charity's main object. All bids are made on an ad-hoc basis with no commitment or strategic deployment from any one individual fund.

All charities must demonstrate, explicitly, that their charitable purposes are for the public benefit and adhere to the following two key principles:

Principle 1: There must be an identifiable benefit or benefits

Principle 2: Benefit must be to the public, or section of the public

The Trustee confirms that they have had regard to the guidance contained in the Charity Commission's general guidance on public benefit when reviewing the trust's aims and objective and in planning future activities and setting grant making policy for the year. It is the opinion of the Trustee that it has followed this guidance by:

- Providing additional amenities, events or equipment for service users and carers, and employees of the Trust throughout the year.

- Ensuring there is no detriment or harm that, in their view, might arise from carrying out the charity's aims.

Further details of specific activities that have been provided can be referenced in Section 4 – Achievements and performance.

3. Organisational structure and relationships

3.1 Organisation structure

Tees, Esk and Wear Valleys NHS Foundation Trust is the sole corporate Trustee of the charity. Delegated responsibility is allocated to the executives and non-executive members of Tees, Esk and Wear Valleys NHS Foundation Trust Board. All those with delegated responsibility of the Trustee are legally co-opted from the Foundation Trust Board and training and development

needs are addressed through the Foundation Trust appraisal process.

Those with delegated responsibility of the Trustee received no remuneration or expenses, and no remuneration or expenses have been paid to any employee.

The Strategy and Resources Committee receives and examines reports on Charitable Trust Funds at three month intervals. The membership of this committee was:

Dr Charlotte Carpenter, Chair
Mr John Maddison, Non-Executive Director
Mrs Roberta Barker, Non-Executive Director
Mrs Liz Romaniak, Director of Finance, Estates and Facilities Management
Mr Mike Brierley, Assistant Chief Executive
Mrs Ann Bridges, Director of Corporate Affairs and Involvement

In order to safeguard the assets of the Charity and ensure income is applied appropriately the Trustee requires charitable funds procedures to comply with the Trust's Standing Financial Instructions and Scheme of Delegation.

For day to day operational and management purposes the Charity is divided into sub funds. These are managed by Trust officers who have delegated authority to apply the funds within the objects of the Charity.

The Head of Accounting and Governance has overall responsibility for the administration of the funds, supplying regular reports to the Strategy and Resources Committee and completing the annual accounts and annual report for the charitable funds.

An administration charge is levied at the sub funds to reflect the financial and clerical work that Tees, Esk and Wear Valleys NHS Foundation Trust provides. The basis of apportionment for this charge is the value of restricted and unrestricted funds as a percentage of the total funds held.

3.2 Relationships

The Charity's principal relationship is with Tees, Esk and Wear Valleys NHS Foundation Trust.

During the year no member of the Trust's Board had any related party transactions with the Charity.

4. Achievements and performance

The following funds had material movement in balances within the year:

Chime Fund
The purpose of this fund is to manage funds for Ridgeway café and shop for the benefit of users, carers and staff and to facilitate the selling and purchasing of items with a therapeutic purpose. The trading account shows fund closing with the same balance as last year.

CDDPS general fund
The purpose of this fund is to provide general funding across all services within the Durham and Darlington areas for service users / carers. The fund increased by £44k in year due to receipt of a £51k grant from NHS Charities Together, and associated expenditure on staff and patient health and wellbeing.

367 Thornaby Road
The purpose of this fund is to provide general funding across all services within 367 Thornaby Road for service users / carers. The fund received a donation of £2k, which was used to purchase a gazebo to make better use of outdoor space.

MHSOP Charitable account north of Tees
The purpose of this fund is to support patient activities, comforts and diversional equipment. The fund decreased by £3k mainly due to the creation of booklets to provide additional support to service users awaiting assessment.

5. Review of activities

There were no new funds set up, and one fund closed during the year. Funds were closed linked to the balance becoming minimal.

An internal audit review was undertaken by Audit North in July 2019 which gave a good level of assurance. All recommendations have been implemented. Due to materiality a full internal audit review is completed every three years, however, should any process change it is reviewed by internal auditors before being implemented. The pandemic interrupted the review cycle, and we are working to reinstate established processes.

6. Financial activity

A full set of accounts for the financial year 2023-24 are included with this report. Mazars LLP undertakes an independent examination of the accounts.

6.1 General review

The year under review saw an increase of £39k in net resources mainly due to grants received from NHS Charities together to support wellbeing. The overall balance of the funds as at 31 March 2023 was £581k.

Income is derived from donations, legacies, raising funds, grants and investment income. Income from raising funds is mainly received from the shop within the learning disabilities' day centre, and the shop and café at the Ridgeway Centre at Roseberry Park.

During the period 1 April 2023 to 31 March 2024 total investment income was £7k which was an increase on the previous year. Investment income has continued to be less than the administration costs of the Charitable Funds – due predominantly to the current economic climate and low interest rates being available. The Trust is exploring investment accounts for charities to improve the rate of return received on cash balances.

There are a number of funds administered by the Trustee for which bids can be made for goods or services where there is no individual specific Trust Fund to draw on. There were 17 bids approved by the Trustee in 2023-24, to use grants received from NHS Charities Together from the donations raised by Captain Tom to improve service user and staff wellbeing.

Trustwide NHS Charities Together grants are included within Trustee funds balances, the full amounts received have been made available to the Health and Wellbeing Committee to ensure they are used as per grant requirements.

The funds classed as "Others" in note 8 of the accounts are further broken down as follows:

	"Others" Balance	Number Of Funds	Average Fund Balance
Restricted	£152,608	87	£1,754
Unrestricted	£43,674	41	£1,065

6.2 Incoming resources

Total income for the year was £211k, a decrease of £19k on last year. Actual figures were:

	2023-24 £000	2022-23 £000
Donations	8	18
Legacies	1	46
Other trading activities	144	161
Income from investments	7	2
Grants received	51	3
Total	**211**	**230**

See Appendix 1 for chart showing the split of income sources.

6.3 Material donations and legacies

The Charitable Fund received legacies totalling £1k in 2023-24 and received donations of £8k to various funds.

6.4 Resources expended

Expenditure for the year was £172k, a decrease of £112k when compared with £284k spent in the previous year. Analysis of expenditure:

	2023-24 £000	2022-23 £000
Purchasing goods for resale	114	117
Patients' welfare	38	115
Staff welfare	9	41
Governance costs	11	11
Total	**172**	**284**

Expenditure has decreased from the previous financial year, mainly due to the prior year including material expenditure linked to the utilisation of grants received from NHS Charities Together to enhance staff and patient welfare.

See Appendix 2 for chart showing the split of expenditure categories.

6.5 Management and administration costs

The administration costs include the internal audit fee, bank charges, and the Trust cost of administering the funds. Charity Commission guidelines state that if a charity does not exceed £1,000k gross income in a financial year and does not have aggregate value of assets of more than £3,260k, it is eligible to have an independent examination rather than a full audit of its accounts. The assets held by the fund are lower than this minimum value, and as such accounts

are eligible for an independent examination.

Following discussions with the Trust's auditors, Mazars LLP, it was decided that it would be appropriate for the charitable funds to have an independent examination of the accounts. This means the overall management costs per annum are £8k, and account for 4.7% of total expenditure.

The basis of apportionment for the administration costs is the value of restricted and unrestricted funds as a percentage of the total funds held.

6.6 Material expenditure

There were no instances of material expenditure from the funds (e.g. in excess of £5k) in 2023-24 from a single fund.

6.7 Going concern

The fund's activities, together with the factors likely to affect its future development, performance and position are set out in the annual accounts on pages 2-8.

The fund has maintained its level of financial resources due to its long-standing policy of only funding one-off in-year applications to the fund, and has no future commitments to discharge other than creditors as disclosed in the balance sheet which reports £10k of creditors compared to £586k of cash in hand.

The return on deposit account investments, even though interest rates have increased, has been poor throughout the year due to low interest rates available on the market. The low return on investment has resulted in all funds suffering a charge to cover governance costs.

The Trustee's view is that the Charity is a going concern and can make the disclosure as recommended by the accounting standards board that:

After making enquiries, the Trustee has a reasonable expectation that the Charity has adequate resources to continue in operational existence for the foreseeable future. For this reason, it continues to adopt the going concern basis in preparing the annual report and accounts.

7. Funds managed for and on behalf of other NHS organisations.

Within the balances of the Funds held by the Tees, Esk and Wear Valleys NHS General Charitable Fund there were no balances relating to other NHS Organisations.

8. Policy on reserves and investments

8.1 Reserves

The Trustee considers that it should be the aim to hold sufficient reserves to be able to provide funds to meet charitable expenditure as it is incurred and to review the position on an annual basis. Access to the funds is encouraged so that cash is used often and the trust can bring the associated benefits to its patients.

There are limitations on expenditure that can be realised within restricted funds (as it must be related to the purpose of the fund), so a minimum level target is not appropriate for any fund classed as restricted. With unrestricted funds the balance is £228k; as this is not material in comparison with the Trust's turnover of £501,566k no minimum level target has yet been set.

8.2 Investments

8.2.1 Statement of policy on investments

The Charity's funds were invested in an interest bearing deposit account with Virgin Money UK at an agreed interest of 1.36%, with a minimal balance in a lower interest bearing account at Barclays Bank PLC. The Trust is exploring other investment accounts to improve this rate of return and generate additional funds.

Funds were invested in this manner, with the objective to provide maximum security and availability. This allows a flexible and prudent level of control over the charity's funds.

8.2.2 Exposure to risks

The Trustee has identified the major risks to the Charity. The main risks can be summarised as:

1. That the Charity is not operating within its objectives.
2. That accounting transactions are inappropriately or inadequately reported.
3. Expenditure is inappropriate, or inappropriately authorised or not spent for the purposes intended.
4. That income is not appropriated to specific sub-funds in accordance with the intention of the donor.
5. Investments are not properly safeguarded, resulting in loss of funds.
6. Registered fund holders do not respond to requests for actions relating to the timely and appropriate administration of funds.

The Trustee has established systems to ensure these risks are kept at a minimum. Namely:

1. The existence and compliance with Standing Financial Instructions.
2. An adequately qualified and resourced finance function.
3. The establishment of internal financial control systems which are reviewed annually by an Internal Audit Department.
4. Reporting and review of audit findings to an Audit and Risk Committee.

8.2.3 Planned future activities of the Charity

The NHS is an ever changing environment and the future direction of the Charity will be shaped by these changes. The priorities for spending charitable funds are determined primarily by the fund holders who are managers in the service. By delegating the responsibility of expending charitable funds to this level ensures that those able to make the decisions are best placed to know the exact needs of service.

9. Legal and administrative information

Registered charity number

1061486

Registered address
The Flatts Lane Centre
Flatts Lane
Normanby
Middlesbrough
TS6 OSZ

Trustee
Tees, Esk and Wear Valleys NHS Foundation Trust is the sole corporate Trustee of the Charity. Delegated responsibility for Trustee duties for the period covered by this report is allocated to members of the Board of Directors. These were:

Non-executive directors:
Mr David Jennings
Prof. Pali Hungin (left 28 February 2024)
Mrs Beverley Reilly
Mr John Maddison
Dr Charlotte Carpenter
Mrs Jillian Murray
Mr Jules Preston
Mrs Roberta Barker

Executive directors
Mr Brent Kilmurray
Mrs Zoe Campbell
Mr Patrick Scott
Mrs Liz Romaniak
Mrs Beverley Murphy (started 01 May 2023)
Dr Kedar Kale
Dr Sarah Dexter-Smith
Mr Mike Brierley
Mrs Ann Bridges
Dr Hannah Crawford

All Board of Directors appointments are made in accordance with the policy and procedures laid down in the NHS code of good practice.

The Secretary of State for Health, in line with statutory requirements approved the Chairman's appointment, and a panel comprising the minimum statutory members, including the Chairman and an expert independent assessor, made the Chief Executive's appointment.

All other executive and non-executive appointments to the Trust Board were made following external advertisement and robust and transparent selection procedures.

Independent examiners
Mazars LLP
The Corner
Bank Chambers
26 Mosley Street
Newcastle upon Tyne
NE1 1DF

Legal advisors
Ward Hadaway
Sandgate House
102 Quayside
Newcastle upon Tyne
NE1 3DX

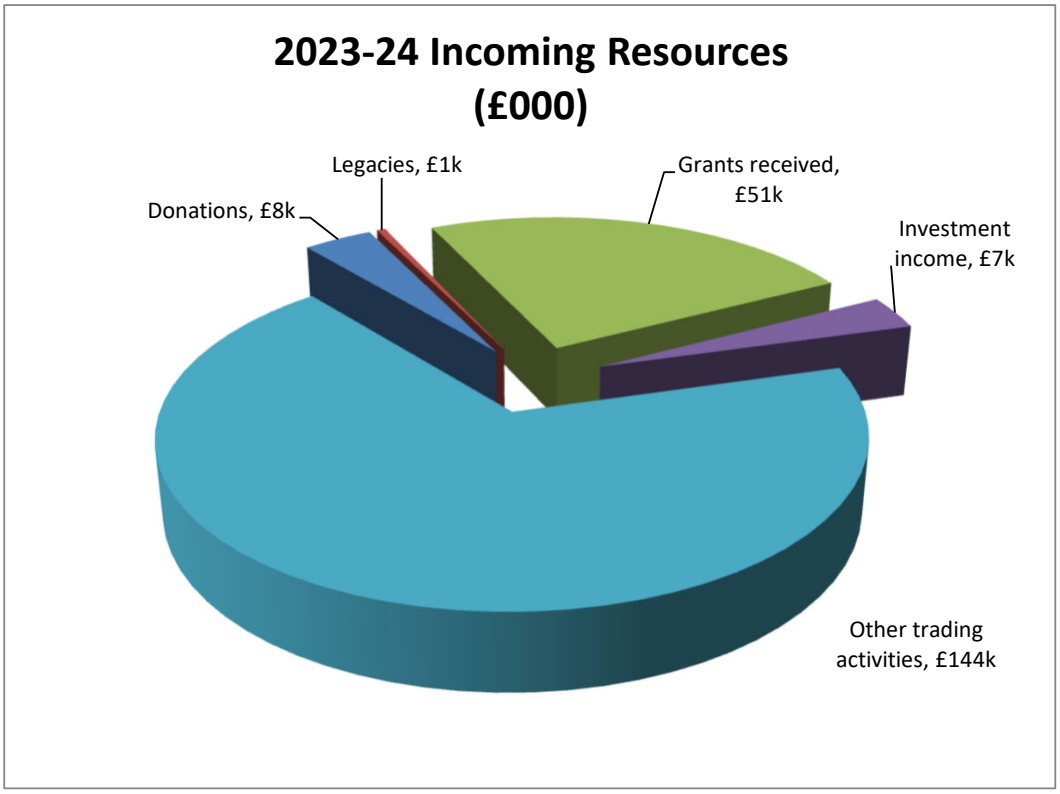
Bankers

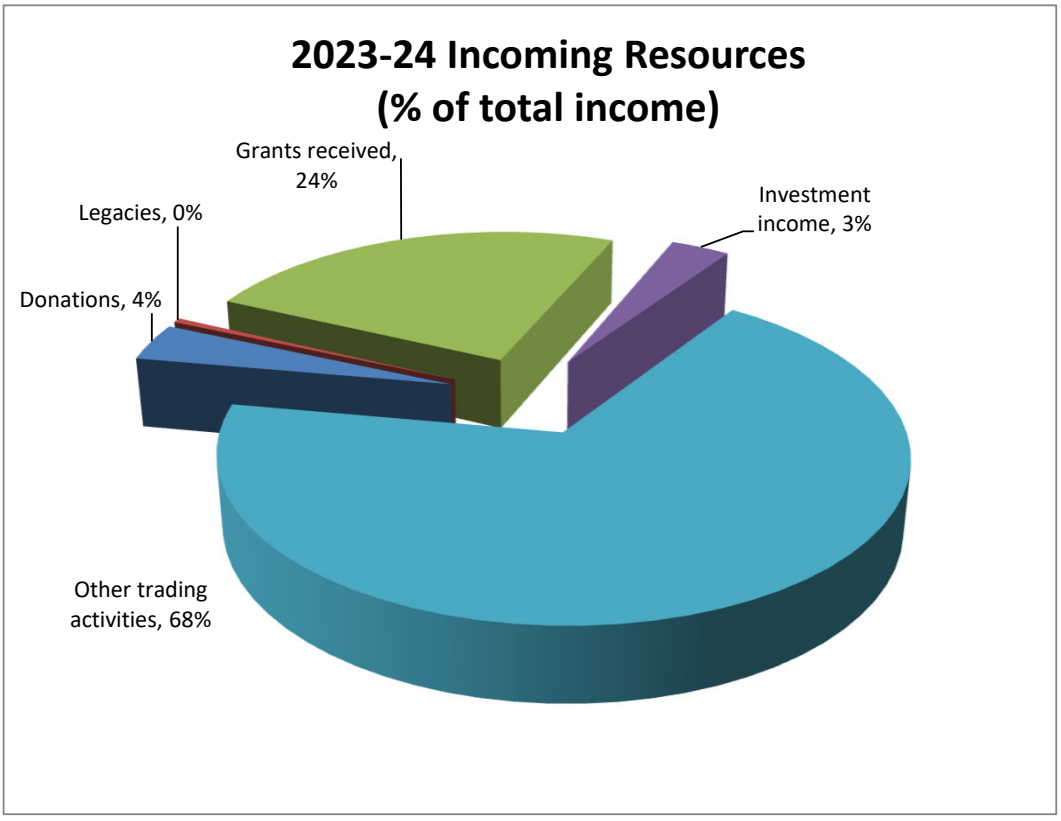
Yorkshire Bank PLC
7 Linthorpe Road
Middlesbrough
TS1 1RF

Barclays Commercial Bank
PO Box 190, 2 Floor,
1 Park Row,
Leeds, LS1 5WU

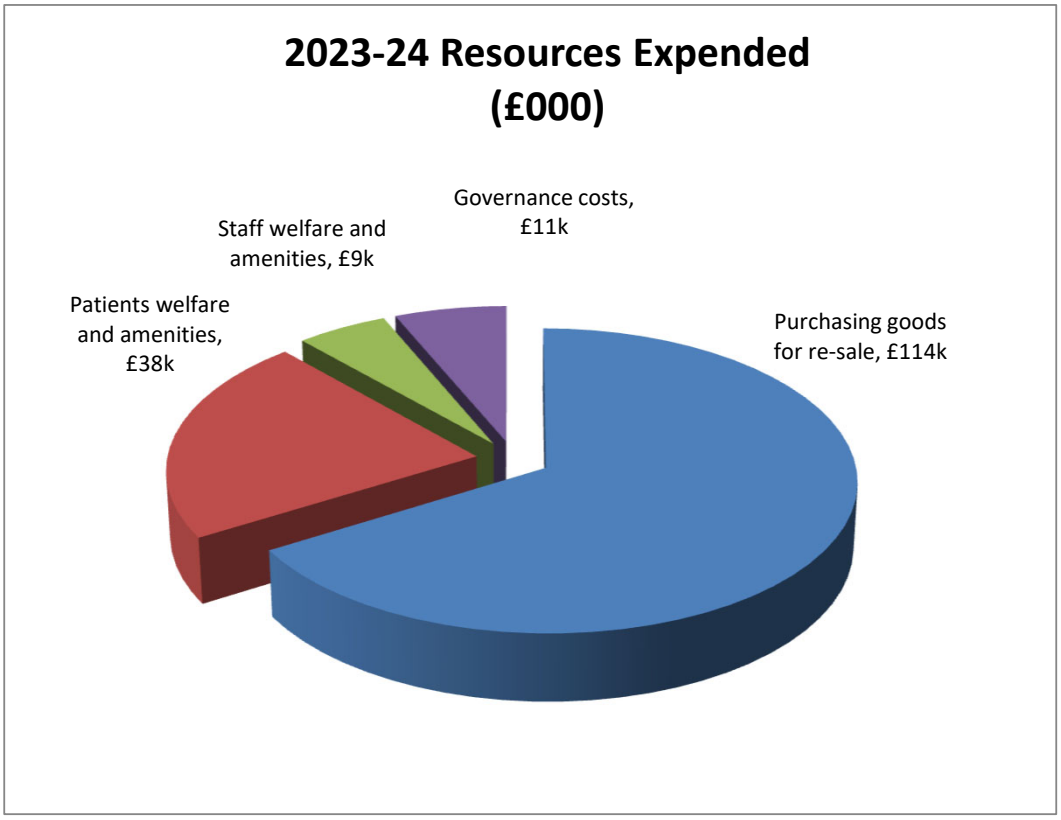
Analysis of incoming resources

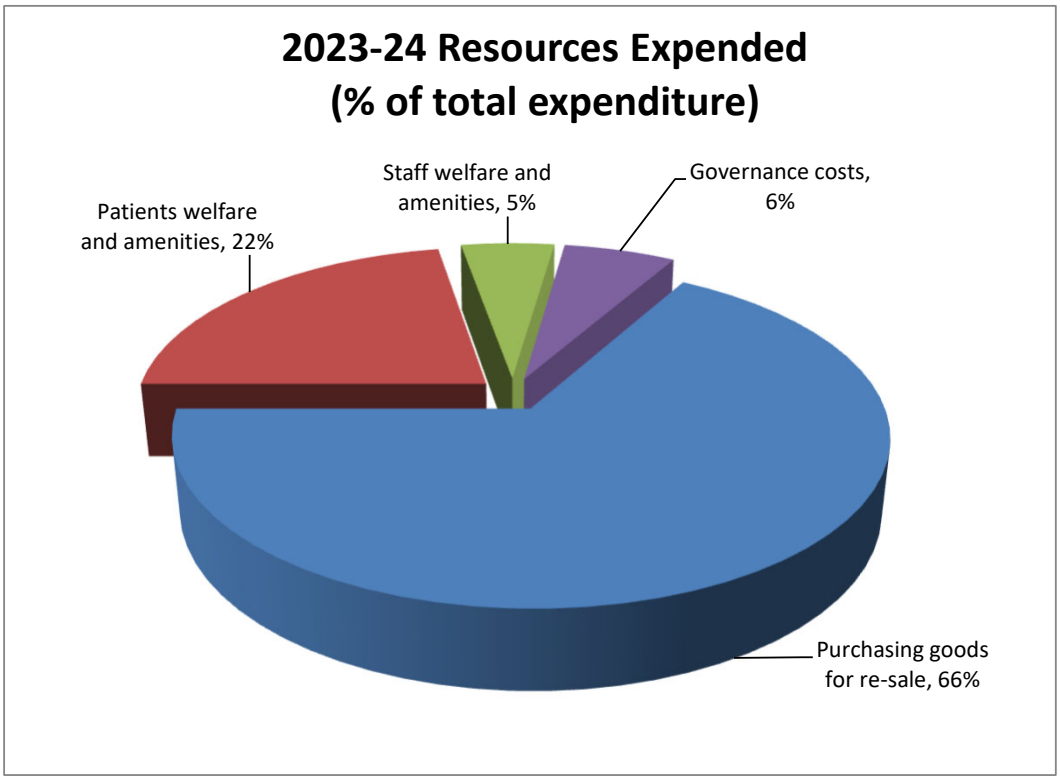
Appendix 1





Analysis of resources expended Appendix 2





10: Charitable Fund Account

Statement of trustee responsibilities

Tees, Esk and Wear Valleys NHS Foundation Trust is the sole corporate trustee of the fund. Delegated responsibility of the trustee is applied to executive and non executive members of Tees, Esk and Wear Valleys NHS Foundation Trust Board.

The trustee is responsible for preparing the trustees' Annual Report and financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

The law applicable to charities in England and Wales/Scotland/Northern Ireland requires the trustee to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period.

In preparing these financial statements the trustee is required to:

select suitable accounting policies and then apply them consistently;

observe the methods and principles in the Charities SORP;

make judgements and estimates that are reasonable and prudent;

state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements; and

prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the charity and enable them to ensure that the financial statements comply with the Charities Act 2022, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the trust deed . It is also responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The trustee is responsible for the maintenance and integrity of the charity and financial information included on the charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

The trustee confirms that it has met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 1-8 attached have been complied from and are in accordance with the financial records maintained by the trustee.

By Order of the trustee, and those with delegated responsibility

Chairman……..…….. Date……

Executive Director ……..…… Date …….

Statement of Financial Activities for the year ended 31 March 2024

	Note	31 March 2024 Unrestricted Funds £000	31 March 2024 Restricted Funds £000	31 March 2024 **Total Funds £000**	31 March 2023 Total Funds £000
Incoming resources					
Income and endowments from:					
Donations		4	4	**8**	18
Legacies		-	1	**1**	46
Grants received	5.1	51	-	**51**	3
Income from investments	5.2	3	4	**7**	2
Other trading activities	5.3	-	144	**144**	161
Total income and endowments		**58**	**153**	**211**	**230**
Resources expended					
Expenditure on:					
Raising funds	3.3	-	(114)	**(114)**	(117)
Charitable Activities	3.1	(17)	(41)	**(58)**	(167)
Total resources expended	4	**(17)**	**(155)**	**(172)**	**(284)**
Net movement in funds	6	**41**	**(2)**	**39**	**(54)**
Reconciliation of funds:					
Fund balances brought forward at 1 April		228	314	**542**	596
Fund balances carried forward at 31 March		**269**	**312**	**581**	**542**

There were no other recognised gains or losses in the year.

Balance Sheet as at 31 March 2024

	Notes	Unrestricted Funds £000	Restricted Funds £000	**Total at 31 March 2024 £000**	Total at 31 March 2023 £000
Current assets					
Debtors		-	5	**5**	-
Short Term Deposit Investment		270	316	**586**	551
Total current assets		270	321	**591**	551
Current liabilities					
Creditors: Amounts falling due within one year	7	(1)	(9)	**(10)**	(9)
Total current liabilities		(1)	(9)	**(10)**	(9)
Total current assets less current liabilities		269	312	**581**	**542**
Total net assets		**269**	**312**	**581**	**542**
Funds of the Charity					
Income Funds:					
Restricted	8.1	-	312	**312**	314
Unrestricted	8.2	269	-	**269**	228
Total funds		**269**	**312**	**581**	**542**

Notes numbered 1 to 13 form part of the accounts.

Signed:

Date:

Notes to the Account

Accounting policies

1 The principal accounting policies are summarised below. They have been applied consistently through out the reporting year 2023-24 and throughout the comparators shown for the previous reporting year 2022-23.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention with items recognised at cost or transaction value unless otherwise stated in the relevant note(s) to these accounts. The accounts have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014, and with the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and with the Charities Act 2011.

The charity constitutes a public benefit entity as defined by FRS 102

1.2 Incoming resources

All incoming resources are included in full in the Statement of Financial Activities as soon as the following three factors are met:

entitlement - control over the rights or other access to the economic benefit has passed to the charity;

probable - it is more likely than not that the economic benefits associated with the transaction or gift will flow to the charity;

measurement – the monetary value or amount of the income can be measured reliably and the costs incurred for the transaction and the costs to complete the transaction can be measured reliably.

Legacies

Legacies are accounted for as incoming resources once the receipt of the legacy becomes reasonably certain. This will be once confirmation has been received from the representatives of the estate that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.

Offsetting

There has been no offsetting of assets and liabilities, or income and expenses.

Grants and donations

Grants and donations are only included in the SoFA when the general income recognition criteria are met.
No performance related grants were received.

Tax reclaims on donations and gifts

Gift Aid receivable is included in income when there is a valid declaration from the donor. Any Gift Aid amount recovered on a donation is considered to be part of that gift and is treated as an addition to the same fund as the initial donation unless the donor or the terms of the appeal have specified otherwise.

1.3 Resources expended and creditors

The Charity accounts are prepared in accordance with the accruals concept. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party.

Cost of generating funds

The cost of generating funds are the costs associated with generating income for the funds held on trust.

Governance costs

These are accounted for on an accruals basis and are recharges of appropriate proportions of the funds administration costs from Tees, Esk and Wear Valleys NHS Foundation Trust, plus Internal and External Audit charges for 2023-24. These costs are apportioned across the funds using the appropriate classification of fund. During 2023-24 the classification split was:

Restricted 56%, Unrestricted 44%.

Creditors

The charity has creditors which are measured at settlement amounts.

1.4 Structure of funds

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are classified as unrestricted funds. Funds which are not legally restricted but which the Trustees have chosen to earmark for set purposes are classified as restricted funds. The major restricted funds held within these categories are disclosed in note 8.

1.5 Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later).

1.6 Pensions contributions

The Charity does not employ staff and does not make pension contributions.

1.7 Change in the basis of accounting

There has been no change in the accounting policy or accounting estimates in the year.

1.8 Prior year adjustments

There are no prior year adjustments in these accounts.

1.9 Going concern

After making enquiries, the Trustee have a reasonable expectation that the Charity has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Please see section 6.7 within the Annual Report for further details

1.10 Stock

A small balance of stock is held to support the activities of the Ridgeway Cafe / Shop and LD Forensic Day Services however, having reviewed the balance of stocks held over time, the Trustee has confirmed that the stocks are both stable and immaterial in value. Consequently stocks are not recognised within the financial statements rather are treated as expenditure as they are purchased.

2 Related party transactions

During the year no members with delegated responsibility for the Trustee, or members of the key management staff or parties related to them has undertaken any material transactions with the Tees, Esk and Wear Valleys NHS Trust General Charitable Fund (2022-23, £nil).

The Charitable Fund does not have the facility to pay creditors therefore, Tees, Esk and Wear Valleys NHS Foundation Trust makes the payments on the Fund's behalf and is re-imbursed on a monthly basis by the Fund.

Certain income for the Charitable Fund is initially banked through Tees, Esk and Wear Valleys NHS Foundation Trust. This income is re-imbursed to the Fund on a monthly basis.

Tees, Esk and Wear Valleys NHS Foundation Trust is the sole corporate trustee of the fund. Delegated responsibility of the trustee is applied to executive and non executive members of Tees, Esk and Wear Valleys NHS Foundation Trust Board (names listed below). All are also members of Tees Esk and Wear Valleys NHS Foundation Trust.

Mr Brent Kilmurray
Mrs Zoe Campbell
Mr Patrick Scott
Mrs Liz Romaniak
Mrs Beverley Murphy (started 01 May 2023)
Dr Kedar Kale
Dr Sarah Dexter-Smith
Mr Mike Brierley
Mrs Ann Bridges
Dr Hannah Crawford
Mr David Jennings
Prof. Pali Hungin (left 28 February 2024)
Mrs Beverley Reilly
Mr John Maddison
Dr Charlotte Carpenter
Mrs Jillian Murray
Mr Jules Preston
Mrs Roberta Barker

3 Details of resources expended on charitable activities

3.1 Activities in furtherance of charities objectives

	Unrestricted Funds	Restricted Funds	**Total 2024**	Total 2023
	£000	£000	**£000**	£000
Patients welfare and amenities	(3)	(35)	**(38)**	(115)
Staff welfare and amenities	(7)	(2)	**(9)**	(41)
Governance costs (see 3.2 below)	(7)	(4)	**(11)**	(11)
	(17)	**(41)**	**(58)**	(167)

3.2 Analysis of governance costs

	Unrestricted Funds	Restricted Funds	**Total 2024**	Total 2023
	£000	£000	**£000**	£000
Establishment costs	(3)	(3)	**(6)**	(6)
Internal / External audit fee*	(1)	(1)	**(2)**	(2)
NHS Charities Together membership	(3)	-	**(3)**	(3)
	(7)	**(4)**	**(11)**	(11)

*Independent examination of the accounts cost £2,000

3.3 Details of costs incurred in raising funds

	Unrestricted Funds	Restricted Funds	**Total 2024**	Total 2023
	£000	£000	**£000**	£000
Purchasing goods for re-sale	-	(114)	**(114)**	(117)
	-	**(114)**	**(114)**	(117)

4 Analysis of total resources expended

	Costs of raising funds	Costs of activities for charitable objectives	**Total 2024**	Total 2023
	£000	£000	**£000**	£000
Internal / External audit fee	-	(2)	**(2)**	(2)
Compliance costs for Trust Funds	-	(6)	**(6)**	(6)
NHS Charities Together membership	-	(3)	**(3)**	(3)
Charitable activities	(114)	(47)	**(161)**	(273)
	(114)	**(58)**	**(172)**	(284)

5 Analysis of income

5.1 Grants received

	Unrestricted Funds	Restricted Funds	**Total 2024**	Total 2023
	£000	£000	**£000**	£000
NHS Charities Together	51	-	**51**	3
	51	**-**	**51**	-

5.2 Income from investments

Income from investments of £7k relates to interest received on individual fund balances held by the Charity. These investments are held in the UK.

5.3 Details of other trading activities

The £144k income from other trading activities was delivered from the re-sale of goods purchased at a cost of £114k, and amounts received for training income.

6 Changes in resources available for charity use

	Unrestricted Funds	Restricted Funds	**Total 2024**	Total 2023
	£000	£000	**£000**	£000
Net movement in funds for the year before transfers	41	(2)	**39**	(54)
Internal transfers	-	-	**-**	-
Net increase /(decrease) in funds for the year	**41**	**(2)**	**39**	(54)

7 Analysis of creditors	Balance at 31 March 2024 £000	Balance at 31 March 2023 £000
Trade creditors	(10)	(9)
Total amounts falling due within one year	**(10)**	**(9)**

8 Details of material funds

8.1 Restricted funds	Balance 1 April 2023 £000	Incoming resources £000	Resources expended £000	**Balance 31 March 2024 £000**	**Description of the nature and purpose of each fund**
CHIME Fund	68	144	(144)	**68**	To provide funds for the well being of patients within Ridgeway
Allinson Bequest	27	-	-	**27**	To provide funds for epilepsy services in the Durham area
Lanchester Road Hospital AMH	16	-	-	**16**	To provide funds for the well being of patients within Lanchester Road Adult MH services
Learning Disabilities	14	-	-	**14**	To provide funds for activities for patients with Learning Disabilities in York and Selby
Community Team Auckland Park Hospital	12	-	-	**12**	To provide funds for occupational therapy services for the patients of Tees Esk and Wear Valleys NHS FT
Occupational Therapy	12	-	-	**12**	To provide funds for activities for patients of Acomb Garth
Epilepsy Fund, Bankfields Court	11	-	-	**11**	To provide funds for epilepsy services in the Middlesbrough area
Others (87 Funds)	154	8	(10)	**152**	
Total	314	152	(154)	**312**	

8.2 Unrestricted funds	Balance 1 April 2023 £000	Incoming resources £000	Resources expended £000	**Balance 31 March 2024 £000**	
Foss Park Fund	148	2	(2)	**148**	To provide general purpose funds for the patients being cared for in Foss Park Hospital
CDDPS General Fund	22	52	(8)	**66**	To provide general purpose funds for the patients being cared for in the Durham area
St Mary's General Fund	12	-	-	**12**	To provide general purpose funds for the patients being cared for at St Mary's Hospital
Others (41 Funds)	46	4	(7)	**43**	
Total	**228**	**58**	**(17)**	**269**	

9 Connected organisations

	2023-24		2022-23	
	Turnover of Connected Organisation £000	Net Deficit for the Connected Organisation* £000	Turnover of Connected Organisation £000	Net Surplus for the Connected Organisation** £000
The charity is administered by Tees, Esk and Wear Valleys NHS FT	**501,566**	**(11,608)**	484,465	(21,837)

* The deficit for 2023-24 includes expenditure for unanticipated impairments of fixed assets totalling £9,725k, and other technical adjustments of £1,887k. Excluding these non operating items would result in a surplus of £4k.

** The deficit for 2022-23 includes expenditure for unanticipated impairments of fixed assets totalling £21,033k (£11,639k resulted from a prior period adjustment during 2023/24 financial year). Excluding these non operating items would result in a surplus of £804k.

10 Other funds held for and on behalf of other NHS organisations

Within the balances of the Funds held by the Tees, Esk and Wear Valleys NHS General Charitable Fund there were no balances relating to other NHS Organisations.

11 Cash flow

The charity has taken advantage of the exemption available to it under section 7 of FRS102 not to produce a cash flow statement due to its size.

12 Taxation liability

As a registered charity, Tees, Esk and Wear Valleys NHS Charitable Fund is potentially exempt from taxation of income and gains falling within Part 10 of the Income Tax Act 2007 and s256 Taxation and Chargeable gains Act 1992. No tax charge has arisen in the year.

13 Post Balance Sheet events

There are no post balance sheet events to report.

INDEPENDENT EXAMINER'S REPORT TO THE TRUSTEE OF TEES, ESK AND WEAR VALLEYS NHS TRUST GENERAL CHARITABLE FUND

I report on the financial statements of Tees, Esk and Wear Valleys NHS Trust General Charitable Fund for the year ended 31 March 2024, which are set out in Section 10

Respective responsibilities of trustees and examiner

The charity's trustee is responsible for the preparation of the financial statements. The charity's trustee considers that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

It is my responsibility to:

- examine the financial statements under section 145 of the 2011 Act;
- follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the 2011 Act; and
- state whether particular matters have come to my attention.

This report, including my statement, has been prepared for and only for the charity's trustee as a body. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustee as a body for my examination work, for this report, or for the statements I have made.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the financial statements presented with those records. It also includes consideration of any unusual items or disclosures in the financial statements, and seeking explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the financial statements present a 'true and fair view' and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, which is complete, no matters have come to my attention which give me reasonable cause to believe that in any material respect:

- accounting records were not kept in respect of Tees, Esk and Wear Valleys NHS Trust General Charitable Fund in accordance with section 130 of the 2011 Act; or
- the financial statements do not accord with those records; or
- the financial statements do not comply with the applicable requirements concerning the form and content of financial statements set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the financial statements give a 'true and fair' view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which, in my opinion, attention should be drawn in order to enable a proper understanding of the financial statements to be reached.

Signed:

Name: Gavin Barker (CPFA) for and on behalf of Mazars LLP
Relevant professional qualification or body: CIPFA
Address: The Corner, Bank Chambers, 26 Mosley Street, Newcastle upon Tyne, NE1 1DF
Date: 02-Dec-24

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Agenda Item 15

Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12th December 2024**
Title:	**REPORT OF THE FREEDOM TO SPEAK UP GUARDIAN**
Executive Sponsor(s):	**Sarah Dexter-Smith/ Kate North**
Author(s):	**Dewi Williams/ Sarah Dexter-Smith**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
1, Safe staffing and 4, Quality of care		The Freedom to Speak Up Guardian is part of the key control on ensuring staff are able to raise concerns in a safe and constructive way. At present it is considered that there is good assurance that this control is operating effectively. Failure to effectively undertake and embed learning could result in repeated serious incidents and adversely affect worker experience. Recommendations within this report highlight learning and improvements that have been identified from those who have chosen to speak up.

Executive Summary:

Purpose: The purpose of this report is to inform the Board of Directors about the last 6 months of Freedom to Speak Up (FTSU) activity, with data covering Quarter 3 and 4. It demonstrates the impact we have made, how through joint working we have responded to speaking up from a range of people, and how we work with services to share learn lessons and develop action plans which help those who spoke up feel listened to and valued. It also includes information for board about the wider routes through which we understand concerns in services the complement the formal FTSU route

Proposal: Board members are asked to note this report and provide guidance on any further information required.

Overview:

Background

The role of the FTSU Guardian (FTSUG) was created in response to the recommendations made in Sir Robert Francis report "The Freedom to Speak Up" (2015).

The FTSUG supports staff who have raised concerns.

In August our FTSU officer left the service, so the Guardian has been providing some extra hours on the fifth day to ensure there is not a significant gap in cover. This reduction in dedicated time has been mitigated by concentrating on the core responsive element of the role and reducing the proactive element eg team visits.

The role reports independently to the CEO and the NED. Roberta Barker is stepping down as she is taking on chair of the committee so I would like to thank her for all her help and support and look forward to working with Jules Preston in the future. The FTSUG works alongside the Trust board to help develop more ways to empower and encourage staff to raise their concerns.

Data

Information on the activities of the FTSUG service is detailed in the appendix.

The upward trend in case numbers appears to have stabilised.

We continue to work closely with operational services asking them to address concerns internally rather than relying on independent reviewers. This has resulted in speeding up resolution, increased satisfaction from those who spoke up, and an increased sense of overview for operational services.

	Quarter 1 2023	Quarter 2 2023	Quarter 3 2023	Quarter 4 2024	Quarter 1 2024	Quarter 2 2024
Total Cases Received	46	44	61	55	52	56

- Detriment: 3 cases of detriment were referred to the Associate Director for Operational Delivery and Resourcing within People and Culture. In the future there will be quarterly summaries of the cases of detriment. Outcomes and themes will then be provided to the NED FTSU champion and to the Director of People and Culture for review. The themes had included having their fitness to practice being reviewed. victimisation.
- Training: Most recent information on compliance shows Speak Up at 89%, and Listen Up is at 91 %. This is a strong position relative to the time this has been available for. Follow up is at 95% and is available to Senior leaders and is strongly recommended for all board members.

Activity

The development of training and support for the Speak Up ambassadors is now progressing following the recent release of new guidance issued by the National Guardians Office. Following discussions with Leanne Jamfrey, professional lead for the Professional nurse advocates, we will be training around 40 PNAs in December, with more to come as the support for speaking up and the reflective practice focus of the PNAs fit well together.

I have started attending the twice monthly induction days, a great opportunity to inform new starters about the value and responsibility to speak up.

Impact / Triangulation of information to advise the board

I continue to meet with the Director of People & Culture and the Associate Director of Delivery and Resourcing on a quarterly basis to review the data regarding the actions taken/lessons learnt and also to review the cases where individuals have said that they remain unhappy despite having their concerns reviewed. I meet the Director of People and Culture monthly to review any barriers I am experiencing.

The speaking up raising concerns group continues to meet on a monthly basis to share any soft intelligence as a result of hearing from those colleagues who regularly have contact with teams to understand if there are any issues arising. I have made arrangements to visit specific teams based upon the soft intelligence that has been received. Members of the group tell us that they have encouraged those that they have received contact from to speak up and this is reflected within the increase in the number of contacts that we continue to receive.

The board are asked to note some of the case examples which show the lessons learnt during the last 6 months within appendix 3. The lessons learnt within the examples provided identified the need for better staff planning, the importance of better communication, a requirement for staff training and wellbeing support for staff, a need to increase staff resource and a requirement for some leadership reflection.

Further work on building a speak up culture and triangulating signs of concern

Board have expressed an interest previously in how assured we can be that the information coming through the FTSUG reflects the concerns across the organisation. There are multiple ways in which we notice and respond to concerns and these are collated through the monthly speak up group (chaired by the Director of People and Culture) and communicated appropriately to the relevant director and people partner, along with information on ongoing support being provided or planned. This ensures that we are sharing information on a regular basis about concerns, interventions and impact. This creates a loop back to the people partners who support services to triangulate other data such as complaints, sickness, leavers drawing on the service people dashboard and other indicators.

A broader culture of speaking up is being built on the model of reflective practice. Clinical professions tend to have this well established, with nursing strengthening

this through the PNA roles (see above). Cathy Byard is leading work on developing shared principles of reflective practice and joined executives (with the FTSUG) for a broader discussion. Next year's culture work will focus on reflective practice across all services, including corporate where we know we have a gap in skills, confidence and practice. This will build on successful trials so far and alongside our broader approach of creating more spaces in the trust where people can reflect on their work and think together about the impact on them and of themselves on others eg lunch and learns, Schwartz rounds, organisational learning group.

The new combined EDG covering workforce, resources and strategy has in its workplan quarterly focus on culture and retention, EDI, and health and wellbeing. These will all provide a governance route for executive level oversight and direction of the key issues that underpin a culture of speaking up and the opportunity to identify and challenge signs of concern.

Recommendations

The board is asked to take good assurance from the processes in place to hear and respond to concerns in the organisation.

Appendix – further information

Caseload

The upward trend in case numbers appears to have stabilised.

The table below displays the figures for ongoing cases over Quarters 1 & 2. And shows the previous year for comparison.

	Q1 2023	Q2 2023	Q3 2023	Q4 2024	Q1 2024	Q2 2024
Total Cases Received	46	44	61	55	52	56
Bullying and Harassment	10	5	7	4	2	0
Worker Wellbeing	20	15	29	32	27	20
Patient Safety/Quality	22	9	15	18	8	7
Inappropriate Behaviours	18	20	25	17	9	18
Other	18	7	17	20	0	4
Demeaning Treatment	2	3	3	3	0	1

Individual cases received often include multiple themes, each case is only counted once

Assessment of Cases

The highest proportion of staff choosing to speak up within Quarters 1 & 2 were from a Nursing and Midwifery.
4 cases were received anonymously during this period.

Service Development

We share an overview of the lessons learnt as a result of people speaking up with our speaking up raising concerns group on a quarterly basis and also review this information with the Director of People and Culture and the Associate Director of Operational Delivery and Resourcing.

We continue meeting with the Lead for Organisational Development (OD) to review those cases where the actions taken/lessons learnt have resulted in a recommendation for OD intervention in order to discuss and triangulate this data.

We also regularly signpost and encourage those who have indicated to us that they are intending to leave the Trust to complete the intention to leave form on the staff intranet so that a discussion can take place with a member of the OD team.

Since the board decision to outsource the service to an external provider, the procurement process has been ongoing. However, there is as yet no date yet for going to tender.

Training

We continue to provide bespoke training for teams or individuals on request, and specialist training for senior staff wishing to undertake reviews.

We continue to develop training and support for our speak up ambassadors.

Support networks

We continue to hold our monthly speak up forum with colleagues from across corporate services who work across multiple teams. We share soft intelligence and then agree how best to feed this information through to the services to ensure early notice of challenges. We are dependent on individuals to come forward. This also triggers guardian visits to services to ensure staff know their speaking up options. The guardian remains very grateful for the support provided by the guardian officer. The additional support has enabled us to provide more proactive support to services much earlier after hearing initial concerns from the wider group.

Opportunities for learning lessons occurs within the forum. We also use the staff intranet and Facebook to share anonymised case examples, primarily to share the message that it is worth speaking up, and the trust does listen and act on concerns raised by our staff.

Professional representation of cases

Profession	Proportion of Trust wide profession	Cases received in Q1 by profession	Cases received in Q2 by profession
Admin and Clerical	19.9%	1	8
Additional Clinical Services	27.4%	4	10
Nursing and Midwifery	26%	28	16
Medical and Dental	3.32%	2	1
Allied Health Professionals	5.29%	12	15
Not known		3	4
Other		1	2

Admin and Clerical: Non-clinical staff, including non-clinical managers, administration officers, executive board members who do not have significant patient contact as part of their role.

Additional Clinical Services: Staff directly supporting those in clinical roles. In addition, support to nursing, allied health professionals and other scientific staff are included. • Have significant patient contact as part of their role

Nursing and Midwifery: Registered nurses and midwives.

Medical and Dental: Registered doctors and dentists.

Allied Health Professionals: Registered clinical staff providing diagnostic, technical and therapeutic patient care, including dieticians, radiographers and physiotherapists. • Includes qualified ambulance staff such as paramedics

Additional Health Professionals: Scientific staff, including registered pharmacists, psychologists, social workers, and other roles such as technicians and psychological therapists.

Other – Governors, Volunteers

Lessons Learnt

Speak Up	**Staff Wellbeing/Staff Safety/ Patient Safety/Quality.** 3 workers from an AMH inpatient service spoke up about their concerns relating to a senior leader who they said was making it impossible to manage. (micromanaging)
Listen Up	The FTSU team raised this with the managing director.
Follow Up	**Actions taken / Lessons learnt:** The director met with two of the people speaking up, and offered support, and outlined their proposed review process. One action was greater visibility of senior leaders on the unit. Meetings were held to share with staff the nature of proposed review and how they could help in the development of the team. Some elements of the of the action plan remain confidential, however, those who spoke up felt they had been listened to, and were satisfied with the outcomes.
Speak Up	**Staff Safety/Wellbeing / Patient Safety/Quality** A number of staff from a therapy team spoke up about unmanageable workloads due to short staffing, being asked to undertake interventions they were not trained for, and unsympathetic managers who made them feel like they were failing as individuals for being overwhelmed and speaking up.
Listen Up	The FTSU team contacted the managing director for the service who along with the other Managers met with the team.
Follow Up	**Actions taken / Lessons Learnt:** The senior leaders met in confidence with those who spoke up, and some other staff to gauge the level of concern. An action plan was agreed upon and more staff were recruited, and

	interventions were reviewed. Those who spoke up were satisfied and were happy to report a successful CQC inspection. However 6 months later these improvement have not been sustained, and they are again speaking up. The managing director has now asked an independent manager to review a number of similar services to establish concerns and develop an action plan

Speak Up	**Behaviour / Staff Wellbeing / Safety / Demeaning Treatment** A senior manager spoke up about the management culture within their service, and that too many other managers had a close relationship which made it challenging for them to work independently and confidentially.
Listen Up	The managing director conducted an initial review which involved the person who spoke up meeting with the CEO. There had been previous concerns raised regarding this issue so required some time to look into.
Follow Up	There was a comprehensive review which found no evidence that these close relationships had impacted on service delivery or decision making. However we have since received an anonymous concern via the CQC and ICB alleging similar concerns. These were again reviewed by the director of operations, and again found no concerns but agreed there were lessons to be learned about how close relations between managers can be addressed to improve transparency.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Committee Key Issues Report		
Report Date to Board of Directors – 12 December 2024		
Date of last meeting: 7 November 2024	**Report of: The Quality Assurance Committee**	
	Quoracy was achieved.	
1	**Agenda -** The Committee considered the following matters: • Summary of the Executive Review of Quality Group meeting: 31 October 2024 • Integrated Performance Report (IPR) • Progress with CQC Actions including HMC Regulation 28 Responses • Flow across Acute Care Services • Progress with the Quality Priorities • Progress with the Quality Dashboard • Quality Assurance and Improvement Programme • Quality Impact Assessments • Co Creation • Complaints/Patient and Carer Experience • Learning from Deaths/Mortality • Resuscitation Report • Medical Devices Report • Infection, Prevention and Control • Organisational Learning Group – theme of learning • Corporate Risk Register • Board Assurance Framework	
2a	**Alert**	The Committee alerts the Board on the following matters: **From the DTVF Care Group:** • Restrictive Interventions: Two long term seclusion and three long term segregation. A new seclusion in month over 48 hours on Bedale. • One unintended prone restraint on Tunstall ward, where patient placed themselves in prone. • Tear proof clothing used twice (SIS) and three of uses of soft cuffs in SIS for escort to Acute Trust. • Safety summary oversight no longer available on IIC. Mitigations include the Quality Assurance audit and caseload supervision until pathway is on CiTo. • A mixed sex/privacy and dignity issue occurred, due to unavailability of beds and was managed safely. • 72 hour follow up breaches are being followed up to ensure people are safe. Four contacted, one readmitted (not now classed as a breach) and one outstanding despite several attempts to follow up. • Focus being given to improvement compliance with seclusion reviews and adherence to policy. • Update received on recent safety incidents on Bransdale and Tunstall **From NYYS Care Group:** • There was one prone restraint on Danby – incorrect hold used, which was followed up appropriately. • NY Crisis Services are likely to move into business continuity with vacancies having a considerable impact. • Delayed discharges in older adult services in NY, roughly equivalent to one ward of patients. Team and external colleagues working to resolve. **Other business matters:** • Significant work needed to improve reviewing incidents within 4-day time frame.

		• Clinical outcomes remains a concern and focus continues to make improvements. The Trust does compare favourably against the national average of 10% for these measures as we have a range of 20-40% dependent on the service. • Committee sought further assurance regarding compliance for section 17 leave and time away from the ward documentation and safety plans. Care groups are giving this focus through the Fundamental Standards Group. • There is limited assurance with compliance for ILS training and care groups have been asked to focus at team/ward level to identify issues. • Whilst the Committee assigned reasonable assurance on the level of performance for people waiting to access our care, there remains overall concern about our position, which requires a Board discussion.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: **From the Care Groups:** DTVF: • Agreed to step back from the enhanced monitoring of Birch ward due to improvements made – internal and Provider Collaborative. More beds to be opened due to improvements in care and leadership. • The numbers of people completing patient experience surveys is significant and the data reports over 77% of positive experience. NYYS: • No episodes of seclusion. • No use of tear proof clothing. **Other business matters:** • Feedback from NICHE ahead of our QAC Extraordinary Meeting is that the quality of care demonstrated in the child and adolescent team records is good and that there are no issues to escalate for attention. • Reasonable assurance linked to progress against the CQC Improvement plan which has been thoroughly reviewed and revised, however good assurance that the systems and processes for oversight and monitoring are appropriate. • There is good assurance related to the progress with the quality priority measures for 2024/25. • There is good assurance on progress with the Quality Impact Assessment Programme. • There is good assurance related to the significant progress made in relation to the co creation agenda. • Compliance with responding to complaints within agreed timescales in September reported an increase from 67% to 72%, which demonstrates more local resolution. • There is good assurance with the reporting and learning from deaths in line with national guidance. • There is good assurance related to progress being made by medical devices services which was reflected in a Corporate Risk Register reduction from 16 to 12. • There is good assurance linked to the management of infection prevention and control that policies and procedures are aligned to national recommendations. • The Committee reviewed the risks aligned to the Corporate Risk Register. Each static risk has now been reviewed and we have seen positive movement in our scores. • There is good assurance that the strategic risks in the BAF are being managed effectively and the Chair reflected a recent discussion at Board and with the Council of Governors in relation to Demand which remains a concern.
2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board:

		From the Care Groups: DTVF: • Variance to practice relating to the use of long term segregation and seclusion policy at Bankfields. The variance has concluded that care requires the same oversight as if the person is secluded. • Theme coming out of the close oversight and support of some wards that have shown signs of challenge is the lack of stability and experience in the leadership teams. This gives us an opportunity to be more proactive with teams where there are changes in leadership. • Carers in SIS are writing a newsletter for other carers, a positive initiative. • DTVF acknowledge that the systematic oversight of safer staffing requires improvement. • Birch ward objective review of recent quality issues identified learning that will be shared appropriately. NYYS: • Ripon ICT to explore bringing forward transformation plans in light of the extended period in BCP. **Other business matters:** • Committee is seeking further clarity on the levels of assurance set out in the Integrated Performance Report. Some nervousness over 'substantial' level of assurance determined based on the Performance Management Framework and the AuditOne internal audit report assigning substantial assurance on the integrated approach to performance. • The development of the new quality dashboard is well underway with full implementation expected in Quarter 4. • The Organisational Learning Group is developing momentum and supports our implementation of PSIRF.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considers that good assurance can be provided that the risks to quality are understood and are being managed appropriately. The Committee considers that the risks relating to section 17 leave require more focus. The Committee also noted the BAF risks in relation to Demand required review.
3	**Actions to be considered by the Board**	That the Board: i) Note the report.
4	**Report compiled by**	Bev Reilly, Chair of the Quality Assurance Committee, Deputy Chair of Trust/Non-Executive Director, Rachel Weddle, Deputy Chief Nurse, Kedar Kale, Exec. Medical Director and Donna Keeping, Corporate Governance Manager

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Committee Key Issues Report		
Report Date to Board of Directors – 12 December 2024		
Date of last meeting: 5 December 2024	**Report of: The Quality Assurance Committee**	
	Quoracy was achieved.	
1	**Agenda -** The Committee considered the following matters: • Summary of the Executive Review of Quality Group meeting: 28 November 2024 • Integrated Performance Report (IPR) • Clinical Outcomes, PROMS/CROMS • Impact of Statutory/mandatory compliance on regulation and quality of care • Section 17 Leave and time away from the ward. • Inpatient Environment Safety Works – sensor doors • Annual Environmental Risk Assessment Surveys • Specialist Services – where we are, what we know and what we report. • Trust Quality and Learning Report • Physical Health Plan • Organisational Learning Group • Six monthly Safeguarding Report • Deloitte Governance Review – Delivery of Plan • Board Assurance Framework • NICHE and CQC	
2a	**Alert**	The Committee alerts the Board on the following matters: **From the DTVF Care Group:** • Care group oversight in place for Overdale and Baysdale ward to proactively support improvements in quality / consistent standards of care. **From NYY Care Group:** • Progress out of business continuity for Ripon ICT is slow. Situation is stable, staffing numbers are increasing with a Band 7 to start and there is additional funding for a further Matron. Executive Review of Quality Group remain sighted on the impact on care. **Both:** • Committee discussed in detail the level of assurance linked to waiting times for all services, which for most community services is reasonable. For neurodevelopmental assessments (CYP and adults) assurance is limited with recognition that improving this position is not within the gift of the Trust alone. It is important that the public understand the complexity of the position, including the issues outside of the Trust direct control. There is reasonable assurance that we understand where people are waiting and the longest waiting times, however the Committee alerts Board that we have limited assurance of the impact on the quality of care and support whilst they wait to access care. **Other business matters:** • We will undertake a review of several patient safety incident investigations associated with inpatient care to consider any potential themes, taking a step back to look at any further potential learning. One theme to explore is people who die by suicide when on leave from hospital. • TEWV took part in a planned POM H audit on rapid tranquilisation in May 2024, with data that was flawed and incomplete due to recent EPR changes. The Head of Pharmacy is collating manual records to establish our position the outcome of which can be shared with the CQC. • Currently there is limited assurance about the rates of supervision and recording on TEWVision, there is a drive to improve this.

		• Although the position with planning section 17 leave has improved, audits currently do not provide assurance of consistent application of the practice standards that is required. Both care groups whilst confident that the improvement work will lead to improved practice, they will put in place daily oversight until this improvement is evident. The Committee did not have assurance and focused on the potential impact on safety. A further report will be received on the actions taken to gain more immediate daily assurance. • The Committee remains concerned about the over occupancy on acute wards and the impact this has on timely access to beds and the quality of care. • The Committee is seeking assurance related to the impact of Cito on data quality. Chief Information Officer will provide a report to the February meeting.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: **From the Care Groups:** DTVF: • Patients rating services as good or very good in October 93%. • Improved oversight of 72-hour breaches. • No mixed sex accommodation breaches. NYYS: • No episodes of seclusion, use of tear proof clothing. • No mixed sex accommodation breaches. **Other business matters:** • Committee agreed there was overall a good level of assurance that the IPD is underpinned by the Performance and Controls Assurance Framework. • The new quality dashboard is developing, where live data will be seen, giving a much richer understanding of quality data. Anticipated to be in full use by April 2025. • Good assurance related to the process for the annual environmental risk assessment survey, which takes place at least once a year. The TEWV environmental tool has been adapted from the national survey tool. • Reasonable assurance linked to the operational and strategic oversight of the key quality and safety areas of patient care described in the Trust Quality and Learning Report. This report will ultimately be replaced by the new quality dashboard. • Reasonable assurance linked to the progress with delivering the physical health plan – now need to see sustained trend of improvement in physical health care. • Good assurance on progress being made to ensure sensor doors programme is completed across the inpatient estate. • Final report from NICHE received at the Extraordinary QAC meeting on 25 November with good level of assurance that care is in line with standards and that there is good quality governance in place. • Good assurance provided on the quarterly tracked progress with safeguarding priorities.
2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: **From the Care Groups:** **NYY:** • Work is underway to support staff at Cross Lane to develop their practice to provide care that is not reliant on seclusion. • Buddying plans have supported Improvements across community teams to ensure completion of the Quality Assurance Schedule across all community teams following a finding that completion was inconsistent. **DTVF:** • Improving approach to timely seclusion reviews aligned to policy. • Phased approach to re-opening beds on Birch ward continues. **Both:**

		• Outcome measures are now better understood and there is more work to do to keep improving the current position. **Other business matters:** • A submission will be made to the CQC following the factual accuracy checks on the report following the inspection of crisis services on Friday 6 December. • Focus being given to improving waiting times for CYP neurodevelopmental assessments and adults waiting for their second contact with Talking Therapies. • Overlapping themes across meetings to be discussed further between Committee Chairs, with a view to providing assurance to the Audit and Risk Committee. • Deputy Place Nurse Director NYH ICB, Helen Hart (new attendee at Committee), to meet with MD of NYYS care group board to discuss system wide challenges. • The potential impact of the street drug 'spice' on staff and patients is being monitored closely, as there is concern it could migrate from prisons into hospital sites. • Steady progress is being made on the review of patient safety incidents within the 4-day time frame. • Further options to be sought for providing sufficient training spaces for ILS including support from acute settings. • Significant improvement actions underway to ensure statutory/mandatory training fits individual job profiles and competencies. QI team looking at compliance flow and training needs analysis. • Change requests to the Quality Assurance and Improvement Programme/NICE baseline assessments were approved. • The Deloitte governance review delivery of plan was received for information retrospectively, having reported into the October Board of Directors. The Committee will focus on Phase 2 of the work.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considers that good assurance can be provided that the risks to quality are understood and are being managed appropriately. The risks relating to section 17 and that we are working with people to plan their leave in a way that keeps them safe needs to be adequately narrated in the BAF.
3	**Actions to be considered by the Board**	That the Board: i) Note the report. ii) Note the concerns linked to waiting times. iii) Note the requirement to update the BAF on the risks to keeping people safe whilst on leave.
4	**Report compiled by**	Bev Reilly, Chair of the Quality Assurance Committee, Deputy Chair of Trust/Non-Executive Director, Beverley Murphy, Executive Chief Nurse and Donna Keeping, Corporate Governance Manager

Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12th December 2024**
Title:	**Learning from Deaths**
Executive Sponsor(s):	**Kedar Kale, Executive Medical Director**
Author(s):	**Rachel Weddle, Associate Director of Patient Safety**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
8	**Quality Governance** - There is a risk that our floor to Board quality governance does not provide thorough insights into quality risks caused by the need to further develop and embed our governance and reporting including triangulating a range of quality and performance information resulting in inconsistent understanding of key risks and mitigating actions, leading to variance in standards.	There is a risk that if we fail to embed key learning from deaths, patient safety and quality will be compromised and the people we serve will lose confidence in the services we provide. This paper sets out key processes for mortality reviews and learning from deaths across the Trust to reduce and mitigate this risk.
10	**Regulatory compliance** - There is a risk that failure to comply with our regulatory duties and obligations, at all times, could result in enforcement action and financial penalties and damage our reputation	

Executive Summary:

Purpose:

The national guidance on learning from deaths requires each Trust to collect and publish specific information. This report covers the period from July to September 2024 (Quarter 2). The Board of Directors is receiving the report for information and assurance of the Trust's approach in line with national guidance.

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

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

Overview:
In line with National Guidance the Learning from Deaths Dashboard at appendix 1 details Q2 information for the Trust and includes 2023/24 data for comparison.

- During Q2 the Trust received 347 death notifications of patients who had been in contact with our services in the preceding 6 months. The Trust received 16 death notifications of people with a learning disability or autism in the time frame. These figures represent all deaths (including natural expected/unexpected, and unnatural/unexpected) in relation to people who were currently open to the Trust's caseload which is largely community and includes older people and memory services (>70,000).
- 6 inpatient deaths were reported. Three of these deaths occurred within an inpatient setting and were expected deaths, subject to Part 1 reviews. Three other deaths occurred in Adult Mental Health wards and are suspected suicides which occurred off the ward and are therefore subject to Patient Safety Incident Investigations (PSII's) which are underway. All deaths have either been reported on the national Strategic Executive Information System (StEIS) and are subject to further investigation as PSII's or are being investigated via the mortality review process.
- 4 unexpected community deaths were reported on StEIS during the reporting period to be investigated as Patient Safety Incident Investigations of which 2 are complete and 2 in progress.
- Immediate After Action Reviews were conducted for all the above unexpected deaths and where appropriate, rapid improvements have been made to improve patient safety.
- 9 Part 2 Structured Judgement Reviews (SJRs) were requested.
- 47 Part 1 reviews and 4 SJRs were completed.
- 28 serious incident investigations / Patient Safety Incident Investigations for unexpected deaths were completed.
- All deaths of people with either a learning disability or a diagnosis of autism require reporting to LeDER in line with national requirements over the reporting period. Deaths are reported to LeDER via the clinical teams and the Patient Safety team have added a prompt to all After Action Review documents. It has also been built into the InPhase reporting system since 30th October 2023. Any discrepancies in reporting are being followed up by the Patient Safety team. Reasons given for not reporting have been identified as deaths occurring in the Acute Trust or a Care home and it was assumed by the TEWV clinical team that the team providing 24-hour care had submitted the referral. Teams are being asked to confirm this with those providers.

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

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

- 1 in relation to environmental risks and issues
- 1 in relation to sharps management
- 1 in relation to privacy
- 1 in relation to emollients and fire risk

To improve learning and measure progress against the Trusts main themes, all learning requires a SMART action plan. To support learning at the earliest opportunity all unexpected deaths are

reviewed in the daily patient safety huddles and subject to an After-Action Review where appropriate.

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

Prior Consideration and Feedback

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

Implications:

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

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

Recommendations:

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

Tees, Esk and Wear Valleys
NHS Foundation Trust

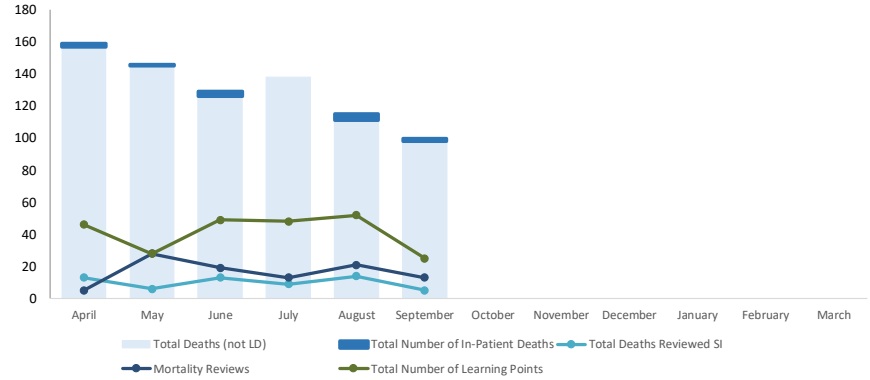
Appendix 1: Learning from Deaths Dashboard Q2 2024/25

Learning from Deaths Dashboard - Data Taken from Paris/CITO
Reporting Period - Q2 2024-25

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

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

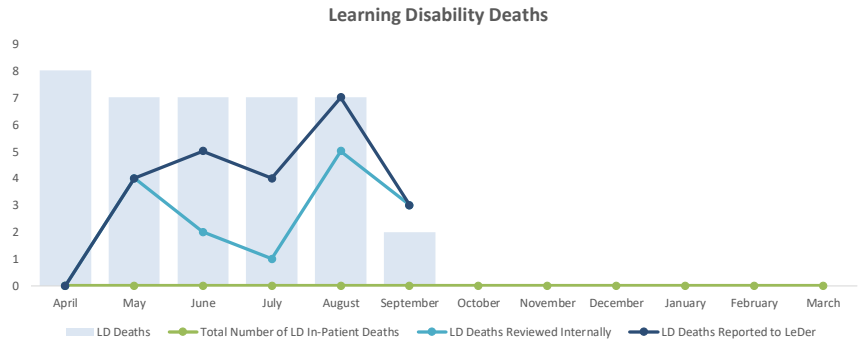
	Total Deaths (not LD)		Total Number of In-Patient Deaths		Total Deaths Reviewed SI		Mortality Reviews		Total Number of Learning Points	
	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24
Q1	428	↘ 510	6	↗ 4	32	↗ 12	52	↘ 175	123	↗ 38
Q2	347	↘ 437	6	↘ 8	28	↘ 41	47	↔ 47	125	↘ 159
Q3	0	↘ 531	0	↘ 9						
Q4	0	↘ 519	0	↘ 6						
YTD	775	↘ 1997	12	↘ 27	60	↗ 53	99	↘ 222	248	↗ 197



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

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

	LD Deaths		Total Number of LD In-Patient Deaths		LD Deaths Reviewed Internally		LD Deaths Reported to LeDer	
	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24
Q1	22	↘ 26	0	↔ 0	6	↘ 12	9	↔ 9
Q2	16	↘ 18	0	↔ 0	9	↗ 7	14	↗ 7
Q3	0	↘ 38	0	↔ 0				
Q4	0	↘ 26	0	↔ 0				
YTD	38	↘ 108	0	↔ 0	15	↘ 19	23	↗ 16



Appendix 2

Mortality Reviews 2024/2025

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

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

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

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

- All in-patient deaths, not subject to a Patient Safety Incident Investigation (PSII) have either had a Part 1 completed or are in the process of having one completed.
- All LD deaths of those open to TEWV have either been reviewed, or are being reviewed under Part 1 of the mortality review process. Where any concerns are identified, a Structured Judgement Review has been or will be requested. All these cases are to be reported to LeDER for review. The LeDER referral will not necessarily be completed by TEWV if the individual is receiving their main care from another provider.
- All community deaths for patients aged 64 and under have been or are being reviewed under Part 1 of the mortality review process and where any red flags/concerns have been identified a Structured Judgment Review has been requested.
- 20% of community deaths for patients aged between 65 and 74 have been reviewed under Part 1 of the mortality review process and where any red flags/concerns have been identified a Structured Judgment Review has been requested. This 20% is selected from deaths within Trust services as opposed to deaths within care homes where the Trust is not the main care provider.
- 10% of community deaths for patients aged 75 onwards have been reviewed under Part 1 of the mortality review process and where any red flags/concerns are identified a Structured Judgment Review has been requested. This 10% is selected from deaths within Trust services as opposed to deaths within care homes where the Trust is not the main care provider.

Appendix 3

1. Mortality Reviews and Learning

Mortality Review 2024/2025

4 structured judgement reviews were discussed and reviewed by the Mortality Review Panel during Q2. One of the cases presented was rated as providing excellent overall care.

A number of Actionable learning points were identified:

- Care planning, interventions and record keeping
- Patient and carer experience
- Medication Management
- Multi-agency working

Learning from actions/assurance

- Findings from SJRs are fed back to the clinical networks, where appropriate, to ensure that learning feeds into existing improvement work. Outcomes are captured in minutes at the following mortality review panel. These will be fed into the re-established Organisational Learning Group for future quarters.
- Where the learning identified is related to the work of a specific professional group, for example Pharmacy, the relevant mortality review panel member ensures this is actioned and shared Trust-wide. Good examples of assurance can be evidenced from the workstreams related to Clozapine, Lithium and Depot Injections.
- Learning for individuals is shared with operational teams where appropriate and addressed via supervision and local governance processes.

Learning from mortality reviews often demonstrate similar themes identified during Serious Incident reviews / Patient Safety Incident Investigations. The themes from mortality reviews are triangulated with learning from serious incidents reviews / Patient Safety Incident Investigations to establish any new themes occurring.

1.2 Learning from deaths and serious incidents

Within Quarter 2 there were a total of 125 learning points from both Serious Incidents, Patient Safety Incident Investigations and mortality reviews. The most frequent actionable learning theme identified related to record keeping and documentation. Processes was the second most frequent learning point identified. Two other themes related to the lack of recording of next of kin contact details and in tow investigations information sharing between GP's and Local trusts was identified.

1.3 Structures to support and embed learning

1.3.1 Fundamental standards group

Practice Development Practitioners are now integrated into the Care Group Fundamental Standards meetings where wider learning and good practice can be shared to facilitate improvements Trust-wide.

1.3.2 Organisational Learning

The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group (OLG). Any significant issues identified by the OLG are

escalated to the Executive Review of Quality Group for further discussion and or actions. The OLG now has a 12-month workplan based on the recurring themes identified.

1.3.3 Patient Safety Incident Management/Investigation

The Trust has a continued focus on improving the quality of incident reporting, investigation, and identification of key actionable learning. Key improvements across the incident reporting and investigation pathway have been implemented incrementally and we continue to develop and embed these changes ensuring they are compliant with the requirements of the National NHS Patient Safety Strategy and the Patient Safety Incident Response Framework (PSIRF).

The Patient Safety Programme Board (PSIM) provides oversight on the Risk management system procurement, and the embedding of the Patient Safety Incident Response Framework (PSIRF) and Learning from Patient Safety Events (LFPSE). The Programme Board reports into the Transformation and Strategy Board.

1.3.4 The Environmental Risk Group

This group receives information where environmental factors may have contributed to harm, as well as progression of initiatives to reduce harm. Any urgent learning identified through this group is distributed Trust-wide via Patient Safety Briefings. The annual Environmental survey programme with a multi professional input from estates, health and safety and clinical services continue. The ligature reduction programme is monitored through this group with assurance provided through the Trusts quality governance structures. Significant investment has been dedicated to assistive technology in the form of Oxehealth and door sensors to make wards safer.

1.3.5 Recruitment and Retention/staffing establishment reviews

When looking at patient safety incidents through a systems and human factors lens, it can be seen that workforce pressures and capacity including community caseloads can impact on the quality of care delivered. Significant work is being undertaken to ensure that we have a suitably skilled and resourced workforce who can carry out their duties in a safe and compassionate way. Further details can be seen within the safe staffing and establishment review papers.

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Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	Board of Directors
Date:	Thursday 12th December 2024
Title:	Medical Education Annual Board Report
Executive Sponsor(s):	Dr Kedar Kale, Executive Medical Director
Author(s):	Hayley Lonsdale, Head of Medical Education & the Medical Education Leadership Team

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
9	***Partnerships and System Working***	***There is a risk that failure to take a proactive role and engage effectively with partners caused by capacity and financial challenges limits our ability to effectively train our doctors and medical students and improve the health of the communities we serve.***

Executive Summary:

Purpose: This annual report provides an overview of medical education activity during the last twelve months and outlines key priorities for the next academic year (2024 / 2025).

Proposal: This report provides good assurance to board members regarding the provision of medical education in the Trust.

Overview: TEWV has 224 resident doctor posts approved for training. During the 2023 / 2024 academic year over 400 resident doctors rotated through these approved posts. In addition to this TEWV hosted 440 medical student placements from four medical schools and a further 45 Physician Associate (PA) student placements from four universities.

Last year the Trust received over £6.9 million from NHS England (NHSE) via the NHS Education Funding Agreement (EFA) to support the salaries and educational infrastructure required to deliver medical education placements.

The Trust has a legal responsibility through the EFA and the GMC (General Medical Council) to quality assure the delivery of medical

education and this is undertaken through a cycle of quality control, namely the self-assessment report (SAR) and quality improvement plans (QIP) and these reports will be shared with NHSE to demonstrate how it meets the GMC domains for training.

The GMC national training survey (NTS) provides an opportunity for resident doctors and trainers to provide feedback, and this allows the Trust to benchmark the level of training provided against other similar organisations.

This year the Trust has demonstrated an exceptionally high level of training across all programmes, despite the constant challenges the Faculty of Medical Education (FoME) face ensuring the provision of high quality training placements whilst dealing with an increasing shortage of consultant psychiatrists / accredited trainers due to the number of consultant vacancies.

Prior Consideration and Feedback

Contents of this report were discussed in the Medical Education Leadership Team (MELT) meeting.

Implications:

- The Trust has a responsibility to meet the EFA and quality assure the delivery of medical education.
- The Trust still does not have sufficient facilities to train medical students and resident doctors at all Trust sites.
- Having sufficient substantive trainers to provide supervision still remains a constant challenge.

Recommendations:

It is recommended that the Trust Board note the content of this paper which provides a comprehensive summary of medical education activity, key achievements, horizon scanning, action planning and conclusions and accepts this as good assurance.

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Summary of Medical Education Activity September 2023 – August 2024

CONTENTS

1. INTRODUCTION & PURPOSE

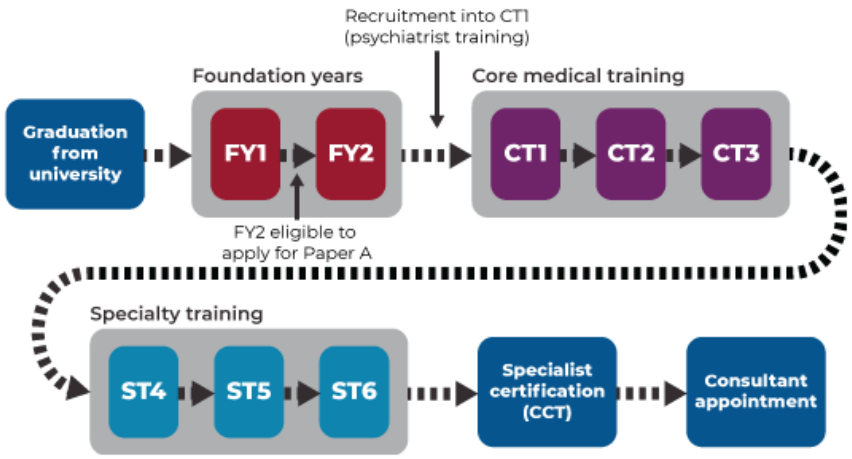
This report will provide an overview of medical education activity in the last twelve months and outline key priorities for the next academic year.

2. BACKGROUND INFORMATION

2.1 The Trust currently hosts x224 approved resident doctor placements in Foundation, GP, core, and higher training. The configuration of these posts is outlined in the embedded spreadsheet below.

Medics Post Configuration Sprea

An illustration of the training pathway in psychiatry created by the Royal College of Psychiatrists (RCPsych) is provided below.



During the 2023-2024 academic year the Trust hosted x440 medical student placements from four universities and x45 Physician Associate (PA) student placements. *Appendix 1* provides an overview of medical student internal feedback for the last academic year. Detailed below is a breakdown of medical student and PA student numbers and their placement stage.

Medical Schools (Medical students)	Stage	Number of students
Newcastle AST (Durham, Darlington & Teesside localities)	5	119
Newcastle ICCP (Durham, Darlington & Teesside localities)	3	105
Sunderland (Durham & Darlington & localities)	3	95
Leeds (Harrogate locality)	4	28
Hull & York (York locality)	3	54
Hull & York (Scarborough locality)	3	27
Hull & York (South Tees locality)	3	12

Universities (Physician Associates)	Stage	Number of students
Newcastle University (Durham, Darlington & Teesside localities)	2	10
Leeds University (Harrogate locality)	1	7
University of Bradford (York locality)	2	12
Hull & York Medical School (York & Scarborough locality)	2	16

2.2 Internal governance of postgraduate medical education is overseen through Postgraduate Doctor Training Forums (PDTF) now known as RDTF (Resident Doctor Training Forum). These represent the two Care Groups in the Trust and oversee the delivery of registrar and senior registrars training. Separate committee meetings are held to oversee the training of Foundation doctors and GP registrars. Similarly, there are local undergraduate groups in each Care Group, overseen by a Trustwide Undergraduate Governance Board (UGB). The Medical Education Committee (MEC) oversees all these groups and sets out the strategic direction of the Faculty.

2.3 From 1st April 2024 the NHS Education Funding Agreement (EFA) replaced the 2021/24 NHS Education Contract, covering both education and placement providers until 31 March 2027. https://www.england.nhs.uk/terms-and-conditions-2/new-nhs-education-contract/

The 2024/27 agreement supports non-competitive, equitable activities listed in the Department of Health and Social Care Education and training tariff guidance and NHS Education funding guidance published yearly, regarding: education and placements funding
salary support funding (where not directly commissioned to a provider and where not under a host / lead contract) education and training grants for programmes published by NHS England (NHSE).

Through these standards, placement providers are required to work with NHSE and other stakeholders to support learners in their career pathways and transition from healthcare education programmes to employment, while also working collaboratively with system partners to maintain and improve practice placement capacity and capability.

2.4 The ongoing cycle of quality control in medical education is undertaken through a self-assessment report (SAR) and quality improvement plan (QIP). These reports are shared with NHSE and set out how the Trust meets the General Medical Council (GMC) domains for training https://www.gmc-uk.org/education

2.5 The quality improvement schedule for medical education is set out in the 2023 / 2024 Quality Improvement Plan and Self-Assessment Report.

Appendix 2: 2023 / 2024 Quality Improvement Plan (QIP)

Appendix 3: *2023 Self-Assessment Report (SAR)*

2.6 The GMC national training survey (NTS) provides opportunity for resident doctors and trainers to provide feedback to the Trust in regard to training satisfaction. It allows the Trust to benchmark the level of training provided against other similar organisations. ***This year the Trust demonstrated an exceptionally high level of training across all programmes***. The most significant of the highlights include TEWV being ranked **9th nationally** from the x227 active Trusts within the 2024 trainee survey results (17th in 2023). Whilst the trainer results have declined slightly, TEWV still ranked **30th nationally** within the 2024 trainer survey results (20th in 2023).

The Trust overall dashboard for the **trainee survey** confirmed **fifteen of the eighteen** indicators were **above this year's national average**. Overall data confirmed there were **fourteen green outliers** (areas of strength) compared to eight green outliers in 2023. There were no overall red or pink outliers (areas of weakness). In addition to fourteen overall green outliers there were a **further 12 strong areas** when drilling down the data **by site** and a **further 41 strong areas** by **specialty** and **post specialty**.

The Trust overall dashboard data for the **trainer survey** showed **nine of the ten indicators were above this year's national average**. There was one green outlier and no overall red or pink outliers. Last year saw a total of one green area of strength overall and a further fifty one strong areas across all sites. This year, there is one green area of strength overall and a **further thirty strong areas**.

Appendix 4: *2024 GMC Trainee Survey Report*

Appendix 5: *2024 GMC Trainer Survey Report*

2.7 The Faculty of Medical Education (FoME) continue to host annual Internal Educational Audit visits to enhance quality monitoring and assurance for all postgraduate and undergraduate activity within the Trust (Framework available at *Appendix 6)*. In December 2023 the visit incorporated undergraduate activity for the first time. The panel heard first hand from medical students on placement in the South care group and also from trainers who host medical student placements. The feedback gleaned was invaluable and an action plan was created to address any negative areas for concern.

Appendix 6: *TEWV Internal Educational Audit Framework v8*

2.8 The Medical Education Operating Framework (MEOF) which was created to provide an overview of the function of the FoME and summarises the governance framework that is used within the Trust to oversee all undergraduate and postgraduate activity continues to be reviewed and updated on an annual basis.

Appendix 7: *Medical Education Operating Framework v13*

2.9 In March 2023, NHSE published the Educator Workforce Strategy. The aim of the strategy was to set out actions that will lead to sufficient capacity and quality of educators to allow the growth in healthcare workforce that is needed to deliver care, now and in the future.

With an urgent need to increase the supply of the healthcare workforce, the development of a sufficient appropriately skilled educator workforce was recognised as a significant challenge internationally. Support and development for current educators, as well as succession planning, must be a priority to meet the challenge to educate future healthcare professionals. The FoME was aware that a consistent culture of valuing education and training needed to be embedded in order that this became a core component for all. The Educator Workforce Strategy was explored in depth at a recent Faculty development event and group work was undertaken to create action plans to ensure the FoME support the development and wellbeing of medical educators within TEWV.

Appendix 8: NHS England Educator Workforce Strategy

2.10 In February 2024 NHSE published the Safe Learning Environment Charter (SLEC). The SLEC aimed to strengthen the NHS workforce and was developed by over x2482 learners,
educators, and key stakeholders in health education. The Charter set out the supportive learning environment required to allow learners to become well-rounded professionals with the right skills and knowledge to provide safe and compassionate care of the highest quality.

The Charter was designed for learners and those responsible for supporting placement learning across all learning environments and all professions within them. It was aligned to the NHS People Promise in recognition that learners are vital to the workforce and are included in the promises we must all make to each other, to improve everyone's experience of working in the NHS.

The FoME has dedicated a large amount of resource to support the development of positive safety cultures and continuous learning across all learning environments in TEWV.
A member of the Medical Education Leadership Team (MELT) is a current member of the Trust working group to ensure a combined Trust-wide approach across all professions are represented to allow completion of the maturity matrix required for NHSE.

Appendix 9: NHS England Safe Learning Environment Charter

3. KEY ACHIEVEMENTS IN MEDICAL EDUCATION

3.1 Detailed below are the key achievements in the last 12 months.

3.2 **Development of Task and Finish Groups**

Last year MELT members attended the Medical Workforce Equality Group that met on a quarterly basis to oversee equality for both resident doctors and career grade colleagues. The overarching purpose of this group was to consider agendas from what you would describe as disadvantaged groups and / or those with protected characteristics.

MELT continues to work closely with the Trust Strategic Lead for Equality, Diversity, Inclusion (EDI) and Engagement and the Director of People and Culture. During the past year five task and finish groups (Race / IMG, Disability, Gender, LGBTQ+ and Religious Practice) have been created with regular meetings taking place to formulate plans to address any negative feedback / outliers received from both internal and external quality visits and surveys.

The overarching aims for each task and finish group in addition to an overall action plan are detailed in *Appendix 10*.

3.3 Resident Doctor Charter

The FoME seek to provide quality educational opportunities for all learners, in line with the NHS England Learning Charter. Whilst the governance for such is strong, it is important that we continue to strive for excellence as we are recognised as one of the best training providers, year on year, as validated by excellent local feedback through our audits and clinics and strong performance through the national GMC surveys.

To support that endeavour, the Trust has developed a Resident Doctor Charter (*Appendix 11*) for all medical postgraduate learners on placement. The Charter provides a commitment to the aspirational target of establishing a safe learning environment in line with the NHS England Charter, that provides an inclusive, psychologically safe place for learning. The Charter will become operational in February 2025.

3.4 Resident Doctor Handover Process

Clinical handover between shifts has been a long standing issue in psychiatric settings as they function differently to acute hospital wards. Psychiatric resident doctors working out of hours shifts cover many large hospital sites spread over the large geography of the Trust resulting in it being impractical to offer individual handover to all clinical areas.

A pilot handover process using Microsoft Teams was designed and implemented successfully by the resident doctors in one locality and was later formally implemented in all other localities across the Trust. The handover process involves a Microsoft Teams based handover where all resident doctors from all relevant clinical areas join between shifts to handover clinical information. The times for

handover have now been included in the resident doctor's work schedules to ensure there is no scope for missed handovers.

The Microsoft Teams based handover is monitored and regularly audited by the Medical Staffing team. This robust process essentially contributes to improved patient safety. The FoME are currently considering future plans to ensure the handover process provides value added learning for resident doctors.

3.5 Clinical and Educational Supervisor Agreement

In May 2024 the Trust received guidance around the role of clinical and educational supervision and the time allocation given to meet the responsibilities of these roles. Medical colleagues asked for further guidance as they believed it was difficult to fulfil the responsibilities and meet the requirements of medical supervision and the supervision of other clinical staff they are asked to undertake.

As such, MELT undertook a review of the current Trust position and that of other Mental Health organisations, whilst considering guidance from other external bodies such as:

- School of Psychiatry – Yorkshire and Humber recommendations November 2023
- School of Psychiatry – North East and Cumbria Guide to Supervision Skills
- NHS England Standards for Supervision
- Gold Guide – 9th Edition
- Medical Education Leaders UK

To support the Trainer workforce, MELT had an agreement (*Appendix 12*) approved by the Medical Directorate Management team to allow a cap to be placed on the amount of trainees each Trainer can supervise.

3.6 Medical Education Annual Awards Ceremony

The FoME wants to recognise and celebrate the valuable contributions in supporting the goals of delivering high quality medical education within the Trust. To achieve this the annual Medical Education Awards ceremony was hosted again and was very well attended by all grades of medical staff.

The annual awards celebrate the success of those individuals who have excelled in their training and / or placement and also those who have gone above and beyond in supporting medical students or resident doctors on placement in the Trust. An overview of the annual awards categories and guidance criteria is available at *Appendix 13*.

3.7 Wellbeing / Networking Events

A new initiative has been introduced by the Medical Development wellbeing lead and resident doctor wellbeing representatives whereby each month resident doctor representatives arrange pizza lunches in each of our inpatient sites. This provides a great opportunity for our doctors to get together, network, and provides a welcome break from daily work over lunchtime with an added boost to wellbeing.

In September 2024 “Welcome events” including an evening meal were introduced in each Care Group. The events bring together all doctors (new or already in the Trust), along with members of the medical staffing and postgraduate medical education teams. The events take place outside of normal working hours at external venues. The events provide a chance for current employees to meet with staff who have recently rotated into the Trust and helps to build relationships and settle into new roles. It also provides an informal setting for resident doctors to meet with supervisors. Providing there is still a demand for this the events will continue to be held every March / April and September / October following the larger changeover / intake of residents doctors.

The Dignity at Work Champion is now a well-established faculty role. The role is twofold in that it offers support and guidance to resident doctors and medical students who believe they may be experiencing bullying / harassment by another member of staff / manager and also to those wishing to raise concerns about risk, malpractice, or wrongdoing, which they believe could harm the service we deliver.

The role was designed to help resolve issues quickly, fairly and in confidence with the least negative impact upon all concerned.

3.8 MRCPsych Examination Pass Rates

Each registrar working within the Trust must pass two written and one practical examination before they can gain membership to the RCPsych and progress to higher training https://www.rcpsych.ac.uk/training/exams The FoME in conjunction with several Consultants and suitably qualified SAS doctors continue to provide MRCPsych Paper A and Paper B practice groups and CASC practice clubs free of charge for all registrars and any Trust doctors who are preparing for their MRCPsych examinations.

Over the last year there has been an increase in the overall pass rate for TEWV registrars. In one diet of the Paper A examination there was an 83% pass rate, one diet of the Paper B examination generated a 100% pass rate, and an 80% pass rate was attained in one of the two diets of the CASC examination.

3.9 Medical Directorate Operational Care Group Meetings

At the beginning of 2024, key members of the Medical Education team and FoME were invited to attend the Medical Directorate Operational Care Group meetings

which are held every other month. Medical education has a regular agenda item to allow medical education issues to be discussed and also allows for updates to be provided to medical management colleagues.

The meeting provides a platform for medical education leaders to discuss any care group specific issues relating to medical education (e.g. lack of placements for medical students due to placement saturation) and also provides medical management colleagues with the opportunity to raise any queries and concerns they may have in relation to both undergraduate and postgraduate learners.

3.10 Senior GP Education and Liaison Consultant Roles

In late 2023 the FoME developed and successfully recruited two senior GP Education and Liaison Consultant roles. The roles were developed as a new pillar of work under the Medical Development Team, deliberately so to utilise the expertise and support already in house, especially that of medical education team. The roles are Trust-wide positions as part of future trust priorities and are funded by monies received from a local Integrated Care Board (ICB).

One postholder is focussing on an educational component and is concentrating on developing a high quality Continuing Professional Development (CPD) programme for general practitioners working in practices linked with our organisation across the North East and North Yorkshire footprint. The second postholder is focussing on the relational component which focusses on nurturing stronger ties with local general practitioners and networks, and to help facilitate better two-way communication between primary and secondary care and looking for new opportunities to collaborate.

Numerous CPD events have already been held and work continues to improve the relationship between TEWV and local GP networks.

3.11 Simulation Initiative

In 2023 the FoME developed and recruited to the novel position of a Simulation Tutor. The post was developed as a Trust-wide role in order to plan, develop and oversee a number of disparate current initiatives already operating under a simulation banner in TEWV. The Simulation Tutor focusses on translating learning from pilot activities in order to deliver effective educational opportunities all with simulation as the central theme.

With large medical school expansion in progress, simulation allows authentic delivery of content without overloading clinical services and patient volunteers and also allows application of theoretical knowledge in a safe way for patients. There is evidence for efficacy in medical education including facilitating acquisition of skills, knowledge, and attitudes with the use of simulation.

Since commencing in post, the Simulation Tutor has created a "Simulation Strategy" (*Appendix 14*), which has been presented at the Medical Education Committee (MEC). The Simulation Tutor is a member of MEC and progress to meet the aims and objectives detailed within the simulation strategy will be regularly tracked via the Medical Education Committee.

3.12 **Ambitious Continuing Professional Development (CPD) Programme**

At the beginning of 2024 the FoME were successful in recruiting to the newly created role of a CPD Tutor. The role was designed to create high quality CPD training for medical staff within the Trust. It was developed as a pillar of work under the FoME intentionally to exploit the expertise within the Trust. The CPD Tutor has already developed a coherent programme of internal CPD that is now supporting all grades of doctors in the Trust.

The CPD Tutor is working with colleagues in I.T. to ensure the most up to date technological solutions are available to maximise CPD participation through use of technology and is also working collaboratively with the Simulation Tutor to support the increasing use of simulation as part of the FoME wider CPD strategy.

The CPD Tutor is also exploring CPD opportunities for interprofessional collaboration within the Trust and external collaboration with independent and third sector organisations where this would be achievable and where this would add further value and potential for income generation for the Trust. The potential to develop a CPD Academy remains an aspiration for the FoME.

4. IMPLICATIONS / RISKS

4.1 **Quality:**

4.1.1 The QIP outlines the quality objectives to be delivered in the next reporting period.

4.2 **Financial:**

4.2.1 The Trust received over ***£6.9 million*** in 2023 / 2024 to support the salaries and educational infrastructure required to deliver medical education placements.

4.3 **Legal and Constitutional:**

4.3.1 The Trust has a legal responsibility through the EFA to quality assure the delivery of medical education.

4.4 **Equality and Diversity:**

4.4.1 There are no implications to consider.

4.5 **Other Risks:**

4.5.1 *Estates and Facilities*

The Trust still does not have sufficient facilities to train medical students and resident doctors at all Trust sites. Whilst this has been highlighted on numerous occasions to the Trust and conversations welcomed, there still remains no definitive decision on a remedy for such. Medical student expansion numbers are not confirmed to date due to the recent change of Government. This leaves the FoME and Trust in a very difficult situation with uncertainty on numbers. A paper that will soon be heard has been written for the Executive Directors to consider options.

The NHSE Quality Interventions Review report produced following the 2022 joint quality visit from the Northern Foundation School and Newcastle University Medical School confirmed that the Trust is not currently meeting the GMC standards for training in relation to the standard of education facilities.

The lack of a dedicated medical education facility is and will become a greater burden as the Trust risks not being able to participate in future medical student expansion or continue to offer placements at the current scale.

4.5.2 *Trainer capacity*

Having sufficient substantive trainers to provide supervision still remains a constant challenge. The FoME outlined proposals for Specialty doctor and Specialist grade (SAS) doctors to become trainers for registrars after the Schools of Psychiatry relaxed their rules. A small number of SAS doctors now supervise registrars yet the amount of medical vacancies, increase on clinical demand and number of Mind the Gap (MTG) arrangements in situ continue to put enormous pressure on the current trainer workforce.

A recent audit regarding the correct allocation of Supporting Professional Activities (SPA) in clinical and educational supervisor job plans was undertaken by the Head of Medical Education. The audit report (*Appendix 15*) confirmed that only 35% of clinical supervisors had the correct allocation of SPA time within their job plan with even fewer educational supervisors (5%) having the correct amount of dedicated time to train.

NHSE continues to use its escalation processes Intensive Support Framework (ISF) to describe and monitor its concerns, based on the level at which it is having to work with an individual organisation, department, programme, or the wider system to ensure the appropriate steps are taken to clarify, improve and resolve the concerns raised. NHSE still have TEWV ranked at ISF Level 1 for “overall workforce” and continue to keep this under close review.

Should the Trust not seek a remedy, this could lead to a decrease in resident doctor training posts alongside the associated funding which in turn would increase agency locum costs.

4.5.3 *Medical Student Expansion*

The Trust requires clear guidance on the number of medical students it is requested to host as part of the national medical student expansion plan. This will help the Trust to understand what teaching facilities it requires on site. As previously stated, there is a lack of certainty as no confirmation has been given to date.

The FoME is therefore left in an unenviable position of trying to plan facilities it needs now, with one eye on expansion for the future, without understanding the true scale of the request. Additionally, at this time it is impossible to say whether the Trust is able to commit to such additional numbers, given placement saturation in clinical areas and chronic medical staffing issues.

The margin of error between a low base and high base for student expansion is so extreme, it makes accurate modelling impossible and high risk which increases the chances of significant miscalculation. Likewise, the option of current state of paralysis or 'doing nothing' leaves us in an increasingly vulnerable position.

4.5.4 *Industrial Action*

Since the submission of last year's report, industrial action continued to massively impact upon service provision up until early July 2024. During this time the Trust continued to re-deploy some resident doctors to inpatient units and also to support Out Of Hours (OOH) rotas. All those who worked outside of their normal location and / or a different specialty, were met by a lead psychiatrist and clinical supervision arrangements were made clear.

5. HORIZON SCANNING

To ensure the FoME remains proactive in its approach to continual improvement, several initiatives are planned for the next academic year.

5.1 *Increased Faculty Support for International Medical Graduate (IMG) Doctors*

The FoME continues to employ an IMG Tutor who takes a lead role in developing and co-ordinating a comprehensive support programme for all international medical graduates working within the Trust. Each category of IMG (IMG Portfolio Pathway, IMG SAS doctor, IMG Trust Doctor) have their respective faculty tutors to support and plan a bespoke induction. These groups and any IMG resident doctors are provided with an additional enhanced induction twice a year by the IMG tutor. Medical Development has a dedicated IMG folder on the Trust shared drive where resources on a wide range of topics relating to IMG can be accessed. It also has a dedicated intranet page that signposts staff to all relevant resources and provides contact details of the IMG tutor and team.

The IMG tutor has worked closely with the Simulation Tutor to develop and deliver "New IMG Psychiatry Simulation" (NIPS) training. The course is based around simulated psychiatric consultations designed to facilitate the learning of IMGs

particularly to those fairly new to TEWV or the NHS in general. The focus of the learning is managing common psychiatric presentations including risk whilst also focusing on the cultural and social factors that might be new to doctors working in the North East and North Yorkshire area for the first time.

Whilst the IMG tutor has undertaken a large amount of work to ensure support mechanisms are available for IMG doctors, there are still areas on which the FoME can improve upon to ensure the best possible onboarding and ongoing support for IMG colleagues.

A core area of work for 2025 will be the operationalisation of a new structured induction programme *(Appendix 16)* for IMG doctors and the development of mentorship roles. A focus group has been created with members from both the medical education and medical staffing teams to support the IMG tutor to introduce the comprehensive induction programme.

5.2 ***Faculty Retreat***

In November 2025 the Faculty will once again host an educational retreat which will run in tandem with the medical managers programme. In November 2024 the second event of this kind was held and the FoME utilised the time to set individual objectives. Numerous sessions at the 2024 event were held which included:

- *Educator Workforce Strategy and the seven pillars underpinning our 2025 approach and focus on trainers*
- *Brief overview of trainer survey feedback*
- *Valuing medical educators*
- *Development of a new Trainer Charter*
- *2025 Faculty Strategic Priorities*
- *Working towards a coordinated simulation strategy*
- *Developing a comprehensive programme for CPD in the trust*
- *Enhancing the clinical exposure of medical students: Model of placements*
- *Workshops:*
    - *Renumeration for medical management roles*
    - *The future medical management programme*
    - *Making our inpatient roles more attractive*
    - *Effective Role Modelling*
    - *Effective communication and engagement*
    - *How to make what we do better*
- *Flexible working - The new “norm”*
- *Update on Equality and Diversity Workshop*
- *Core themes and actions from EDI Task and Finish groups*
- *GMC National Trainer Survey (NTS) Results*
- *Presentation of main NTS findings to wider group*
- *Presentation of draft new Trainer Charter including discussions for further suggestions*

- *Action planning our responses required to address outliers in GMC NTS trainer survey*
- *Creating a safe learning environment - What does an acceptable 'zero-tolerance' approach look like for our trainers and trainees?*
- *We really have to talk... don't we?*
- *Challenging conversations in teamwork and leadership*
- *A 'goldfish bowl' space to reflect and respond on times when we've had tough conversations at work*
- *The ones we plan to have... and the ones that take us by surprise*
- *Directorate Debate*
- *Our Medical Journey to Change*
- *Verbal reflection on journey to date*
- *Emerging themes*

The retreat will continue to allow networking between the FoME and medical managers and will continue to incorporate a professional challenge to medical managers, who in turn will pose a professional challenge to FoME on key agenda areas.

6. ACTIONS

6.1 To address the risks outlined in this report, MELT have agreed high level objectives for 2025. These objectives are detailed in *Appendix 17.*

7. CONCLUSIONS

7.1 The Trust continues to have a pro-active and strong FoME. Feedback demonstrates more than ever that despite ongoing challenges, the Trust continues to achieve high results in relation to the delivery of all medical education programmes.

8. RECOMMENDATIONS

8.1 It is recommended that the Trust Board note the content of this paper.

Authors: **Hayley Lonsdale, Head of Medical Education**
Medical Education Leadership Team (MELT)

Appendices

Appendix 1: Medical Student Internal Feedback 2023 / 2024

UG Feedback COMBINED 2023 - 2(

Appendix 2: 2023/2024 Quality Improvement Plan (QIP)

QiP - August 2023 to July 2024.xlsx

Appendix 3: 2023 Self-Assessment Report (SAR)

2023 Self-Assessment Rep

Appendix 4: 2024 GMC Trainee Survey Report

2024 GMC NTS Trainee Report.pdf

Appendix 5: 2024 GMC Trainer Survey Report

2024 GMC NTS Trainer Report.pdf

Appendix 6: TEWV Internal Educational Audit Framework v8

TEWV Internal Educational Audit F

Appendix 7: Medical Education Operating Framework v13.0

Medical Education Operating Framewo

Appendix 8: NHS England Educator Workforce Strategy

NHS England Educator Workforce

Appendix 9: NHS England Safe Learning Environment Charter

NHS England Safe Learning Environme

Appendix 10: Task and Finish Focus Group Actions – November 2024

Task & Finish Focus Group Actions - Nov

Appendix 11: Resident Doctor Charter

Resident Doctor Charter.pdf

Appendix 12: Clinical and Educational Supervisor Responsibilities

Clinical and Educational Supervi

Appendix 13: Medical Education Annual Awards – Categories and Guidance Criteria - 2024

Annual Awards - Categories Guidanc

Appendix 14: Simulation Strategy

Simulation Strategy.pdf

Appendix 15: Audit of Clinical and Educational Supervisor Job Plans – October 2024

Audit of CS & ES Job Plans - October

Appendix 16: IMG Induction Proposal

IMG Induction Proposal.pdf

Appendix 17: 2025 MELT Objectives

MELT Objectives 2025.pdf

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Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12 December 2024**
Title:	**Feedback from Leadership Walkabouts – Oct-Nov 2024**
Executive Sponsor(s):	**Ann Bridges, Director of Corporate Affairs & Involvement**
Author(s):	**Ann Bridges**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
All		The report highlights summarised feedback from leadership walkabouts in October and November 2024, which can contribute to the Board's understanding of strategic risks, quality of services and the operation of key controls.

Executive Summary:

Purpose: The purpose of this report is to provide the Board with high-level feedback from leadership walkabouts that took place in October and November 2024.

Overview:

1 **Background**

1.1 The Trust undertakes a monthly programme of regular leadership walkabouts to services. These visits are not inspections however offer an opportunity for teams to have conversations directly with Board members and Governors to raise any matters of importance.

1.2 Walkabouts provide an opportunity for Board to meet with teams to really understand the strengths of the service and consider the more challenging areas, and how we can work together to resolve these and co-create any potential solutions. Full feedback reports and actions are reported and monitored via Management Group.

2 Speciality areas visited

2.1 Leadership walkabouts took place on 21 October and 18 November 2024 across a range of services including AMH, MHSOP and LD inpatient locations, CAMHS and MHSOP community, as well as crisis and home treatment team.

3 Key issues

- Strengths:
    - Patient and carer experience: across our teams, there were great examples of how they are working with patients and their carers to really understand their individual needs, as well as those of their carers and the support they might need. This was evident in the positive feedback received from carers via FFT.
    - Multi-disciplinary team (MDT): multiple teams reported they really welcomed the MDT approach and skills-mix and knowledge that brought, particularly in relation to ensuring teams have right input particularly for those with complex needs. This led to more integrated teams, with strong team spirit and focus on health and wellbeing.
    - Co-creation: working with together with others to find the right solutions was common place, including across MDTs as well as partner organisations, and with patients and families themselves, with many reporting they routinely co-produced plans including formulation, really demonstrating a strong personalised care approach.

- Challenges:
    - Staffing: whilst some teams saw the value of MDTs, having a full complement of the full required skill-mix was often challenging. Vacancies had often been difficult to recruit to, and recruitment processes were seen as unnecessarily complicated and lengthy.
    - Complexity in caseloads: speciality areas reported an increase in complexity of diagnosis and caseloads. This related specifically to neurodiverse conditions across CAMHS and AMH, and significant increased in organic patient referrals in MHSOP eg dementia. Caseloads were therefore building up as patients needed more support and for longer, and some teams reported staff burnout.
    - Infrastructure and estates: issues raised with some locations and/or financial pressures or lack of investment in facilities. CITO had caused some frustration however fixes / updates and improvements were welcomed.

Recommendations: The Board is asked to:

- Receive and note the summary of feedback as outlined.
- Consider any key issues, risks or matters of concern arising from the visits.

Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12 December 2024**
Title:	**Register of Sealing**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Report Author:	**Phil Bellas, Company Secretary**

Report for:

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

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

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

Strategic Risks relating to this report:

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

Executive Summary:

Purpose: To advise the Board of the use of the Trust's seal in accordance with Standing Order 15.2.

Proposal: The Board is asked to receive and note this report.

Overview: The Trust's seal has been used as follows:

Ref	Document	Sealing Officers
437	Licence to underlet relating to part of Whitby Community Hospital, Springhill, Whitby	Patrick Scott Deputy Chief Executive Phil Bellas, Company Secretary

Prior Consideration and Feedback None relating to this report.

Implications: None relating to this report.

Recommendations: The Board is asked to note this report.

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