MEETING OF THE BOARD OF DIRECTORS
Thursday 28th October 2021
at 1.00 p.m.

The meeting will be held via MS Teams

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

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

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

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

The timings provided in the agenda are indicative only.

Pre-Meeting Governor Session with the Chair:
The Chair has invited all Governors to join him for a pre-meeting question and answer session from **12.00 noon**. This provides an opportunity for them to raise any matters on the reports due for consideration during the meeting.

Joining instructions for the event have been circulated separately.

AGENDA

Standard Items (1.00 pm – 1.15 pm):

1	Apologies.	**Chair**	**-**
2	Chair's Introduction.	**Chair**	**Verbal**
3	To approve the minutes of the last meeting held on 29th July 2021.	**-**	**Draft Minutes**
4	To receive any declarations of interest.	**-**	**Verbal**
5	To review the Board Action Log.	**-**	**Report**
6	Chairman's Report.	**Chair**	**Verbal**
7	To note any matters raised by Governors.	**Board**	**Verbal**

Strategic Items (1.15 pm – 2.15 pm):

8	Chief Executive's Report.	**CEO**	**Report**
9	BAF summary report.	**Co Sec**	**Report**
10	To consider the report of the Audit and Risk Committee.	**Committee Chair (JM)**	**Report**
11	To consider the Finance Report as at Quarter 2, 2021/22.	**DoF&I**	**Report**
12	To consider the Performance Dashboard Report as at Quarter 2, 2021/22.	**ACEO**	**Report**
13	Based on the assurances provided by the Audit and Risk Committee, to approve the Emergency Preparedness Resilience and Response (EPRR) self-assessment, action plan and statement of compliance for submission to the Head of EPRR for Yorkshire & the Humber.	**COO**	**Report**
14	To consider an assurance report on winter preparations.	**COO**	**Report**

Goal 1: To Co-create a Great Experience for our Patients, Carers and Families (2.15 pm – 2.45 pm):

15	To consider the public report of the Quality Assurance Committee.	**Committee Chair (BR/SR)/ DoN&G**	**Report**
16	To consider the Learning from Deaths Report as at Quarter 2, 2021/22.	**DoN&G**	**Report**
17	To consider the report of the Mental Health Legislation Committee.	**Committee Chair (PH)/ MD**	**Report**

Goal 2: To Co-create a Great Experience for our Colleagues (2.45 pm – 2.55pm):

18	To consider the Report of the Guardian of Safe Working.	**Dr. Jim Boylan to attend**	**Report**

Governance (2.55 pm – 3.15 pm):

19	To approve the Annual Report and Accounts of the Charitable Trust Funds for submission to the Charity Commission. *(Assurances on this matter are provided in the report of the Audit and Risk Committee – see agenda item 10)*	**DoF&I**	**Report**
20	To review arrangements for meetings of the Board of Directors for the remainder of the Financial Year.	**Chair**	**Verbal**
21	To appoint the Chairs and Non-Executive Director Members of the Board's Committees	**Chair**	**Report**
22	To receive and note a report on the use of the Trust Seal.	**Co Sec**	**Report**

Exclusion of the Public (3.15 pm):

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

Paul Murphy
Interim Chair
22nd October 2021

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 29TH JULY 2021 COMMENCING AT 1.00 PM via MS Teams

Present:
Ms M Harte, Chairman
Mr B Kilmurray, Chief Executive
Prof P Hungin, Non-executive Director
Dr A Khouja, Medical Director
Mr J Maddison, Non-executive Director
Mr P Murphy, Non-executive Director/Deputy Chairman
Mrs B Reilly, Non-executive Director
Mrs S Richardson, Non-executive Director/Senior Independent Director
Mrs R Hill, Chief Operating Officer
Mrs E Moody, Director of Nursing and Governance/Deputy Chief Executive
Mrs L Romaniak, Director of Finance, Information and Estates
Dr S Dexter-Smith, Director of People and Culture (Non-voting)
Mrs S Pickering, Director of Planning, Commissioning, Performance and Communications/Assistant Chief Executive (Non-voting)

In Attendance:
Mr P Bellas, Trust Secretary
Mr J Boylan, Consultant in Medical Education and Guardian of Safe Working
Ms L Hughes, Interim Corporate Governance Advisor
Mrs W Johnson, Team Secretary
Ms D Oliver, Deputy Trust Secretary (Corporate)
Mrs S Paxton, Head of Communications
Mr D Williams, Freedom to Speak up Guardian

Observers/Members of the Public
Ms S Baxter, Public Governor, Redcar & Cleveland
Mr L Bell, Staff Governor, Corporate
Mrs M Booth, Public Governor, Middlesbrough
Mr R Cabrera, Staff Member, Trainee Clinical Psychologist
Mr S Double, Strategic Partner, Alder
Ms H Griffiths, Public Governor, Harrogate and Wetherby
Mrs J Haley, Member of the public (appointed as Non-executive Director to commence in post from September 2021)
Mrs J Kirkbride, Public Governor, Darlington
Dr M Sani, Public Governor, Stockton
Mr B Posmyk, Appointed Governor, NHS Tees Valley CCG
Mr R Tuckett, Member of Public
Mrs J Wardle, Public Governor, Durham

21/07/1/138 APOLOGIES

1.1 There were no apologies for absence.

21/07/2/139 CHAIRMAN'S INTRODUCTION

2.1 The Chairman welcomed everyone to the meeting and was pleased to welcome Governors and Mrs Haley as observers of the meeting.

21/07/3/140 MINUTES OF PREVIOUS MEETING

3.1 **Resolved:** the minutes of the previous meeting held on 27 June 2021 were approved as a correct record and agreed to be signed by the Chairman subject to the penultimate paragraph commencing Dr Khouja, is changed to:
Dr Khouja added that following the redesign work undertaken on the Trust information system Paris, safety incidents can now be visible alongside the safety summary in the patient overview.

21/07/4/141 DECLARATIONS OF INTEREST

4.1 There were new interests declared and no declarations of interest received in relation to open agenda items.

21/07/5/142 PUBLIC BOARD ACTION LOG

5.1 The Board noted that there were no actions outstanding on the action log.

21/07/6/143 CHAIRMAN'S REPORT

6.1 The Chairman provided a verbal report and drew reference to the following:

6.1.1 Two Non-executive Director's had been appointed following the interviews held in July 2021: Mrs Jill Haley and Mrs Charlotte Carpenter who would commence in post in September 2021.

6.1.2 The organisation was under extreme pressure at present as a consequence of the increased COVID infection rates in the community and an increased demand for the Trust's services, which had resulted in workforce challenges. She thanked staff at all levels who had worked additional hours to mitigate the disruption to patient services.

6.1.3 The Chairman thanked NHS England and Improvement (NHSE/I) representatives for supporting Trust colleagues during such challenging times.

6.1.4 The Care Quality Commission (CQC) Well Led inspection was scheduled to take place on 3 and 4 August 2021.

6.1.5 The Chairman thanked Mrs Hill for her contributions and leadership during her employment at the Trust and noted it was Mrs Hill's last Board meeting. She wished her well for the future and in her new role at Harrogate and District NHS Foundation Trust.

6.1.6 Mr Russell Patton will join the Trust in September 2021 as Interim Chief Operating Officer. Mr Patton is joining the Trust from Cumbria Northumberland Tyne and Wear NHS Foundation Trust.

6.1.7 Finally, the Chairman thanked Mrs Gill Findley who had supported the Board and members of the Executive Team in preparation for and during the CQC inspections since January 2021. Mrs Findley was leaving the Trust at the end of July to join Gateshead NHS Foundation Trust as Director of Nursing. The Board wished Mrs Findley and Mrs Hill well in their new roles.

6.2 **Resolved:** the Chairman's verbal report was noted.

21/07/7/144 MATTERS RAISED BY GOVERNORS

7.1 It was noted that the Chairman had met with Governors at their information meeting prior to the Board meeting. Governors had highlighted their shared concern with regards to the number of staff absences due to the increased COVID infection rate in the community and the impact this may have on patient care. The Governors were in support of the interim arrangements that had been put in place earlier with the Trust declaring Operational Pressures Escalation Level (OPEL) 4.

21/07/8/145 CHIEF EXECUTIVE'S REPORT

8.1 The Chief Executive's Report was received and noted. The Chief Executive drew attention to the following:

8.1.1 During July 2021 there had been a noted increase in bed occupancy with the added pressure of increased staff absences, which resulted in the Trust moving to OPEL 4 during week commencing 19 July 2021. There were several contributing factors, which included the increased community COVID infection rate, the bed pressures and the increased number of staff absences. These issues combined had resulted in additional pressure on the Trust to continue to sustain safe staffing levels with staff either self-isolating or absent due to childcare requirements as a result of children required to isolate from school or nursery. Discussion took place around the Trust reprioritising its services and declaring OPEL 4, which is used in extreme circumstances when organisations seek support from the wider system to support the delivery of comprehensive care to maintain patient safety. Despite the added pressure being a national concern, the Trust had received a number of offers of support to date. At the time of the meeting there were four community COVID positive patients with infection acquired from the community and no hospital acquired COVID cases.

8.1.2 The CQC Well Led inspection on 3 and 4 August 2021 was planned to be led by Dr Kevin Cleary, Deputy Chief Inspector. It was anticipated that the outcome of the Well Led inspection would be received for factual accuracy in the autumn. The report of the re-inspection of the Working Age Adult Acute and psychiatric intensive care unit was due to be received for factual accuracy at any time.

8.1.3 Work continued to progress on the new structures with engagement taking place with the Trust's Joint Consultative Committee. Agreements had been made to progress with the recruitment campaign to appoint two Managing Directors and plans are in place to support staff throughout the consultation process. It was acknowledged that some staff may feel anxious around potential changes and continued communication and engagement with staff at every opportunity is anticipated will help to support staff through the process.

8.2 Prof Hungin, Non-executive Director drew reference to the increased demands on any organisations when inspections are taking place and queried if as a result of the current position regulatory inspections may be paused. In response, the Chief Executive explained that the CQC was aware of the current national pressures and they had adjusted their inspection regime accordingly. The CQC was also aware of the Trust's current pressures and in response to that they had deferred the Trust's Well Led inspection by one week.

8.3 Mr Maddison, Non-executive Director queried if the Trust had an opportunity to respond to the concerns raised by the CQC in relation to staffing establishments within Forensic services. In response the Chief Executive and Mrs Moody explained that the Trust had reviewed its business continuity plans with adjustments made and staff had been redeployed to areas of demand. At present the position is challenging and the Trust was seeking mutual aid from outside the Trust but is conscious that there is currently pressure across the system nationally. The Trust was also working to improve recruitment practices to minimise the appointment process wherever possible. It was noted that at that time all the Trust's critical services continued to be provided.

8.4 **Resolved:** the Chief Executive's Report was noted.

21/07/9/146 DEVELOPMENT OF INTEGRATED ASSURANCE REPORT

9.1 Progress against the development of the Integrated Assurance Report was received. It was noted that the work aligned to the Trust's new Strategic Framework and the recommendations of the Good Governance Institute (GGI) independent review. Discussion

took place around the role of the Board Sub-committees in relation to monitoring and oversight of the Integrated Assurance Report. In response to Mrs Pickering's recommendation the Board supported the proposal that the Commissioning Sub-committee would have no indicators aligned to it for monitoring or review; and noted that further discussion would take place around the role of Audit and Risk Committee in relation to the Integrated Assurance Report at the September 2021 Board Seminar.

9.2 Board Sub-committees had confirmed the indicators for alignment to each Board Sub-committee. In response to the requests made by some Board Sub-committee Chair's it was agreed that a collective discussion would take place with Board members to agree the first set of indicators prior to the final Integrated Assurance Report being presented to the Board. The Board Seminar agenda in September 2021 would include the Integrated Assurance Board Report and the Board Assurance Framework. **ACTION (P Bellas)**

9.3 **Resolved:**
i) the progress and development of the Integrated Board Assurance Report was received and noted;
ii) a collective discussion would take place at the Board Seminar in September 2021 to consider and agree the first set of Board indicators; and
iii) further discussion on the Audit and Risk Committee's role in relation to the Integrated Board Assurance Report would take place at the Board Seminar in September 2021.

21/07/10/147 FINANCE REPORT (QUARTER 1)

10.1 The Finance Report as at 30 June 2021 was noted, which reflected performance within the context of the national financial arrangements that supports the NHS to respond to the COVID pandemic. Mrs Romaniak drew reference to the following:

10.1.1 The Trust's outturn surplus of £3.7m, which is £0.3m ahead of the high-level run-rate plan;
10.1.2 A forecast surplus of £4.7m as at 30 September 2021, which is in accordance with information shared to inform ICP/ICS plans;
10.1.3 Cash Releasing Efficiency Savings (CRES) framework 2021/22 had been agreed; indications are a national waste reduction target of circa 3% may apply from 1 October 2021. In response to this the Trust is working to identify new schemes;
10.1.4 Capital expenditure of £4.3m, £0.3m over plan as a result of some schemes delayed during 2020/21; and the sale of property (£1.5m capital receipt), which was initially anticipated to be completed in June but had been deferred into Quarter 2;
10.1.5 Annual planning activities for 2021/22 had been deferred nationally to enable a continued focus on COVID. The Trust at that time did not have a budget for the second half of the financial year, which is consistent with national plans as a result of COVID. Planning and financial settlements for 1 October 2021 to 31 March 2022 is anticipated to take place during September/October 2021; and
10.1.6 The Use of Resources Risk Rating (UoRR) national monitoring had been suspended since the onset of the COVID pandemic. The Trust had continued to self-assess against the UoRR methodology, which was noted to be on plan at UoRR 1.

10.2 Mr Maddison, Non-executive Director drew reference to the financial pressures as a result of COVID. He queried if there had been any intelligence received on how the financial pressures would be managed in future. In response, Mrs Romaniak explained that plans had yet to be reviewed by the Partnership Board and commissioning investment plans were unknown at that time.

10.3 Mr Maddison highlighted the drive to continue to improve quality and patient safety against workforce efficiency schemes and how this could be inconsistent with plans to invest in staff.

In response, Mrs Romaniak explained that centrally there had been a change of focus moving from efficiency to waste reduction, which was different to the approach that focussed on tariff efficiency pre-COVID.

10.4 **Resolved:** the Finance Report for Quarter 1 (as at 30 June 2021) was received and noted.

21/07/11/148 PERFORMANCE REPORT (QUARTER 1)

11.1 The Performance Dashboard for Quarter 1 (as at 30 June 2021) was noted. Mrs Pickering drew reference to the following:

11.1.1 The majority of national standards within the NHS Oversight Framework had been achieved, subject to two exceptions: i) inappropriate use of out of area placements; and ii) one admission to adult facilities of a patient under 16 years old. NHSE/I had been involved in the discussions to identify a secure bed for the patient admitted under the Mental Health Act. She explained that Durham and Darlington, Tees; and North Yorkshire and York continued to indicate concern with out of area placements. The Board noted that these had taken place due to the increased bed pressure demands and the decant arrangements in place at Roseberry Park, which had 20 less Adult beds. Out of the total 'out of area placements' there had been one patient placed out of the Trust's footprint since the onset of the COVID pandemic, all other patients had been placed within the Trust's footprint. Executive Directors had agreed that additional bed capacity would be sought from the independent sector in the short-term with additional resource commissioned to undertake an independent review in the medium term to gain an understanding of the drivers behind the increased bed demands.

11.1.2 There had been a Patient Experience analysis carried out across Locality areas to identify areas for improvement with the outcome reported to the Quality Assurance and Improvement Group;

11.1.3 The Clinical Outcome Group had been re-established, which is Chaired by the Medical Director;

11.1.4 Appraisals performance is anticipated to decline against trajectory levels from September 2021 as a result of the known workforce constraints and COVID restrictions being lifted.

11.2 Mrs Reilly, Non-executive Director drew reference to the number of out of area placements reported in Durham and Darlington and queried if the Board should be concerned. She confirmed her support towards the Trust's restructures and asked Executive's to be mindful of the current pressures on staff whilst taking forward the restructures. In response, Mrs Pickering and Mrs Hill explained that all the Trust's Localities were experiencing bed pressures. Durham and Darlington's pressures had increased due to their acceptance of other Locality patient placements, which included out of area placements in response to Crisis Team requests. Mrs Hill reassured the Board that there had been improvements made and it was anticipated that the Quality Assurance Committee would note an improved position at its September 2021 meeting.

11.3 Mrs Richardson, Non-executive Director noted the 50% increase in the children's neurological pathway. In response, Mrs Pickering explained that there had been a significant number of children with autism and ADHD referred to the CAMHS services. In response to this, North Tees had introduced a needs-based service with children supported prior to diagnosis, which had reduced the level of CAMHS referrals. The model was planned to be introduced in South Tees and Darlington, with discussions taking place over the possibility of introducing in Darlington.

11.4 Mr Maddison, Non-executive Director queried the short and medium term workforce plans against acuity demands. In response, Mrs Pickering explained that the Trust was working

with the independent sector to secure additional workforce support in the short term. The Trust was introducing a bed management system, which would be operational seven days a week; and the outcome of the independent review would inform the Trust's workforce plans for the medium term.

11.5 Prof Hungin, Non-executive Director sought assurance around the processes in place to manage children's services waiting times. He referred to a recent visit to Redcar when he observed a large case load with a continuous increase in referrals and he was informed that some staff had left the Trust to work in the independent sector. In response, the Chief Executive explained that it had been noted that some staff had left the Trust's employment to work in the independent sector in the past and a proportion of those staff had returned to the Trust. The Trust's Service Transformation plans included focus for this area as one of the key priorities.

11.6 **Resolved:** the Performance Report for Quarter 1 (as at 30 June 2021) was discussed and noted.

21/07/12/149 QUALITY ASSURANCE COMMITTEE REPORT

12.1 Mrs Reilly, Non-executive Director (Chair of Quality Assurance Committee (QAC)) confirmed that QAC had continued to meet monthly with the exception of the August recess. The QAC report for meetings held on 3 June and 1 July 2021 was received and noted. Mrs Reilly confirmed there were no actions recommended for consideration by the Board and she drew attention to the following of note:

12.1.1 A revised meeting schedule was approved, which included a minimum of four meetings and two development sessions for 2022.

12.1.2 Localities had reported a challenge to embed some of the changes included in the CQC Action Plan due to the current bed occupancy and acuity of patient admissions.

12.1.3 Staff health and wellbeing was highlighted of concern over the last two months due to the increased number of staff required to self-isolate.

12.1.4 Durham and Darlington Crisis Team Report and Action Plan were received. The Committee noted there had been an internal and external review carried out and the service required to be closely monitored.

12.1.5 Assurances were received in relation to progress against the Sexual Safety Strategy, the six monthly Safeguarding update, the positive impact of staff wearing body cameras on wards, the Positive and Safe Annual Report 2020/21, health, safety, fire and security; and the monthly safe staffing exception report.

12.2 **Resolved:** the Quality Assurance Report from meetings held on 3 June and 1 July 2021 was received and noted.

21/07/13/150 FREEDOM TO SPEAK UP GUARDIAN REPORT

13.1 The Freedom to Speak Up Guardian (FTSUG) bi-annual Report was received. It was noted that on this occasion the report covered a nine month period. Mr D Williams, Freedom to Speak Up Guardian confirmed that 40 people had contacted the FTSUG over the last quarter, returning to levels prior to the COVID pandemic. In response to the recommendation made by internal audit and the CQC, the FTSUG had increased his hours from 18.5 per week to full-time for two months in the first instance and he continued to be supported by Mr B Speak, Deputy FTSUG. It was noted that Dr Dexter-Smith is the new Chair of the Raising Concerns Group (RCG). The RCG reports into the Workforce Subgroup of Senior Leadership Group and will also provide assurance to the People Culture and Diversity Committee in future.

13.2 Mr Williams thanked Mr Griffiths, the previous FTSUG Non-executive Director lead and welcomed Mr Maddison as the new Non-executive Director lead. He also thanked Mrs Hill for her support over the time he had covered the FTSUG role.

13.3 **Resolved:** the Freedom to Speak Up Guardian bi-annual Report was noted.

21/07/14/151 NURSE SAFE STAFFING BI-ANNUAL REPORT

14.1 The Nurse Safe Staffing Report for the period 1 December 2020 to 31 May 2021 was received. Mrs Moody confirmed that the report aimed to provide assurance on the key areas of Safe Staffing at the Trust for nurse (inpatients) staffing. It was noted that the Trust is working to improve staffing establishments and is working with partners to support its recruitment drive to ensure that the Trust continues to deliver quality services to patients.

14.1.2 Management during the COVID pandemic continued to present staffing pressures. At the beginning of 2021 the Trust had a significant number of COVID outbreaks, which affected the health and wellbeing of staff and patients. At that time the region had the highest incidence of COVID nationally. The Trust had also seen an increased clinical surge post COVID (wave one and two) with an increased acuity of patient admissions, which had added to staffing pressures. Localities continued to identify solutions to staffing pressures to manage the needs of patients. Secure Inpatient Services (SIS) had moved into Business Continuity Planning Daily oversight of staffing across services, which continued to be overseen by Gold Command with services required to provide assurances that services are safe.

14.1.3 The skill mix of registered to unregistered staff had been progressed through the establishment review programme of work and staff are being recruited to the additional posts in AMH acute and Secure Inpatient Services (SIS). The first Wave Surge recruitment was completed in line with projected increases to help support post COVID acuity and demand for mental health services.

14.2 In response to Mr Murphy's query regarding the review of headroom that is underway, Mrs Moody confirmed that 5% headroom was built into budgets for staffing but throughout the reporting period time sickness absence was above 5%. She confirmed that currently maternity leave is not included within the headroom allowance, but the Trust did routinely recruit or use temporary staffing to back-fill maternity vacancies.

14.3 The Chairman queried how the Trust monitored Community/Locality nurse staffing. In response, Mrs Moody explained that the Trust had received funding from NHSE/I to implement a process to support the development of community rosters. Work was also underway to develop a community safe staffing dashboard using the IIC.

14.4 **Resolved:** the Nurse Staffing (inpatient) Bi-annual Report was received and noted.

21/07/15/152 LEARNING FROM DEATHS (QUARTER 1)

15.1 The Learning from Deaths Report for the period of 1 April to 30 June 2021 was received and noted. Mrs Moody explained that the Trust's approach to Learning from Deaths was to identify themes to drive improvements in the quality and safety of patient care. She drew reference to how the Trust was strengthening arrangements around organisational learning from deaths to improve patient safety by embedding learning across the organisation.

15.2 Mrs Moody explained that the Better Tomorrow Programme runs across all acute NHS Trusts to support the Learning from Deaths programme of work. She was pleased to report that Sheffield NHS Trust with the support of NHSE/I planned to work with the Trust to share the Better Tomorrow Programme work, which would commence with a desk top review in September 2021. There are also plans to re-establish the Northern Care Alliance across the nine organisations, which the Board were pleased to note.

15.3 Mr Murphy, Non-executive Director commended the work that was taking place and noted the significant improvements to date on the Trust's approach to learn from deaths. He queried if the large number of deaths in quarter 1 (2019/20) were in relation to COVID. In response, Mrs Moody explained that the numbers reported included all deaths including COVID recorded deaths.

15.4 **Resolved:** the Learning from Deaths Quarter 1 Report (as at 30 June 2021) was noted.

21/07/16/153 MENTAL HEALTH LEGISLATION COMMITTEE REPORT

16.1 The Mental Health Legislation Committee (MHLC) Report from the meeting held on 22 July 2021 was received and noted. Prof Hungin, Non-executive Director (Chair of the MHLC) explained that the meeting was observed by Ms Joanne Allot, CQC Mental Health Act Reviewer. The MHLC agreed to escalate two matters for the Board's attention, which included: i) the number of concerns raised by the CQC following their face to face inspection of the Harrier/Hawk, which were included in the CQC quarterly update report; and ii) the work that is underway to compare the Trust's new Long Term Segregation Policy and approach against other NHS Mental Health provider policies.

16.1.2 Prof Hungin drew reference to the Case Study, which the Committee found most insightful to support their understanding on patient's seclusion episodes.

16.2 The Chairman thanked Prof Hungin for escalating the two matters to the Board and noted that the CQC feedback would continue to be a focus whilst the Trust is taking forward improvement actions.

16.3 **Resolved:** i) the Mental Health Legislation Committee Report from the meeting held on 22 July 2021 was received and noted; and
ii) the two matters escalated to the Board were discussed and considered with actions noted.

21/07/17/154 GUARDIAN OF SAFE WORKING REPORT

17.1 The Guardian of Safe Working Report, which included a quarterly and annual update was received and noted. Mr J Boylan reported that since the last report to the Board he had been appointed at the Trust's Guardian of Safe Working (GoSW). He drew reference to the following:

17.1.1 Internal Audit report, which provided assurance on the functioning of the GoSW role. Since the Internal Audit report was received the two minor recommendations had been actioned, which included improvements to the timing of exception report records and the inclusion of expenditure details from the Guardian fund on Junior Doctor's wellbeing.

17.1.2 Two areas of concerns with regards to section 136 assessments had been escalated to the Medical Director. Following receipt of issues raised by junior doctors to the GoSW and issues raised by consultants to the LNC around the availability of the Crisis Team staff during out of hour assessments in Durham, additional information was being collected from junior doctors. The information collected is planned to be shared with the Medical Director and the Director of Medical Education.

17.1.3 The number of exception reports received from Localities were mainly in relation to when non-residential on-call rotas had been in place. To mitigate this there are plans to split on-call rotas to two working days in future.

17.2 The Board were pleased to note that the outcome of the GMC National Training Survey with the Trust ranked within the top 10 organisations nationally.

17.3 **Resolved:** the Guardian of Safe Working Report was received and noted.

21/07/18/155 ANNUAL REPORT OF THE RESPONSIBLE OFFICER ON MEDICAL REVALIDATION

18.1 The Medical Revalidation Annual Report was received and noted. In response to Dr Khouja's recommendation the Board approved the Annual Report and Statement of Compliance for submission to NHS England and Improvement.

18.2 **Resolved:** the Medical Revalidation Annual Report and Statement of Compliance was approved for submission to NHS England and Improvement.

21/07/19/156 WORKFORCE RACE EQUALITY STANDARD AND WORKFORCE DISABILITY EQUALITY STANDARD

19.1 The Board were pleased to note the progress made with regards to workforce race and disability equality. Mr Murphy, Non-executive Director (Resource Committee Chair) confirmed that the Resource Committee had reviewed the report prior to it being presented to the Board and in future the People and Culture Committee would receive assurance on workforce legal and regulatory requirements, including Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES).

19.2 In response to Dr Dexter-Smith's recommendation the Board approved the report for publication on the Trust's website.

19.3 **Resolved:** the Workforce Race Equality Standard and Workforce Disability Equality Standard Report was approved for publication on the Trust's website.

21/07/20/157 CONFIDENTIAL MOTION

20.1 **Resolved:** 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 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.

Any advice received or information obtained from legal or financial advisers appointed by the Trust or action to be taken in connection with that advice or information.

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

Following the transaction of the confidential business the meeting concluded at 3.20 pm.

Paul Murphy
Interim Chair
28 October 2021

Board of Directors

Public Action Log

RAG Ratings:

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

Date of Board Meeting	Minute Ref No.	Action	Owner(s)	Timescale	Update	Status
29-Jul-21	21/07/9/146/9.2	The Board Seminar in September 2021 would include an agenda item on the Integrated Assurance Board Report and the Board Assurance Framework; and further discussion on the Audit and Risk Committee's role in relation to the Integrated Board Assurance Report	P Bellas	29 September 2021	Completed, discussed at the September Board Seminar	Completed

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 8

PUBLIC

BOARD OF DIRECTORS

DATE:	**Thursday, 28 October 2021**
TITLE:	**Chief Executive's Report**
REPORT OF:	**Brent Kilmurray, Chief Executive**
REPORT FOR:	**Information**

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

Executive Summary:

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

Recommendations:

To receive and note the contents of this report.

Care Quality Commission

The Care Quality Commission completed the well led inspection in August. This came after several weeks of inspection activities relating to four core services: crisis and healthcare places of safety; children and adolescent mental health services (CAMHS); adult mental health community services; and adult secure inpatient services (Forensics).

The CQC gave initial feedback, which has been followed up in correspondence, as has been previously reported to the Board. The Trust has not waited to receive the final report to commence the implementation of a range of actions to address the feedback.

We have been advised that the report is nearing finalisation and should be issued to the Trust for factual accuracy checking any time in the next few weeks. We will then have a short period of time (10 days) to provide comments based on factual accuracy. We would then expect the report to be issued within a week or so of the

return of our comments. On this basis I would expect that the final report and ratings will be published by the time of our next meeting in November.

Integrated Care Systems Development

Since our last meeting a good deal of further guidance has been published regarding the development of Integrated Care Systems (ICS). The legislation is progressing through the parliamentary process and it is intended it will have cleared Royal Assent in order for there to be a transition to ICSs by 1 April 2022. The two ICSs that TEWV is part of have been making progress in development of the leadership structures and system architecture at the different levels of the system. There has also been some development in the appointments processes of leadership positions (even though there has yet to be an announcement regarding CEO appointments). Interviews for the CEOs of the two ICSs took place on week commencing 11th October. It is understood that both appointments are to be announced within the next week or so following national approval.

North East North Cumbria ICS - As previously reported Sir Liam Donaldson has been Chair Designate of the Integrated Care Board for some time. Sir Liam has been working with partners to design the system across the ICS footprint to ensure that there is the right balance of emphasis in terms of place, natural service flows at a sub-regional level, the various key sectors and political considerations. The process has been running for some weeks now and includes provider collaborative representation as well as other partners, notably from local government. The work is considering the structure of the ICS, the composition of the Integrated Care Board, the role of the Integrated Care Partnership and the distributed leadership arrangements, including the management of resources across the ICS patch. Discussions will continue over the coming weeks prior to decisions being taken by Sir Liam with the advice of the ICS Management Board.

Humber Coast and Vale ICS - Sue Symington, current chair of York and Scarborough NHS FT has been appointed Chair designate of HCV Integrated Care Board. The system arrangements within the HCV are fairly clear now with plans for two strategic partnerships, six places and the sector provider collaboratives. HCV is currently consulting on transitional arrangements and the future structure of the ICS, including the key functions to be undertaken at each level. The discussions are being progressed through the multi sector Partnership Board.

Place Based discussions - The Trust is still heavily involved in discussions across Durham, Tees Valley, North Yorkshire (including Selby) and York.

Durham Health and Care Partnership - Is making good progress in beginning to articulate the case for a strong place based approach to integrating care across primary care, community, mental health and acute services. There are strong relationships and a number of work streams underway. The mental health and learning disability work is located within the Durham and Tees Valley Mental Health partnership and has a strong focus on community transformation, transforming care (learning disability services) and the key developments within the long term plan.

There is a good sense of momentum at a leadership level within the Durham place arrangements. The Durham Health and Care executive has been shortlisted for a partnership award by the HSJ.

Tees Valley Integrated Care Partnership - Discussions within Tees Valley have been focussed on the benefits of seeing the place as the Tees Valley sub-region. Clearly where appropriate there is the ability for services to focus at each borough within the Tees Valley. The emphasis on talks so far has been on the development of a clinical strategy. This will include mental health and autism, however the early work is focussing on acute hospital services. There is also a clear emphasis on long term financial sustainability of services in Tees Valley. The approach on mental health and learning disabilities is similar to Durham as there are currently shared partnership arrangements across the two areas.

North Yorkshire - A strategic partnership has been established across North Yorkshire to consider the place based approach. Local plans for Harrogate, Hambleton Richmondshire, Whitby, Scarborourgh and Selby are at different stages of progression. The Clinical Commissioning Group on behalf of partners has been completing a self assessment process to determine the partnership development requirements and potential readiness to take on responsibility in line with the HCV plans as mentioned above. Mental health and learning disability services arrangements currently remain under the current countywide partnership arrangements. This also involves partners from York.

City of York Health and Care Alliance - As previously reported the York discussions on place based arrangements are more advanced. An alliance has been created of all health and care partners. The ICS has invested in external facilitation and partnership development plans are being worked through with the creation and development of a board, the development of a wider group of health and care leaders, the development of an ambition and consideration of future partnership structures. The alliance has started to work together on a small number of priorities including diabetes, urgent care and physical health of people with learning disabilities.

Structures

We have now concluded the consultation on our new clinical and operational leadership structures. We received over 300 contributions from people, some of which were from groups. As a consequence of feedback there have been a number of changes to structures, mainly to the alignment of services. The proposals are now subject to a business case to be considered by the Board later today. The proposals are in line with the key principles previously outlined including an emphasis on being clinically led and operationally enabled, based on collective leadership across a multi-disciplinary team, a simplified structure, introducing lived experience leadership roles and being locally focussed. The organisational change approach has been agreed with staff side. One to one discussions are now getting underway. Colleagues have also been offered access to a range of support.

Covid Vaccine Booster

The staff booster vaccinations are being delivered by our local acute trust partners (York, CDD and South Tees) with staff also attending GP, PCN, community pharmacy and local vaccination centres. We are providing vaccinators into each acute trust setting.

Communications have created a scrolling banner on the intranet linked to a COVID booster article and now have links through the COVID-19 support page. A desktop image for COVID and Flu will go live week commencing 25 October. A further communication will be created regarding booking an appointment. Vaccinations for patients will be explored during November.

As of 20 October 2021 there was a reported 14% uptake of the booster dose which is up to 23% in the over 50s category. This is likely to be an underestimate as we rely on self-reporting of vaccination when received through GP/PCN, community pharmacy or local vaccination centre. Some people won't yet have hit the 182 day minimum wait from 2nd dose and 10-15% have not had the primary course.

2021-2022 Staff Flu Vaccination Campaign

The Trust's 2021-22 staff flu vaccination programme commenced on 4 October 2021 and clinics and vaccinations have been taking place right across the Trust since then – clinics have been planned and are available to book well into November.

Flu vaccination uptake was 20% of the Trust as at 18 October 2021, this is officially down from 24% on the corresponding day in 2020, however some inputting of vaccinations, especially notifications from staff who have had their vaccination at their GP practice (which we are receiving in record numbers) are outstanding ; also some vaccination details have been delayed being received into the Flu Team due to a couple of Flu Fighters isolating, therefore it is estimated that in reality vaccination levels are similar to this time last year. The next uptake reports will be produced as at 1 November.

- Low uptake areas in Localities and Services will be targeted following analysis of the next uptake information being produced on 1 November 2021.
- As stated the Flu Team are seeing that more staff at this early stage are informing the Trust if they have had a flu vaccination with their GP or local Pharmacy than ever before and this information being sent to the Trust via tewv.flufighter@nhs.net continues to encouraged.
- The first prize draws will take place on 25 October – many staff each week can win a Love to Ship gift card as an incentive/thank you for having their flu vaccination.
- The Flu Team continue to work closely with the Communications Team to raise awareness of the staff flu vaccination campaign across Trust platforms such as the Intranet and within the Enquiries bulletin, Brent's Blog has also referenced the Flu campaign a number of times; an all staff email was also

sent recently highlighting a number of key points and offering a simpler guide to the vaccine choice for staff aged 50 or over or those with long-term health conditions (following feedback from a small number of staff that the letter they had received was not clear).

Tees, Esk and Wear Valleys NHS Foundation Trust

Committee Key Issues Report

Report Date: 28 October 2021		**Report of: The Audit and Risk Committee**
Date of last meeting: 9 September 2021		**Membership Numbers: 3** Quoracy met -100%
1	**Agenda**	The Committee considered the following matters: ▪ An update on the implementation and effectiveness of the arrangements for managing Patient Property Money and Valuables (PPMV). ▪ The draft submission to NHS England on the Core Standards for Emergency Preparedness, Resilience and Response (EPRR). ▪ The draft Board Assurance Framework. ▪ The Corporate Risk Register. ▪ A Counter Fraud Progress Report. ▪ An Internal Audit Progress Report. ▪ An updated Technology Risk Assurance (TRA) audit plan for 2021/22 ▪ The External Auditors' Annual Report for 2020/21. ▪ The Annual Report on the Performance of the External Auditors for 2020/21. ▪ The draft External Auditors' Engagement Packs for 2021/22 ▪ The External Auditors' report on the summary of findings from the Independent Examination of the Charitable Funds 2020/21 ▪ The draft Annual Report and Accounts of the Charitable Trust Funds 2020/21. ▪ The draft Assurance Tracker for the 2021/22 audit year.
2a	**Alert**	There are no matters of concern which the Committee wishes to bring to the attention of the Board.
2b	**Assurance**	The Committee wishes to draw the following positive assurances to the attention of the Board: ▪ The findings of the Independent Examiner of the Trust's General Charitable Fund for 2020/21 that: *"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."* ▪ The self-assessment on the position against the EPRR standards which demonstrated that the Trust can effectively respond to emergency planning and business continuity incidents whilst maintaining services to patients. ▪ No issues had been identified by the Internal Auditors which might significantly impact upon the annual Head of Internal Audit Annual Opinion for 2021/22, based on the audit findings to date. ▪ There continues to be a decreasing trend in the numbers of overdue high and medium priority Internal Audit recommendations. ▪ The performance of the External Auditors during 2020/21 was

		satisfactory.		
2c	**Advise**	The Committee wishes to advise Members of the Board that: ▪ Consideration of its role in regard to the BAF and risk management will be taken forward through the Board Development Programme. ▪ A plan is in place to address control issues in relation to leases. ▪ It is continuing to seek assurances with regard to the arrangements for managing PPMV. Covid-19 has impacted on the implementation of new controls but monitoring and oversight is being improved through the reinstatement of the Operation Development and Delivery Group and PPMV being included in the new Modern Matron Ward review process. The Committee has asked for a further update to be provided in Q4 2021/22 and, prior to this, information on the availability of safes and losses is to be provided to Committee Members. ▪ A briefing note is being prepared to provide clarity on the actions required to change those counter fraud functional standards rated 'amber' to 'green'. ▪ Following on from approaches by AuditOne in relation to the non-disclosure of details held about referrals by the NHS Counter Fraud Authority, the ongoing failure to disclose is to be raised with the Healthcare Financial Management Association. • An amendment, to defer the Internal Audit assignment on Lessons Learned from Serious Incidents until Q3 or Q4 of 2021/22, was approved due to ongoing work being undertaken regarding Trust policy and operational procedures. • An updated Technology Risk Assurance Audit Plan has been approved following the completion of an audit needs assessment. • The report on the Performance of the External Auditors during 2020/21 was approved for circulation to the Council of Governors. • It was content with the External Audit Engagement Packs for 2021/22 and has recommended them for approval to the Council of Governors. • The Assurance Tracker has been reset for the 2021/22 audit year. This now reflects the changes made to the Committee's terms of reference in May 2021. Assurances on clinical waste and the freedom to speak up have been included in the future reporting schedule.		
2d	**Review of Risks**	▪ The Committee was satisfied with the progress being made on the development of the BAF but considered that the following risk ratings s should be revisited: ▪ No. 1 – Recruitment and Retention ▪ No. 4 – Quality ▪ No. 9 – Regulatory Action ▪ In regard to the Corporate Risk Register it was considered that: ▪ Improvements were required, at pace, to risk management processes and systems. ▪ Assurance was required, in view of the length of time some risks were remaining on the CRR, that mitigations were being progressed.		
3	**Actions to be considered by the Board**	Following the receipt of satisfactory assurances, the Committee has recommended that the Board approve: ▪ The EPRR self-assessment, action plan and statement of compliance for submission to the Head of EPRR for Yorkshire & the Humber (see public agenda item 13). ▪ The Annual Report and Accounts of the Charitable Trust Funds 2020/21 for submission to the Charity Commission (see public agenda item 19).		
4	**Report compiled by**	*John Maddison* *Chairman of Committee* *Phil Bellas* *Company Secretary*	**Minutes available from**	*Angela Grant* *Senior Administrator*

Tees, Esk and Wear Valleys
NHS Foundation Trust

Item 11

PUBLIC

BOARD OF DIRECTORS

DATE:	**28th September 2021**
TITLE:	**Finance Report for Period 1 April 2021 to 30 September 2021**
REPORT OF:	**Liz Romaniak, Director of Finance, Information and Estates**
REPORT FOR:	**Assurance and Information**

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

Executive Summary:

The Month 6 report reflects performance within the context of national financial arrangements supporting the NHS to respond to the Coronavirus Pandemic. Revenue funding allocations were provided for the first half (or H1) only of 2021/22 initially. System-level allocations have recently been received for the second half of the year (H2) and organisation and system planning activities are now underway to service related H2 plan submissions during November. Full year Integrated Care System capital envelopes were confirmed in March 2021, allowing organisation level funding to be agreed. We expect the imminent Comprehensive Spending Review to offer the NHS vital clarity of capital resource assumptions for the next 3 years.

- **Statement of Comprehensive Income:** The year to date position is a surplus of £5.0m, which is £0.3m ahead of the submitted plan for a £4.7m surplus. This is before £0.4m additional unplanned profit on disposal of fixed assets, which is excluded when assessing NHS provider financial performance.
- **Capital Programme:** Annual capital requirements were prioritised to establish a 2021/22 Programme that was deliverable within the Trust's capital allocation of £13.6m. Schemes were impact assessed to inform the final re-prioritised plan. Capital expenditure is marginally above plan, and two planned asset sales have been delayed meaning the Trust is above its overall capital plan by £1.0m at the end of H1. In July the Trust re-forecast commitments. Expenditure is behind the re-forecast by £0.5m, with a number of minor schemes commencing later than anticipated. The Trust expects to fully commit the £13.6m capital allocation.
- **Cash:** The Trust's cash balance is £83.6m as at 30 September 2021, which is £0.7m ahead of plan. More detail can be found in section 3.7.

Following recent publication of H2 national planning guidance budgets and workforce plans are being drafted. Allocations are broadly consistent with H1, but with some reduction in Covid support and an increased efficiency of 1.1% (0.28% in H1).

Recommendations:

To receive and note the contents of this report.

1. INTRODUCTION & PURPOSE:

This report sets out the financial position for month 6 of 2021/22; 1 April to 30 September 2021 and based on a draft plan submission for the first half (H1) of 2021/22, of £4.7m surplus.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This report will enable the Board of Directors to monitor the Trust's key financial duties and key performance indicators (KPIs) which are both statutory requirements. Appendix 1 provides an overview of the Trust's KPIs for the year to date.

2.2 NHS Improvement's (NHSI) Use of Resources Rating (UoRR) evaluates Trusts based on ability to service debt, liquidity, income and expenditure (I&E) margin, achievement of planned I&E margin, and agency expenditure.

2.3 National financial arrangements operated throughout 2020/21 and H2 block funding mechanisms continued into H1 2021/22 to support the NHS in responding to the Covid-19 Pandemic. The Trust supported the submission of high level systems plans for H1 that would deliver a H1 surplus of £4.7m for the Trust and a breakeven plan for the Tees Valley 'place' and Integrated Care System (ICS). It is important to note however that the Trust's H1 funding incorporates £9.1m net (of £3m required minimum surplus) non-recurrent income allocated at 'place' level for growth and Covid costs, meaning an underlying recurrent deficit position for the same period at plan. This was largely due to the pump priming of £5.4m adult acute and forensic inpatient staffing investment. In subsequent months three out of four host CCG partners have been able; through our collaborative Mental Health Partnership Boards, to support £3.1m (of £3.6m in aggregate) of the related CCG commissioned adult acute inpatient investment.

2.4 National Planning guidance and ICP/ICS system(s) funding envelopes were published on 1st October. As anticipated, the H2 allocation is broadly consistent with H1, but with a reduction for funding (£0.5m) allocated to support the response to the covid pandemic, and a higher efficiency / waste reduction requirement of 1.1% (compared with 0.28% in H1).

2.5 The North East and North Cumbria ICS one-year 2021/22 allocation of the national capital departmental expenditure limit (CDEL) was received at the end of March 2021. The ICS envelope of £185m was less than the sum of organisations' composite 'aspirational' plans. Individual plans were re-visited and prioritised on a more consistent 'pre-commitment' and 'safety' basis, to inform envelopes to individual organisations. The Trust's capital funding envelope on this basis is £13.6m.

3.1 Key Performance Indicators

Appendix 1 provides a summary of all KPIs for the period ending 30 September 2021.

3.2 Statement of Comprehensive Income – Year to date

The Trust is reporting a year to date surplus of £5.0m for month 6, which is £0.3m ahead of its draft plan, Excluded from the Trust's £5.0m surplus is an adjustment relating to a profit on disposal of land in July of (£0.4m). This adjustment is excluded when assessing NHS provider performance financially, and is therefore included as a 'below the line' adjustment at Table 1.

Performance is summarised in table 1:

Table 1

	H1 Plan	Year to Date		YTD	YTD
	M1-6	Plan	Actual	Variance	Last Month Variance
	£000	£000	£000	£000	£000
Income From Activities	191,769	191,769	197,553	-5,784	-1,077
Other Operating Income	9,801	9,801	10,166	-365	-579
Total Income	**201,570**	**201,570**	**207,719**	**-6,149**	**-1,656**
Pay Expenditure	-159,060	-159,060	-164,045	4,985	625
Non Pay Expenditure	-34,091	-34,091	-34,955	864	725
Depreciation and Financing	-3,699	-3,699	-3,697	-2	-1
Surplus / (Deficit)	**4,720**	**4,720**	**5,021**	**-301**	**-302**
Profit on sale of Assets	0	0	420	-420	-420
Surplus / (Deficit) incl adjustments	**4,720**	**4,720**	**5,441**	**-721**	**-721**

Income from patient care activities was £5.8m higher than plan, with additional income received including for Mental Health spending review allocations that were clarified after plan submission. Pay award outcomes, and related national funding of £4.2m was also not known, or included, in the plan.

Other operating income is £0.4m higher than planned due to increased research and development and non-patient care income not anticipated at plan.

Pay expenditure was higher than planned by £5.0m due to:

- £4.2m nationally determined pay award not confirmed at plan;
- £2.3m higher than planned agency and bank expenditure, largely relating to the Trust Board's decision to bolster acute and forensic inpatient safer staffing, but also reflecting observations and sickness and vacancy cover;
- £0.5m higher than planned trainee grade expenditure due to successful recruitment within the last medical rotation; and
- This was offset by £2.1m net vacancies across the Trust. Activities to progress recruitment and attract and retain staffing are ongoing, with some financial impacts expected from H2.

Non pay expenditure is £0.9m higher than planned, due to:

- £0.4m higher than planned prescribing costs, largely relating to changes implemented in response to the covid pandemic;
- £0.3m higher than planned clinical supplies and services largely relating to voluntary and community sector collaboration associated with Community Mental Health Transformation. The Trust has also block contracted (and is fully utilising) four independent sector adult Mental Health assessment and treatment beds; and
- £0.2m of minor variances across other operating expenditure categories.

3.4 Cash Releasing Efficiency Savings (CRES)

The Trust has offset its H1 CRES requirements in full, using non-recurrent under spending linked to a reduction in travel expenditure due to remote working arrangements. These offsets are not reported as CRES and have not been quality impact assessed. Recurrent related smart working schemes are however being worked up for 2022/23.

Detailed full year financial planning is in train in anticipation of an increased efficiency requirement, and will assess the level of aggregate efficiency as national tariff efficiency requirements are clarified and local cost pressures assessed through Business Planning processes. In preparation, the Trust continues to identify and consider schemes to deliver future requirements and will include quality impact assessments (QIA) where schemes have been identified and due to commence.

3.5 Capital

The month 6 report shows capital expenditure is marginally higher than plan. Two modest planned asset sales have been delayed meaning the Trust is above its Capital Allocation by £1.0m at the end of H1. One asset sale is pending registration of an alternative location and may not proceed during 2021/22, the other sale is expected to complete by the year end.

The Trust is forecasting to outturn in line with its agreed ICS capital allocation of £13.6m, however plans have required re-prioritisation to keep required expenditure within the overall envelope (plus disposals and VAT recovery).

3.6 Workforce

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for overtime, 2.4% for agency (based on NHSI agency cost cap metric), and are flexed in correlation with staff in post for bank and additional standard hours (ASH).

The NHSI agency cap has not applied during the pandemic, but would equate to a cost cap equivalent to £3.8m for H1. Agency expenditure to date is £5.8m; which is £2.0m above the indicative cap for the period ending 30 September 2021. Expenditure is across all localities and reflects operational and business

continuity staffing pressures experienced due to community infection rates and the impact on staffing levels, and substantive staff recruitment gaps.

Nursing and Medical expenditure headings account for 94% of total agency expenditure; cover is required to maintain essential services and to cover vacancies, sickness, increased test and trace isolation levels and to support enhanced observations with complex clients.

The Senior Leadership Group is considering a number of actions to target improved substantive recruitment and retention and will consider related resource implications as Business Plans for 2022/23 are developed.

3.7 Statement of Financial Position

Cash balances are £83.6m as at 30 September 2021 and £0.7m ahead of the H1 plan. This is largely due to slightly higher than planned creditors. Despite this, the Trust achieved year to date Better Payment Practice Code (BPPC) compliance, for the prompt payment of suppliers, above the required 95% target.

3.8 Use of Resources Risk Rating (UoRR) and Indicators

3.8.1 The UoRR is impacted by Covid-19 and national monitoring is currently suspended. However, the Trust will continue to assess the UoRR based on run rate assumptions approved for H1. Detail can be found in table 2 below.

Table 2: Use of Resource Rating at 30 September 2021

NHS Improvement's Rating Guide	Weighting	Rating Categories			
	%	1	2	3	4
Capital service Cover	20	>2.50	1.75	1.25	<1.25
Liquidity	20	>0	-7.0	-14.0	<-14.0
I&E margin	20	>1%	0%	-1%	<=-1%
I&E margin distance from plan	20	>=0%	-1%	-2%	<=-2%
Agency expenditure	20	<=0%	-25%	-50%	>50%

Actual performance 30 September 2021	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	3.86x	1	3.72x	1	
Liquidity	41.7	1	39.6	1	
I&E margin	2.4%	1	2.3%	1	
I&E margin distance from plan	-0.1%	1	0.0%	1	
Agency expenditure (£000)	£5,752k	4	£3,786k	1	
Overall Use of Resource Rating		**2**		**1**	

3.8.2 The **capital service capacity** metric assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 3.86x (can cover debt payments due 3.86 times), which is ahead of plan and is rated as a 1.

3.8.3 The **liquidity** metric assesses the number of days' operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric is 41.7 days; this is on plan and is rated as a 1.

3.8.4 The **Income and Expenditure (I&E) margin** metric assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 2.4%, this is broadly on plan and is rated as 1.

3.8.5 The **I&E margin distance from plan ratio** metric assesses the I&E surplus/deficit relative to planned performance. The Trust I&E margin distance from plan is -0.1% which is rated as a 1 and is marginally ahead of plan.

3.8.6 The **agency expenditure** metric assesses agency expenditure against a capped target (pre-pandemic) for the Trust. Agency expenditure of £5.8m is in breach of the capped target by £2.0m (52%) and is rated as a 4.

3.8.7 The 'headroom' margins on the individual metrics are as follows:

- Capital service cover - to deteriorate to a 2 rating the Trust's financial position would have to decrease by £4.6m.
- Liquidity - to deteriorate to a 2 rating the Trust's working capital position would have to decrease by £45.4m.
- I&E Margin – to deteriorate to a 2 rating the Trust's financial position would have to decrease by £2.9m.
- Agency Costs – to improve to a 3 rating the Trust's agency expenditure would have to decrease by £0.1m.

4. IMPLICATIONS:

4.1 There are no direct CQC, quality, legal or equality and diversity implications associated with this paper.

5. RISKS:

5.1 There are no risks arising from the implications identified in section 4.

5.2 Despite including an increased efficiency requirement in H2, national financial arrangements provide short term assurance on the 2021/22 financial positions. However, uncertainty in relation to 2022/23 funding arrangements / allocations and regulation makes coherent longer term financial planning challenging. Key concerns include the extent to which real terms mental health investment standard funding is maintained. Risks include the impact of Agenda for Change pay award costs and the future mechanism for funding the 6.3% increase in employers' NHS Pensions contributions (currently remitted centrally). These significant uncertainties have the potential impede progress to deliver long term plan priorities. Discussions are continuing, including through local Partnership

Boards, to agree immediate and future investment priorities. National planning guidance for H2 was published on 1st October and is being reviewed alongside activities to develop draft H2 financial plans.

5.3 CRES targets have been offset by non-recurrent underspending in H1 which is forecast to continue into H2. The Trust's Finance Sustainability Board (FSB) oversee CRES planning and delivery and are coordinating overall financial planning activities. Nationally efficiency requirements in H2 are more challenging; equivalent to 1.1%. There has also been a 5% reduction in non-recurrent covid support funding. The FSB and Business Planning work will take account of anticipated CRES requirements as the Trust begins to formulate sustainable recurrent plans for future years.

5.4 The UoRR is impacted by Covid-19 and national monitoring is currently suspended. However, agency usage is increasing, and the Trust has moved to from a score of 3 to a score of 4 against this individual metric.

6. CONCLUSIONS:

6.1 For the period ending 30 September 2021 the Trust has achieved a surplus of £5.0m which is £0.3m ahead of the plan for H1.

6.2 The CRES framework is yet to be agreed for 2022/23, however the Trust is stepping up work to identify schemes to deliver requirements on a recurrent basis, and will provide an update in due course. Mitigations to offset efficiency requirements during 2021/22 have been identified, with scope to make some savings recurrent.

6.3 To enable continued focus on the pandemic, annual planning activities for 2021/22 were deferred nationally; initially, for H1 into the first half of 2021/22. H2 planning and NHS financial settlements have recently been published and FSB reviewed initial draft plans and considered next steps when it met on 20th October.

6.4 The UoRR for the Trust is assessed as 2 for the period ending 30 September 2021 and is behind plan.

7. RECOMMENDATIONS:

7.1 The Board of Directors is requested to receive the report, consider the issues and risks raised and any related further assurances needed.

Liz Romaniak
Director of Finance, Information and Estates

Appendix 1

Key Financial Indicators for the period ending 30 September 2021

Surplus variances are shown as negative	Year to date			RAG	Prior Month Variance	RAG
	Plan	Actual	Variance			
I&E (Surplus) / Deficit £m	-4.7	-5.0	-0.3		-0.3	
Profit on sale of Asset (Excl in H1 totals)	0.0	-0.4	-0.4		-0.4	
Income £m	-201.6	-207.7	-6.1		-1.6	
Pay Expenditure £m	159.1	164.0	5.0		0.6	
Non Pay Expenditure £m	34.1	35.0	0.9		0.7	
Non Operating Expenditure £m	3.7	3.7	0.0		0.0	
Capital Expenditure (including disposals) £m	5.1	6.1	1.0		-0.5	
Capital Service Cover	3.72x	3.86x	-0.14x		-0.32x	
Liquidity Days	39.6	41.7	-2.1		-3.6	
I&E Margin	2.30%	2.40%	-0.10%		-0.1%	
Variance from I&E Margin plan	0.0%	0.1%	-0.10%		-0.2%	
Agency Expenditure £m	3.8	5.8	2.0		1.4	
Cash Balances £m	82.9	83.6	-0.7		-2.1	
Total debt over 90 days	5.0%	10.4%	5.4%		5.4%	
BPPC NHS invoices paid < 30 days	95.0%	95.9%	-0.9%		-1.2%	
BPPC Non NHS invoices paid < 30 days	95.0%	95.7%	-0.7%		-1.5%	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Board Performance Dashboard
As at 30th September 2021

journey to change

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

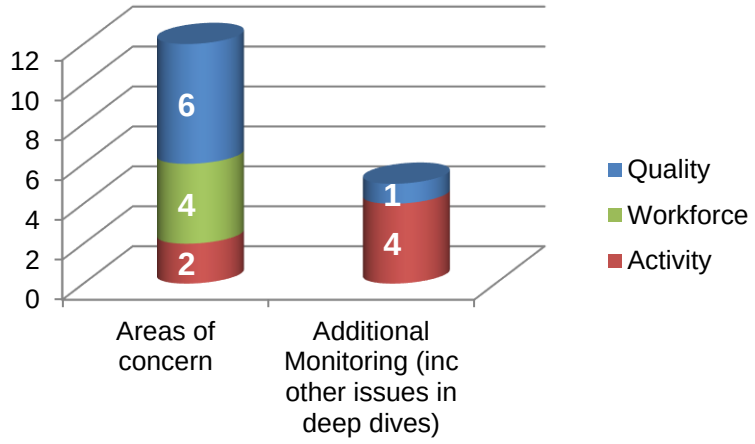
CONTENTS

Executive Summary at a glance

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

These are the areas of concern we are trying to improve:

- We are not seeing as many patients **within 4 weeks for a first appointment** as we would like (6427 patients out of 7775 in September which is 82.66% compared to our standard of 90%).
- The number of **patients receiving treatment within 6 weeks** is not as high as we would like (926 patients out of 1769 in September which is 52.35% compared to our standard of 60%).
- We are not treating as many people in their local hospital as we would like. There were 235 patients placed in a bed outside their local hospital accounting for 3530 **inappropriate OAP days** in the 3 months ending September.
- Whilst **patients report their overall experience** as very good it is not as positive as our ambition (706 patient surveys out of 771 in September which is 91.57% compared to our standard of 94%).
- We recognise the potential to improve our learning from **Serious Incidents.** In September, 2 Serious Incidents (from a total of 5) were found to have a root cause or contributory finding. This is 40% compared to our standard of 32%.
- Our Adult and Older Persons' teams are not demonstrating the **improvement we would like in patient outcomes (HONOS)** (43 out of 95 in September which is 45.26% compared to our standard of 60%).
- The number of **patients being referred and taken on for treatment** is fewer than we would expect (2197 patients out of 9129 referred in June which is 24.07%). No standard has been set for this measure.
- Our wards are extremely busy and **bed occupancy** is higher than we would like it to be (10,477 occupied bed days out of 10,560 available bed days which is 99.21% in September compared to our standard of 90%).
- The number of **vacancies** is higher that we would like (421 out of 7431 (5.67%) whole time equivalent staff in September). No standard has been set for this measure.
- The number of **staff with a current appraisal** is not as high as it was previously (4157 members of staff out of 6278 in September which is 66.22% compared to our standard of 95%).
- The number of **staff compliant with their mandatory and statutory training** is not as high as we would like it to be (86,186 training courses out of 102,623 in September which is 83.98% compared to our standard of 92%)
- **Sickness Absence rates** for staff are higher than we would like them to be (14,473 working days out of 211,864 in August which is 6.83% compared to our standard of 4.3%)



These are the areas that require monitoring to better understand what's happening before we are certain that they are an area of concern:

- Our Adult and Older Persons' teams are not demonstrating the **improvement we would like in clinical outcomes (SWEMWBS)**, particularly in Durham & Darlington.
- The number of **patients referred** is higher than we would expect, particularly within Forensics Services.
- The number of **patients with an assessment completed** is lower in North Yorkshire & York than we would expect.
- The number of **patients discharged** is lower in Tees than it was previously.
- The number of **patients staying in beds longer than 90 days** is increasing, particularly in Durham & Darlington

There are currently no areas showing that they are continuously improving or providing full assurance that we are delivering the service we aspire to.

Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

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

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

Assurance: is the target/standard achievable?

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

Our Approach to Data Quality and Action

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

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

Data Quality Assessment status

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

Action status

	Positive Assurance	We are doing well in this area and therefore no action is required
	No Concerns	No further action is needed at this point in time
	Additional Monitoring	We need to monitor this more closely to better understand what's happening before it becomes an area of concern
	An Area of Concern	We need to investigate this to understand what's happened and/or take action

Trust Dashboard Summary

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Quality

Measure Name	Variation Ending Sep - 2021	Assurance Ending Sep - 2021	Standard (YTD)	Actual (YTD)	Annual Standard
1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral	L	?	90.00%	87.01%	90.00%
2) Percentage of patients starting treatment within 6 weeks of an external referral		?	60.00%	57.92%	60.00%
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	H	?	1,833	3,530	1,833
4) Percentage of patients surveyed reporting their overall experience as excellent or good		?	94.00%	88.58%	94.00%
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding		?	32.00%	56.36%	32.00%
6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind	L	?	60.00%	47.82%	60.00%
7) % of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) - month behind		?	65.00%	66.08%	65.00%

Activity

Measure Name	Variation Ending Sep - 2021	Assurance Ending Sep - 2021	Standard (YTD)	Actual (YTD)	Annual Standard
8) Number of new unique patients referred				48,809	
9) The percentage of new unique patients referred with an assessment completed (2 months behind)	H			76.34%	
10) The percentage of new unique patients referred and taken on for treatment (3 months behind)	L			29.87%	
11) Number of unique patients discharged (treated only)				17,366	
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	H	?	90.00%	97.73%	90.00%
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot		P	61	44	61
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)		?	9.90%	8.44%	9.90%

Workforce

Measure Name	Variation Ending Sep - 2021	Assurance Ending Sep - 2021	Standard (YTD)	Actual (YTD)	Annual Standard
15) Finance Vacancy Rate	H			-5.67%	
16) Percentage of staff in post with a current appraisal	L	F	95.00%	66.22%	95.00%
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	L	?	92.00%	83.98%	92.00%
18) Percentage Sickness Absence Rate (month behind)	H	?	4.30%	5.84%	4.30%

Money

Measure Name	Plan (YTD)	Actual (YTD)
19) Delivery of our financial plan (I and E)	-4,720,000	-5,440,662
20) CRES delivery	0	0
21) Cash against plan	83,019,000	83,583,937

TD01) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral – *Trust Standard 90%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, and carers and families by ensuring access to the right care and treatment is timely as we know this supports patient safety, wellbeing and quality of care. We want to ensure our patients receive an assessment at the earliest opportunity so they are placed on the most appropriate treatment pathway in a timely manner, enhancing their experience and outcomes and reducing the risk of a deterioration in their condition and the potential need for admission.

7775 patients attended a first appointment during September; of those, **6427 (82.66%)** were within 4 weeks of referral

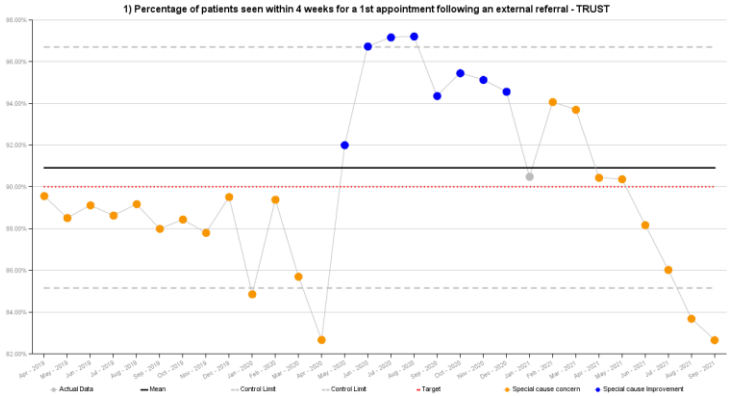
We're aiming to have high performance and we're moving in the wrong direction.

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

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

DQ

100%



Locality	Variation	Assurance
TRUST	L	?
DURHAM AND DARLINGTON		?
FORENSIC SERVICES		P
NORTH YORKSHIRE AND YORK	L	?
TEESSIDE	L	?

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that we are not seeing as many of our patients in a timely manner as we would like. This was first identified as a potential area of concern in July 2021.	Actions are detailed on the following pages.		No visible impact; however actions remain ongoing.

TD01) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Within **Tees** Children & Young People's Services (CYPS), a delay in processing referrals through the Single Point of Access Team has led to a reduction in the number of patients being triaged to the community teams in a timely manner.	A plan to be developed to clear the current waiting list.	**Completed**. The plan has been developed and completed. The backlog is now cleared and increased monitoring will continue to ensure the plan has the desired impact.	Although an increasing position is now visible within the data, this does not yet denote an actual improvement.
High levels of sickness and an increase in referrals has impacted capacity within the **Tees** Adult Mental Health (AMH) Stockton Access Team.	Overtime support is to be provided by the Affective Disorder Team and Perinatal Services during October. The Associate Nurse Consultant is to work with the team during October to review processes and identify potential blockages in the system.	**Ongoing.** Overtime slots have been filled, which will enable the backlog to be cleared by the end of October.	No visible impact at this point; however actions remain ongoing.
Whilst waiting times within **Tees** Mental Health Services for Older People have been impacted by support provided into our Forensic Wards to help manage current pressures, the main concerns have been staff sickness, vacancies and increased acuity.	Recruitment is ongoing to appoint new staff to enable demand to be met.	**Ongoing**. Additional clinical staff have been recruited and will be in post by mid December.	No visible impact at this point; however actions remain ongoing.
Further analysis of **Tees** Learning Disability services has shown that there has been increased sickness and acuity.	Increased monitoring to be undertaken during October to confirm whether this is an area of concern.	**Ongoing**.	No visible impact at this point; however actions remain ongoing.
Potential concerns were identified within **Durham & Darlington** and **North Yorkshire & York** in August 2021.	Analysis to be undertaken within the localities to identify any areas of concern.	**Completed**. The detailed findings are on the following pages.	

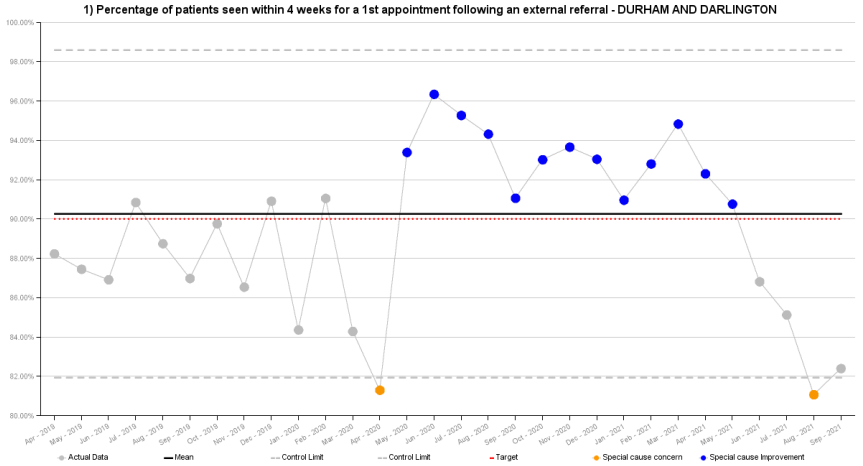
TD01) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral – Durham and Darlington locality

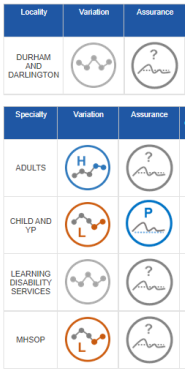
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

DETAILED ANALYSIS

We are not seeing as many of our patients in a timely manner within Durham Locality as we would like. Analysis at speciality and team level has identified the following.

- Within Children & Young People's Services (CYPS) analysis has identified that whilst many teams are seeing patients within the 4 week standard, there may be a concern within the Darlington, Easington, North Durham and South Durham Targeted Teams and the specialist Autism and Eating Disorder teams.





- No concerns were indicated within Mental Health Services for Older People (MHSOP) in the initial analysis; however this is now a potential area of concern therefore this will be included within further analysis.
- No concerns have been identified within Adult Mental Health and Adult Learning Disabilities.

CONCLUSIONS	ACTIONS BEING TAKEN
Within CYPS potential concerns are identified within a number of teams. Further work is required to confirm whether these are actual areas of concern. A potential concern is now highlighted within MHSOP and further analysis is required to understand the teams that are impacted and whether this is an actual area of concern.	The Corporate Performance Team is to work with the CYP Service Manager to investigate further to confirm whether this is an actual area of concern. This work will be undertaken during October with findings and any actions to be undertaken reported in November 2021. The Corporate Performance Team is to work with the MHSOP Service Manager to investigate further to confirm whether this is an actual area of concern. This work will be undertaken during October with findings and any actions to be undertaken reported in November 2021.

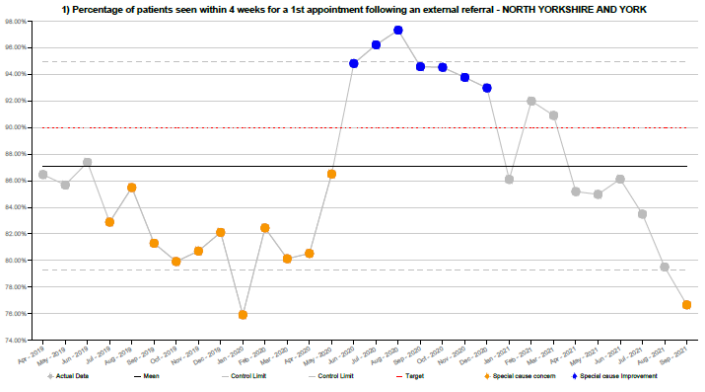
TD01) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral – North Yorkshire and York locality

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

DETAILED ANALYSIS

We are not seeing as many of our patients in a timely manner within North Yorkshire & York Locality as we would like. Analysis at speciality and team level has identified the following.

- Whilst most patients are seen within the 4 week standard within Adult Mental Health (AMH), there may be a concern within the Hambleton & Richmondshire East, Scarborough, Whitby & Ryedale and York North generic community teams, North Yorkshire & York Perinatal team and York & Selby Mental Wellbeing Access team. In addition, whilst patients are currently being seen in a timely manner within the Harrogate generic community team, this is lower than we would like to see and therefore this should be investigated further.



Locality	Variation	Assurance
NORTH YORKSHIRE AND YORK		

Specialty	Variation	Assurance
ADULTS		
CHILD AND YP		
LEARNING DISABILITY SERVICES		
MHSOP		

- Within Children & Young People's Services (CYPS) there are potential areas of concern within the Northallerton, Selby & York East generic community team and Scarborough Mental Health Support team. In addition, whilst patients are currently being seen in a timely manner within the Harrogate, Scarborough & York generic community team this is lower than we would like to see and therefore this should be investigated further.

- Within Mental Health Services for Older People (MHSOP) we are seeing fewer patients within 4 weeks than we would like within the Memory Services and Harrogate, Scarborough & Ryedale community services and therefore this should be investigated further.

- Whilst there a concern is highlighted within Adult Learning Disabilities (ALD) analysis has confirmed that the majority of patients are seen within the 4 week standard and that chart is being impacted by the small numbers of patients involved. We can confirm this is not an area of concern at this point.

CONCLUSIONS

Potential concerns are identified within a number of AMH teams and further work is required to confirm whether these are actual areas of concern.

Potential concerns are identified within a number of CYP teams and further work is required to confirm whether these are actual areas of concern.

Potential concerns are identified within a number of MHSOP teams and further work is required to confirm whether these are actual areas of concern.

ACTIONS BEING TAKEN

The Corporate Performance Team is to work with the Locality Managers for AMH, CYP and MHSOP to investigate further to confirm whether these are actual areas of concern. This work will be undertaken during October with findings and any actions to be undertaken reported in November 2021.

TD02) Percentage of patients starting treatment within 6 weeks of an external referral – *Trust Standard 60%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, and carers and families by ensuring access to the right care and treatment is timely as we know this supports patient safety, wellbeing and quality of care. We want our patients to begin their treatment at the earliest opportunity to improve their experience and outcomes and also to reduce the risk of a deterioration of their condition and the potential need for admission.

1769 patients started treatment during September; of those, **926 (52.35%)** started within 6 weeks of being referred

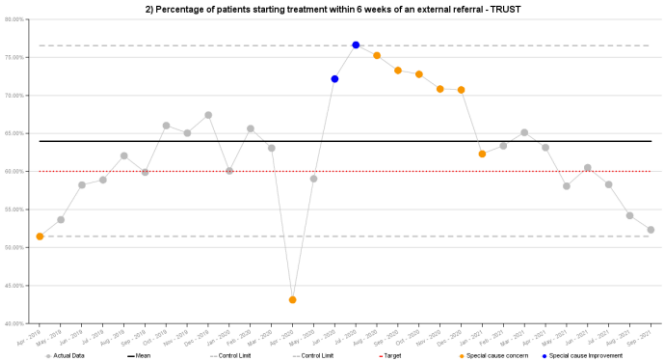
Nothing to note. Our activity is within the expected levels of performance

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

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

DQ

85%



Locality	Variation	Assurance
TRUST		
DURHAM AND DARLINGTON	L	
FORENSIC SERVICES		P
NORTH YORKSHIRE AND YORK	L	
TEESSIDE		

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that we are not starting treatment for patients in a timely manner. This was first identified in January 2021.	Actions are detailed below and following for each locality.		No visible impact; however actions remain ongoing.
In **Durham & Darlington** Children & Young People's Services (CYP) we have been impacted by staff vacancies.	Recruitment is underway, which would provide more staff to offer treatment.	**Ongoing.** Recruitment is continuing. Further details on outstanding recruitment and any issues or further actions will be provided in November 21.	No visible impact; however actions are still ongoing.
Waits for **Durham & Darlington** CYP on a neurological pathway to start treatment are longer due to the complexity of assessments.	Service Development Group (SDG) to consider whether these patients should be counted in this measure as they are not waiting for treatment but further assessment.	**Ongoing.** SDG have had initial discussions; however the September meeting did not take place as focus was given to the Care Quality Commission work on CYP waiters. This discussion will be progressed during October and an update provided in November 21.	
Some data quality issues were identified within the Darlington Team and **Durham & Darlington** Mental Health Services for Older People.	Work to be undertaken to understand and correct data quality issues.	**Ongoing.** Issues identified in MHSOP have been rectified. Work continues to correct those in CYPS.	

TD02) Percentage of patients starting treatment within 6 weeks of an external referral – continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
In **Tees** Adult Mental Health patients have been impacted by appointment availability for medication reviews.	The AMH Associate Clinical Director to ensure there are no blockages to patients starting treatment.	**Completed.** These were data quality issues (not medic capacity) and training has been provided.	No visible impact; however actions are still ongoing.
High levels of sickness and an increase in referrals has impacted capacity within the **Tees** Adult Mental Health (AMH) Stockton Access Team.	Overtime support is to be provided by the Affective Disorder Team and Perinatal Services during October. The Associate Nurse Consultant is to work with the team during October to review processes and identify potential blockages in the system.	**Ongoing.** Overtime slots have been filled, which will enable the backlog to be cleared by the end of October.	
There is a delay in the assessment process within the **Tees** CYP Single Point of Contact (SPOC) team.	The Service is to review SPOC processes to improve efficiency. Backlog of referrals to be managed with support from the Getting Help Teams. Following clearance of the backlog, patients are to be prioritised for treatment according to clinical need.	**Completed.** Review completed and process streamlined. **Completed.** The backlog has been cleared and triaged as appropriate. **Ongoing.**	No visible impact; however actions are still ongoing. As the 6 week standard has already lapsed it will take some time before we start to see an improvement in the waiting times for our patients.

TD03) The total number of inappropriate OAP days over the reporting period – *Trust Standard 1833 days*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

3530 days spent by patients in beds away from their closest hospital during July, August and September 2021.

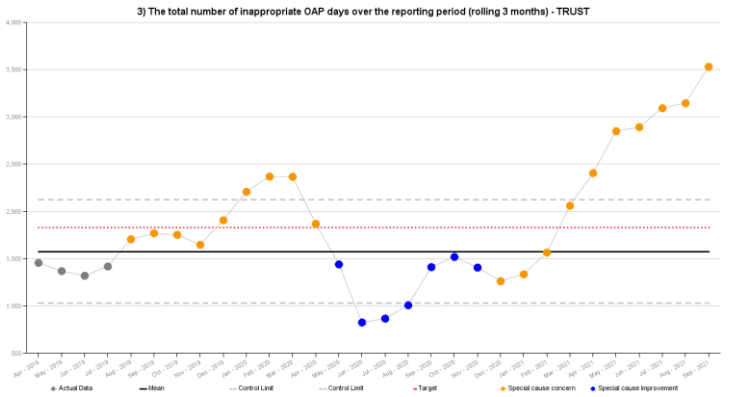
We're aiming to have low performance and we're moving in the wrong direction.

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

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

DQ

90%



Locality	Variation	Assurance
TRUST	H	?
DURHAM AND DARLINGTON	H	
NORTH YORKSHIRE AND YORK	H	
TEESSIDE	H	

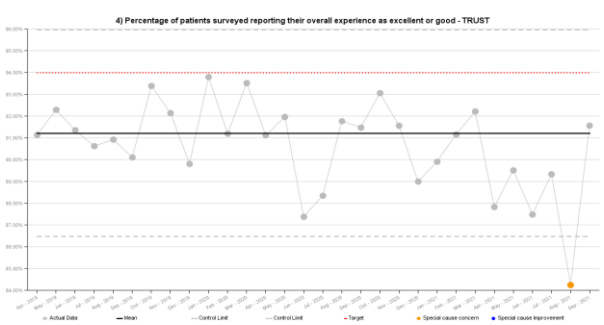
KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
More patients in our Adult Mental Health (AMH) and Mental Health Services for Older People (MHSOP) services are spending time in Trust beds away from their closest hospital. This was first identified in March 2021 and is being largely impacted by current pressures on our inpatient services. The Executive Team has agreed that we need some external support to help with this and this is currently being progressed.	Analysis to be undertaken to understand the impact of inpatient and community pressures on our out of area placements, to identify any areas of concern.	**Completed.** Following initial analysis, data is monitored monthly.	No visible impact; however it will be December before we see the true impact on our patients of our adherence to the continuity of care principles.
	A Trust-wide review to be undertaken to ensure the Continuity of Care Principles are embedded within all Service processes by the 30th September 2021.	**Completed.** A paper was presented to the Executive Oversight Team on the 5th October 2021. All recommendations were supported and regular assurance monitoring has been requested.	
Four beds have been purchased in the independent sector until the 31st January 2022 (extended from September 2021) for AMH and MHSOP patients; 5 patients occupied these beds during September (117 bed days) and 3 patients was admitted externally to the Trust due to no beds being available (45 bed days).	The Out of Area Protocol to be reviewed to ensure is up to date and fit for purpose.	**Ongoing.** Work continues on the draft protocol.	

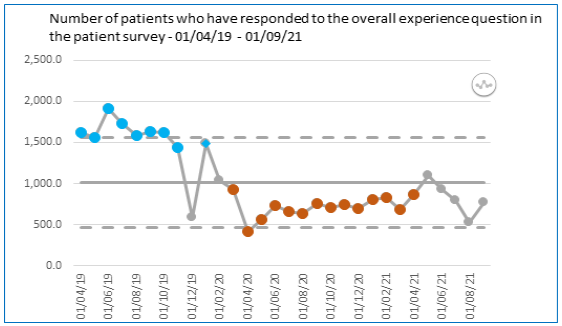
TD04) Percentage of patients surveyed reporting their overall experience as excellent or good – *Trust Standard 94%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

771 patients responded to the patient survey question "Overall how would you rate the care you have received?". Of those, **706 (91.57%)** scored 'excellent' or 'good'





KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
A number of our patients are not rating our services as excellent or good. First identified in September 2020, concerns included waiting times, access to services, activities and feeling safe. The number of responses to our surveys are lower than we would like and have been impacted by Infection, Prevention & Control restrictions on the use of touch screen technology (Tablets and Kiosks) and the continued lack of face to face contact.	Patient Experience Improvement Plans to be established in all localities to monitor response rate, response numbers and the nature of the feedback concerning patient experience. Monthly monitoring of response rates and progress against the Patient Experience Improvement Plans to be established. A comparison exercise to be undertaken with Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust on the 'Feeling Safe' theme. This is due to be completed December 2021.	**Completed.** Improvement plans have been agreed in all localities and monitoring will be through local governance processes, with updates presented to the Quality Improvement and Assurance Subgroup (QA&I). **Ongoing. 4 out of 18 actions completed** (with an additional 3 partially complete) across all localities**.** The work continues to be impacted by operational pressures, acuity and demand. There are a number of actions that have been implemented including the updating of carer leaflets, and offering intensive support in Early Intervention in Psychosis services, promoting the use of alternative technology to disseminate the surveys and the recruitment of new activity co-coordinators. However, these have not been fully embedded. **Ongoing.** Initial meeting with CNTW was held in October. CNTW agreed to undertake similar comparison work to identify themes. The next meeting is scheduled to take place in November where key staff from both Trusts will consider the findings and agree the next steps.	Although an increasing position is now visible within the data, this does not yet denote an actual improvement.

TD05) Percentage of Serious Incidents which are found to have a root cause or contributory finding (month behind) – *Trust Standard 32%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

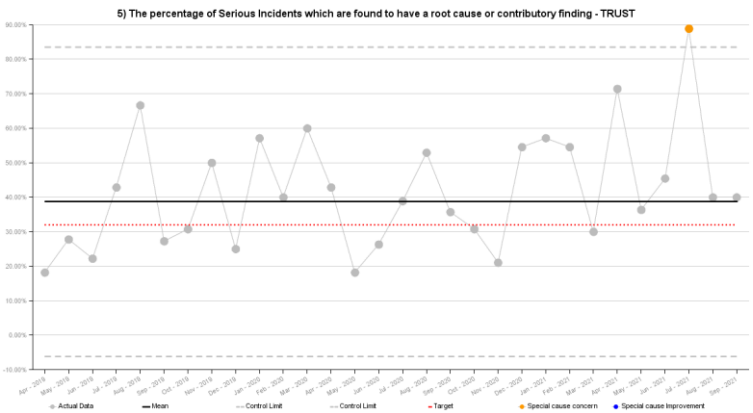
5 serious incidents were reported to the Trust Director Panel during August; of those, **2 (40%)** were found to have a root cause or contributory finding

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

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

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

DQ ✓ **85%**



Locality	Variation	Assurance
TRUST		
DURHAM AND DARLINGTON		
TEESSIDE		

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that we have not seen a reduction in the number of serious incidents in which lapses and/or serious lapses in patient care and treatment have been identified. First identified in August 2021, this was discussed at the September Organisational Learning Group Meeting. Themes identified included sexual safety, perinatal care and safeguarding.	Work to be undertaken to identify the nature of Serious Incidents and any emerging themes. These will inform any areas of learning and will be used to drive forward any improvements or changes to practice where necessary.	**Ongoing.** All findings are captured on a central database within the Patient Safety Department to enable the identification of themes and key learning. This is reviewed monthly and informs any actions or improvement work to be initiated and existing work programmes. Updates are provided to the Organisational Learning Group to provide assurance and learning bulletins are issued following Serious Incident Assurance Panels.	No visible impact; however whilst our improvement work helps us to understand the nature of incidents and prevent recurrence, the wide variance of incidents means that there will not always be a visible impact on the data.

TD06) Percentage of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) (month behind) – *Trust Standard 60%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

95 in scope teams have discharged patients from Trust services in the last three months; of those, **43 (45.26%)** achieved the agreed improvements in their Health of the Nation Outcome Score (clinician rated outcome measure)

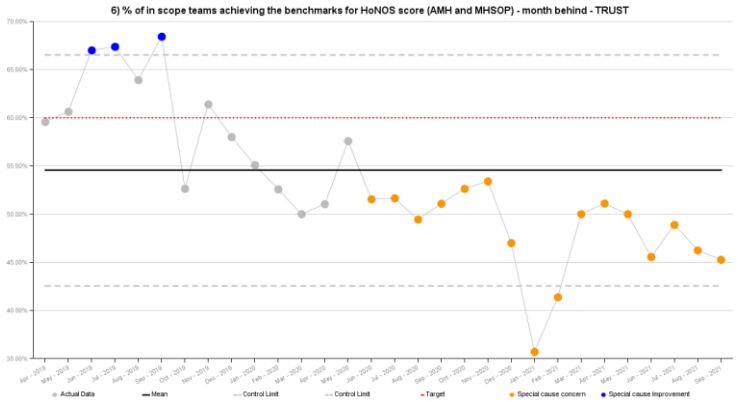
We're aiming to have high performance and we're moving in the wrong direction.

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

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

DQ

95%



Locality	Variation	Assurance
TRUST	L	?
DURHAM AND DARLINGTON		?
NORTH YORKSHIRE AND YORK		?
TEESSIDE	L	?

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
A number of our teams are discharging patients that have not shown as much improvement as we would like. This was first identified as a concern in October 2020 and work is required to understand the underlying reasons. Please see overleaf for Locality concerns.	The Clinical Outcomes Steering Group (COSG) to develop a work plan that will include an approach for integrating outcome measures within our clinical services. This will include training for staff and analysis to understand what is impacting on our patients' improvement. Information to be analysed to understand why our patients feel that they have experienced an improvement (see TD07 SWEMWBS) but clinically have not shown that.	**Ongoing.** Work commenced in October to develop the work plan; this will be completed by 31st December 2021.	No visible impact; however actions are still ongoing.

TD06) Percentage of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) (month behind) continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that patients within our **North Yorkshire & York** Mental Health Services for Older People (MHSOP) are not showing as much improvement as we would like due to staff training requirements.	The Head of Service to arrange training to support staff's knowledge regarding the completion of HoNOS.	**On Hold.** Due to pressures within the clinical outcomes teams training cannot be progressed at the current time. In the interim, the MHSOP leadership team is supporting staff with outcome queries but the need for formal clinical outcomes training remains, especially for new staff. Training is to be incorporated within the work of the Clinical Outcomes Steering Group.	An increase has been visible since June 21; however this does not yet denote an actual improvement..
We are concerned that patients within our **Durham and Darlington** Adult Mental Health (AMH) services are not showing as much improvement as we would like.	Analysis at patient level to be undertaken by the clinical leadership team to identify any key areas of concern.	**Ongoing.** A discussion is to take place at the October Locality Quality Assurance & Improvement meeting to agree actions. A support group, supported by a Psychologist and an Outcomes trained Clinician, has been created to support and train staff in the use of outcomes tools and to understand the reporting requirements.	No visible impact; however actions remain ongoing.
We are concerned that patients within our **Tees** AMH and MHSOP services are not showing as much improvement as we would like.	A caseload management review at patient level to be undertaken by the clinical leadership team to identify any key areas of concern.	**Ongoing**. Due to pressures on clinical services this has not yet been progressed and a timescale for the work has not been provided. An update on timescales will be confirmed next month.	No visible impact; however actions remain ongoing.
	AMH Community Matrons to reinstate clinical outcomes monitoring within huddles, reinstate caseload management reviews and arrange training for staff.	**Not started.** Vacancies, sickness and acuity have continued to impact on progress. However, new staff are booked onto outcomes training and the Service is currently looking at strategies to provide more support to teams in general before they can address HoNOS.	
	MHSOP Service Development Group to consider an appropriate approach for monitoring outcomes for patients with degenerative illness.	**Ongoing.** Further discussion is to be tabled at the Locality Quality Assurance & Improvement Meeting in October.	

TD07) Percentage of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) (month behind) – *Trust Standard 65%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

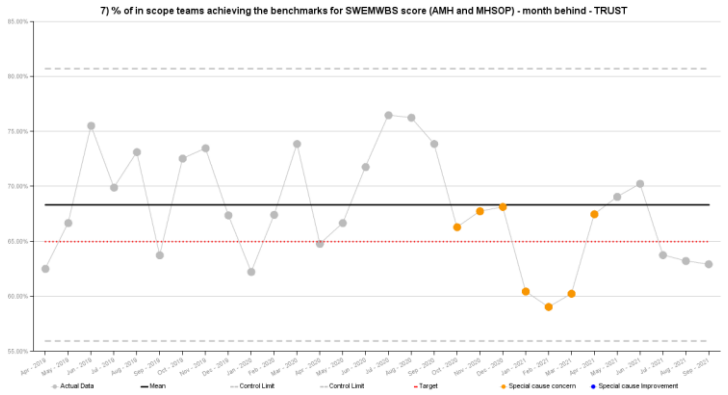
89 in scope teams have discharged patients from Trust services in the last three months; of those, **56 (62.92%)** achieved the agreed improvements in the short version of the Warwick–Edinburgh Mental Wellbeing Scale (patient rated outcome measure)

There is no significant change in our performance. – it is within the expected levels.

We need to monitor this more closely to better understand what's happening before it becomes an area of concern

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

DQ ✓ **95%**



Locality	Variation	Assurance
TRUST		
DURHAM AND DARLINGTON	L	
NORTH YORKSHIRE AND YORK		
TEESSIDE		

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that a number of our teams are discharging patients that have not reported as much improvement as we would like. This was first identified as a concern in August 2021 within our **Durham & Darlington** Adult Services.	Analysis to be undertaken to identify any areas of concern.	**Completed.** This was included within the August 21 report and highlighted a potential concern within Adult Mental Health Services (AMH).	No visible impact; however further work is required to identify any appropriate actions for improvement.
A potential concern has been identified within a number of teams: Tunstall/Farnham Inpatient service, Derwentside & Chester le Street Affective team, Durham City Affective team, North Durham & South Durham Psychosis team, Eating Disorders Community team and Durham and Darlington Crisis team.	The Corporate Performance Team is to work with the team and Locality Managers to investigate further to confirm whether these are actual areas of concern. This work will be undertaken during September and findings reported in October 2021.	**Not started**. Due to pressures within the Corporate Performance Team this work has been delayed and will be completed during October and findings reported in November 2021.	

TD08) Number of new unique patients referred – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

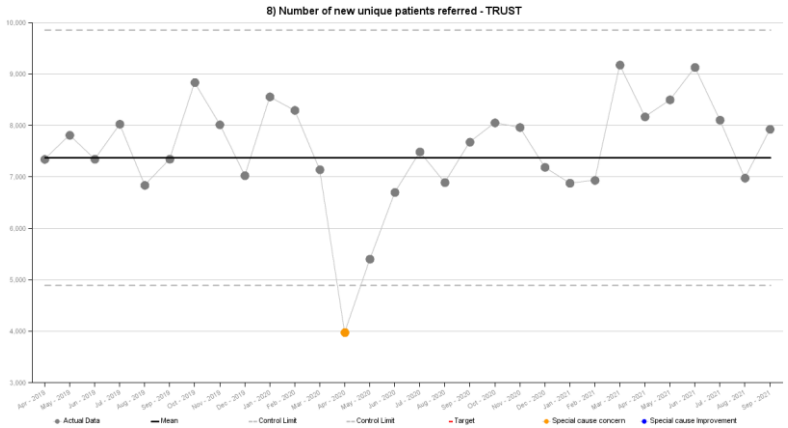
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment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

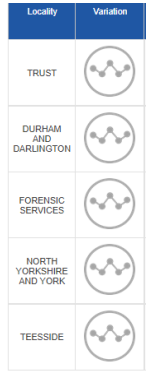
7928 patients referred in September that are not currently open to an existing Trust service

There is no significant change in our performance. – it is within the expected levels.

We need to monitor this more closely to better understand what's happening before it becomes an area of concern

DQ ★ **100%**





KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We have received a high number of referrals for new patients into our **Forensics** services due to an increase in referrals to the Cleveland and Durham Liaison & Diversion teams. This was first identified in May and is anticipated to continue. The service has reviewed their processes to ensure those with the greatest need are prioritised but without further support from commissioners they cannot manage increasing demand.	The Head of Health & Justice Services to submit a business case to commissioners outlining options to manage the current demand by the end of May 2021. The Service, with support from the Corporate Performance Lead, will continue enhanced monitoring of progress. Referrals to be reviewed over the next 6 months to understand demand and to inform the discussion and business case with commissioners.	**Completed.** A business case was submitted and the commissioners requested more information. **Completed.** The number of referrals for Forensics and all three L&D teams are now at a level we would expect to see. **Ongoing.** Update to be provided end November	The service is reporting lower numbers of referrals and activity is now at a level that we would expect to see.

TD09) The percentage of new unique patients referred with an assessment completed (2 months behind) – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

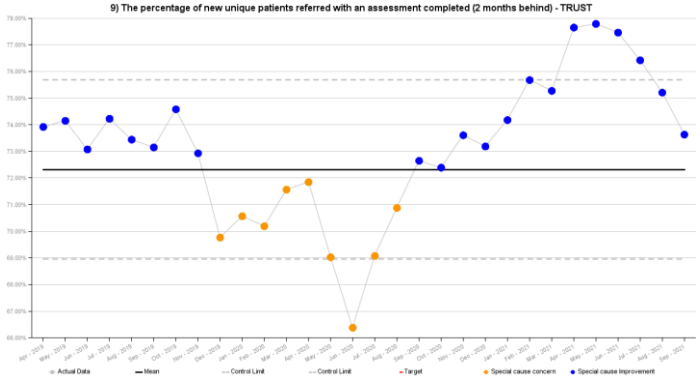
8105 patients referred in July; of those **5968 (73.63%)** patients have now had an assessment

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

We need to monitor this more closely to better understand what's happening before it becomes an area of concern

DQ

100%



Locality	Variation
TRUST	H
DURHAM AND DARLINGTON	H
FORENSIC SERVICES	H
NORTH YORKSHIRE AND YORK	L
TEESSIDE	

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Whilst as a Trust we are not assessing the numbers of new patients that we would aspire to, potential concerns were first highlighted in September 2020.	Analysis to be undertaken to understand whether there were any areas of concern.	**Completed.** Since September analysis has been undertaken in three localities and a number of issues have been identified. These are detailed on this and the following page.	Sustained improvements have been visible since September 2020.
We are concerned that we are not assessing as many new patients within our **Forensics** services as we would like. Following changes to the Liaison & Diversion Services national specification, it was incorrectly assumed assessments undertaken by our sub-contractors should not be recorded on Paris.	All staff and subcontractors are to record their assessment contacts and enhanced monitoring is to be established to ensure this continues, including the provision of Paris training.	**Completed.** All three L&D teams are reporting an improvement and spot check audits have been undertaken to ensure assessment codes are recorded.	Sustained improvements have been visible since January 2021. Therefore, this will not be continued as an issue in future reports unless something changes.

TD09) The percentage of new unique patients referred with an assessment completed (2 months behind) continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are not assessing as many children & young people (CYP) within our **Tees** generic Middlesbrough Community Team as we would like due to staff movement and sickness.	Plans to address staff absence and recruitment within the Middlesbrough Community team are underway.	**Ongoing.** Absence levels have improved. One Band 6 nurse post is pending a start date. A Psychological Therapist post is out to advert until the end of October and adverts for a Psychologist and Assistant Psychologist are to be placed.	Although an increasing position is now visible within the data, this does not yet denote an actual improvement. However, actions remain ongoing.
There has also been an increase in the number of referrals to the Hartlepool and Stockton Autism Spectrum Disorder (ASD) Team.	To support demand, 2½ days triage for waiting patients is to be implemented. A discreet 'triage service' is to be established.	**Completed.** We have seen an increase in the number of assessments during July. **Ongoing**. A Triage Co-ordinator has been appointed and is due to start in November. An Applied Psychologist post has been recruited to and is pending a start date and a 0.5 whole time equivalent Applied Psychology post is due to start in October.	
We are not assessing as many of our **North Yorkshire & York** Mental Health Services for Older People and Learning Disabilities services patients as we would like.	Further analysis to be undertaken within North Yorkshire & York Locality to identify any areas of concern.	**Completed.** The detailed findings are provided overleaf.	No impact; however the analysis has just been completed.

TD09) The percentage of new unique patients referred with an assessment completed (2 months behind)

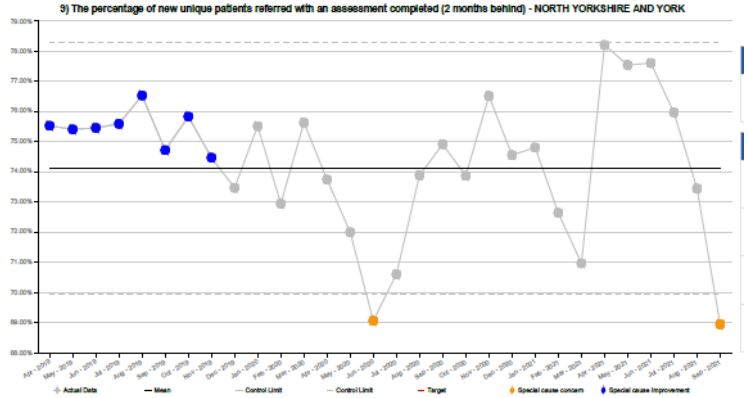
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

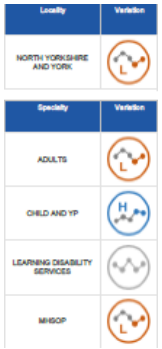
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment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

DETAILED ANALYSIS

We are not assessing as many new patients as we would like within North Yorkshire & York. Analysis at speciality and team level has identified the following.

- Whilst the majority of teams within Mental Health Services for Older People (MHSOP) are assessing the numbers of patients that we would expect, there may be potential concerns within the Harrogate Vanguard Community Care service, Hambleton and Richmondshire Memory service, Harrogate Memory Service and Scarborough Memory Service.





- Whilst the majority of teams within Adult Mental Health Services (AMH) analysis are assessing the numbers of patients that we expect, there may be a potential concern within the York & Selby Mental Wellbeing Access service.
- There are no concerns highlighted within Adult Learning Disabilities or Children & Young People's Services at this point.

CONCLUSIONS

There is a number of teams within MHSOP and AMH that are not assessing the numbers of patients that we would expect. Further work is required to confirm whether these are actual areas of concern.

ACTIONS BEING TAKEN

The Corporate Performance Team is to work with the Locality Managers for MHSOP and AMH to investigate further to confirm whether these are actual areas of concern. This work will be undertaken during October and findings reported in November 2021.

TD10) Percentage of new unique patients referred and taken on for treatment (3 months behind) – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

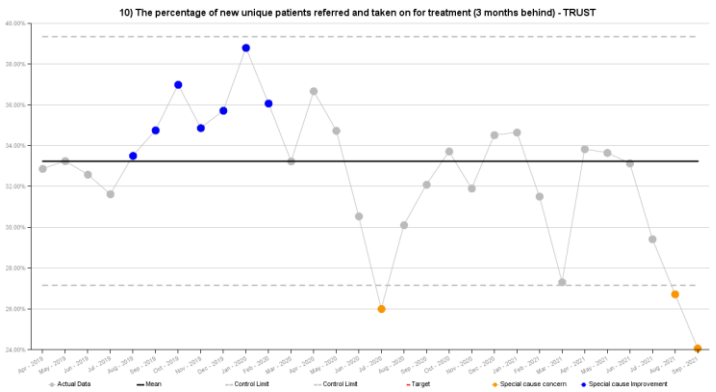
9129 patients were referred in June; of those, **2197 (24.07%)** patients have now been taken on for treatment

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

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

DQ

100%



KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that we are not starting treatment with as many of our patients as we would like. Potential concerns were first highlighted in September 2020.	Analysis to be undertaken to understand whether there were any areas of concern.	**Completed.** Since September analysis has been undertaken in all localities and a number of issues have been identified. These are detailed on this and the following page.	No visible impact; however actions are still ongoing.
We are treating fewer patients within our **Forensics** Liaison & Diversion Services than we would like. Many referrals are not appropriate for the service and are redirected for appropriate care and a number of clients leave custody prior to receiving assessment and treatment. Many contacts are via telephone, which is currently excluded from this measure.	A list of appropriate treatment codes to be agreed with Team Managers and Paris options to be limited to those relevant to the service. The Head of Health & Justice Services to raise the appropriateness of telephone contacts as a treatment method at the Service Development Group (SDG) in June 2021.	**Completed.** Agreed codes were circulated to staff with effect from December 2020. Paris changes implemented in June 2021. **Ongoing**. SDG agree telephone contacts are clinically appropriate but a further review is being undertaken to confirm whether the care provided by the service can be deemed clinically to be treatment. A report on the findings will be submitted to Forensics SDG for consideration. An update will be provided in November.	There has been some improvement visible but actions remain outstanding.

TD10) Percentage of new unique patients referred and taken on for treatment (3 months behind) continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are treating fewer patients within **Tees** Mental Health Services for Older People teams than we would like due to waits for a Computed Tomography scan to support a dementia diagnosis.	The Service to review the dementia pathway to minimise the number of patients referred for a scan.	**Completed.** Patient progress and health is monitored at all times.	No visible impact; however actions remain ongoing.
Some treatment codes are not recorded correctly.	Service Development Manager (SDM) to review all data quality issues.	**Completed**. The SDM has developed training, which will be rolled out to all staff on the 1st October 2021.	
Potential concerns have been identified within the MHSOP Middlesbrough and Hartlepool generic community teams. Sickness and vacancies within the teams is impacting the ability to progress as many patients to treatment as would be expected.	Sickness to be managed through the Long Term Sickness Team.	**Ongoing.** Sickness is being managed but return to work dates for absent staff are not confirmed.	
	Recruitment to be undertaken to fill all vacancies.	**Ongoing.** Recruitment issues are continuing. An update will be provided in November.	
Potential concerns have been identified within the MHSOP North Tees Liaison and South Tees Frailty teams.	Analysis to be undertaken by the Service Development Manager and Head of Service to determine whether this is attributable to the service model.	**Complete.** Analysis has confirmed that performance is attributable to the service model, as the teams primarily do not take patients on for treatment but signpost patients to the most appropriate services.	
Tees Children & Young People's Services have a new service model, triaging referrals in a Single Point of Contact team so they can be directed to appropriate services for their needs. A high number of referrals has resulted in delay.	Development of an interim plan to streamline the referral processes	**Complete.** The plan is in place, incorporating a streamline of the referral process and temporary support from Getting Help Teams to process the back log of referrals. Monitoring will continue to ensure the actions have had the desired impact.	No visible impact; however as the delay to assessment has already occurred within the backlog, it will take some time before we will see some visible improvement in the data.

TD10) Percentage of new unique patients referred and taken on for treatment (3 months behind) continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that within our **North Yorkshire & York** Mental Health Services for Older People (MHSOP), there is a high number of patients waiting for treatment within the Harrogate Memory Service and this is attributable to capacity within the team.	Recruitment is underway with all staff due in post by the 15th October 2021, with an aim is to complete 20 assessments per week from November.	**Ongoing.**	No visible impact; however actions remain ongoing.
Potential data quality issues have been identified in the Harrogate Vanguard Community Care service.	The Locality Manager to undertake a deep dive during October to understand the underlying reasons; findings will be reported in November 2021.	**Not started**. Action to be completed in October.	
The York Care Home and Dementia service is treating a low number of patients; however their service model includes referrals from Care Homes where advice is given via telephone contact. They were also temporarily impacted by staff sickness and one vacancy.	No actions required.		No impact; however activity is as expected within the service model, therefore, this will not be continued as an issue in future reports unless something changes.
Within Adult Mental Health (AMH) there are potential areas of concern within the Harrogate Community service and York & Selby Wellbeing Access service.	The Corporate Performance Team is to work with the Locality Managers to investigate further to confirm whether these are actual areas of concern. This work will be undertaken during October and findings reported in November 2021.	**Not started**. Action to be completed in October.	No visible impact; however investigations are still underway.
Within Children & Young People Services (CYP) there are potential areas of concern within the Northallerton, Scarborough, Selby and York East generic community teams.	The Corporate Performance Team is to work with the Locality Manager to investigate further to confirm whether these are actual areas of concern. This work will be undertaken during October and findings reported in November 2021.	**Not started**. Action to be completed in October.	No visible impact; however investigations are still underway.

TD11) Number of unique patients discharged (treated only) – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

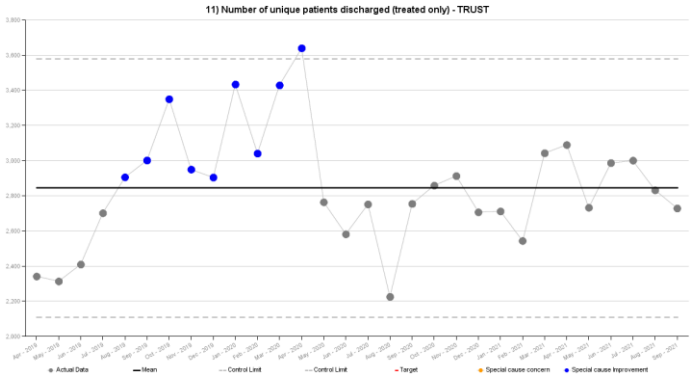
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are discharged from our services is important as it demonstrates that our patients are recovering and allows us to ensure we can maintain sufficient capacity to take on new patients.

2728 have been discharged in September after receiving treatment

There is no significant change in our performance. – it is within the expected levels.

We need to monitor this more closely to better understand what's happening before it becomes an area of concern

DQ ✓ **85%**



Locality	Variation
TRUST	
DURHAM AND DARLINGTON	
FORENSIC SERVICES	H
NORTH YORKSHIRE AND YORK	
TEESSIDE	L

SUMMARY

Whilst there is no concern with regards to the number of patients we are discharging from a Trust perspective, at a locality level there is a visible concern highlighted for **Tees**. First identified in July 2021, this has been fully investigated and attributed to:

- a restructure within the Children & Young Peoples Services generic community teams
- work with the Local Authority and commissioners to discharge Mental Health Act Section 117 patients back to local care from the Mental Health Services for Older People Intensive Community Liaison & Psychiatry team

Therefore at this point we can conclude this is not an area of actual concern.

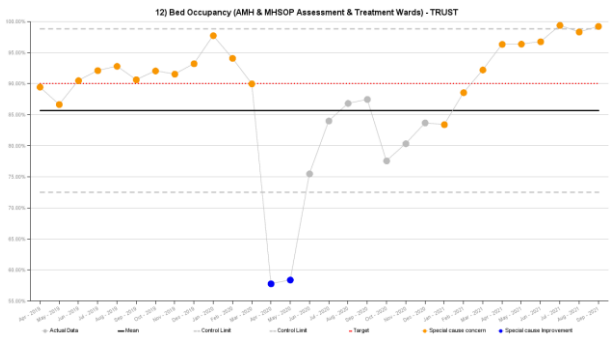
TD12) Bed Occupancy (AMH & MHSOP A & T Wards) – *Trust Standard 90%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

During September **10,560** daily beds were available for patients; of those, **10,477 (99.21%)** were occupied.

- H — We're aiming to have low performance and we're moving in the wrong direction.
- ! — We need to investigate this to understand what's happened and/or take action
- ? — Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves
- DQ ✓ — **85%**



Locality	Variation	Assurance
TRUST	H	?
DURHAM AND DARLINGTON	H	?
NORTH YORKSHIRE AND YORK	H	?
TEESSIDE	H	?

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned we have a greater number of patients occupying our inpatient beds than we would expect. Whilst this was first identified as a concern in June 2021, it has been monitored since September 2020 as there are a number of pressures on inpatient services within Adult Mental Health (AMH) and Mental Health Services for Older People (MHSOP).	Analysis to be undertaken to understand the impact of community pressures, available resources and other factors, including out of area placements, to identify any areas of concern.	**Completed.** Following initial analysis, data is monitored monthly.	No visible impact; however actions are still ongoing.
	Demand forecasting analysis to be undertaken to understand future pressures.	**Completed.** Analysis shared with Chief Operating Officer, directors and key representatives of inpatient management	
	Four beds to be purchased in the independent sector for AMH and MHSOP patients.	**Completed:** Contract commenced 13th August 21 and will now run to the 31st January 22. All 4 beds are occupied.	
Whilst the number of admissions are at a level we would expect, occupancy is above a safe level and we have been unable to identify a safe, sustainable and robust plan to enable us to be flexible with bed capacity when required.	Increased focus to be given to inpatient pressures at Locality Quality Assurance & Improvement Groups.	**Ongoing.**	
	External support to help manage inpatient pressures and out of area placements to be commissioned.	**Ongoing**. The specification has been completed and is currently with County Durham & Darlington Foundation NHST Trust for process of the procurement request.	

TD13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards – T*rust Standard no more than 61 patients*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

As at the 30th September 2021, **44** inpatients had a length of stay longer than 90 days

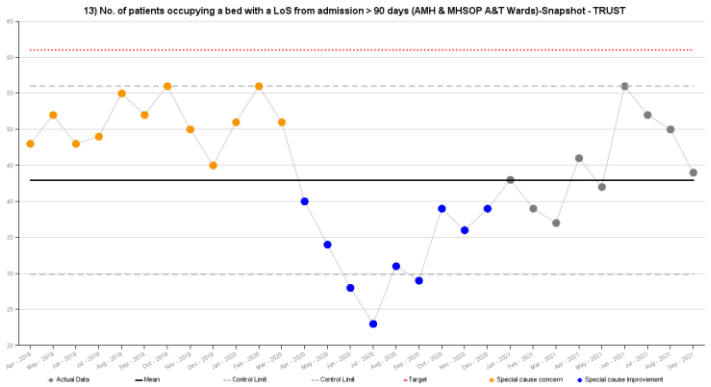
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

We need to monitor this more closely to better understand what's happening before it becomes an area of concern

Our system is expected to consistently hit the target/expectation

DQ

100%



Locality	Variation	Assurance
TRUST		P
DURHAM AND DARLINGTON	H	?
NORTH YORKSHIRE AND YORK		P
TEESSIDE		?

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Whilst we are achieving standard, we are concerned there are a small number of our Adult Mental Health (AMH) and Mental Health Services for Older People (MHSOP) patients staying in beds longer than they need to be. This was first identified as a potential area of concern in **Durham & Darlington** in June 2021 and is due to the needs and level of support required for the patients in their care.	Analysis to be undertaken to understand the impact of community pressures, available resources and other factors, including out of area placements, to identify any areas of concern.	**Completed.** Following initial analysis, data is monitored monthly.	Although a decreasing position is now visible within the data, statistically this does not yet denote an actual improvement. However, actions remain ongoing.
	Demand forecasting analysis to be undertaken to understand future pressures.	**Completed.** Analysis shared with the Chief Operating Officer, directors and key representative of inpatient management	
	AMH service to form a Quality Assurance Group sub group to discuss and agree further actions. An update will be provided in November.	**Ongoing.**	
	Work is underway within MHSOP with Local Authorities to facilitate discharges into local care following the issue of new legislative guidance. An update will be provided in December.	**Ongoing.**	

TD14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days – *Trust Standard 9.90%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

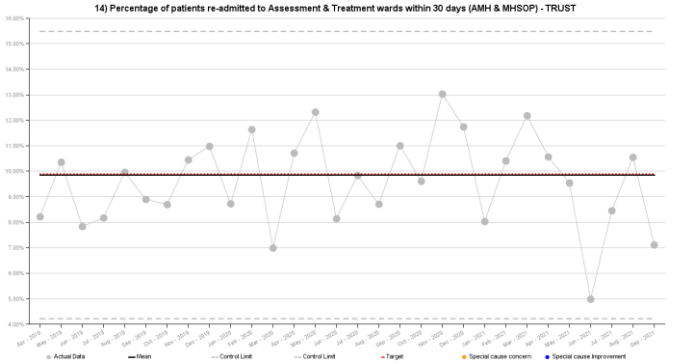
267 patients were discharged during September; of those, **19 (7.12%)** were readmitted within 30 days

There is no significant change in our performance. – it is within the expected levels.

No further action is needed at this point in time

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

DQ ✓ **85%**



Locality	Variation	Assurance
TRUST		
DURHAM AND DARLINGTON		
NORTH YORKSHIRE AND YORK		
TEESSIDE		

SUMMARY

Whilst we have achieved the standard we have set ourselves, we are concerned there are a number of pressures on inpatient services within Adult Mental Health (AMH) and Mental Health Services for Older People (MHSOP); however the number of patients being readmitted within 30 days of their previous admission are not a concern at this time.

All of these patients have 'Familiar face' plans in place to support their care and transition into the community. These plans continue to be reviewed and updated following each admission.

TD15) Finance Vacancy Rate – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, and carers and families by ensuring we have staff available in the right place and with the right skills, supporting continuity of care for our patients. As a Trust having a full establishment ensure we can manage our resources and finances effectively.

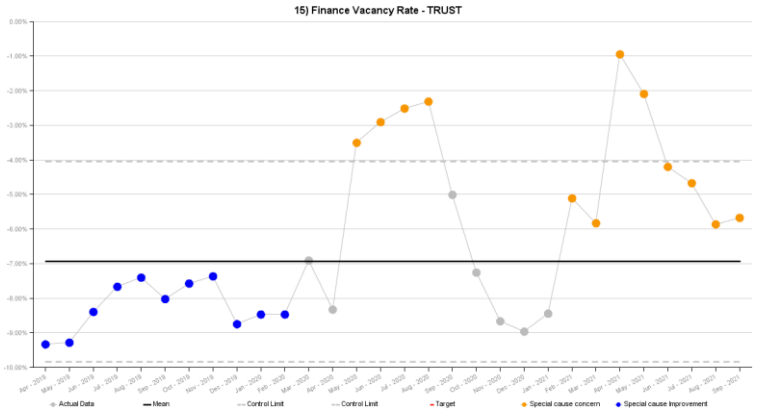
During September we budgeted for **7431.2** full time posts; however **421.47 (-5.67%)** of these were vacant

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

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

DQ

80%



Locality	Variation
TRUST	H
DURHAM AND DARLINGTON	
FORENSIC SERVICES	
NORTH YORKSHIRE AND YORK	H
TEESSIDE	H

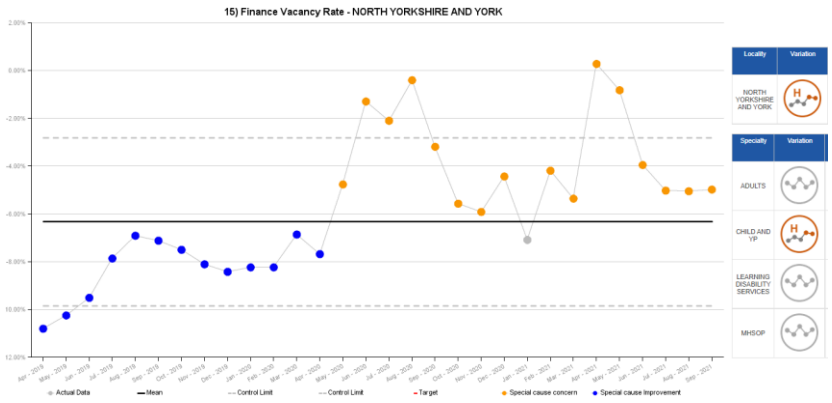
KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that we have a high number of vacancies across the Trust. The highest levels are within North Yorkshire and York and Tees Localities and further work is required to understand whether these are an area of concern.	Analysis to be undertaken to identify any areas of concern.	**Completed.** The detailed findings are provided overleaf.	No visible impact; however investigations are still continuing.

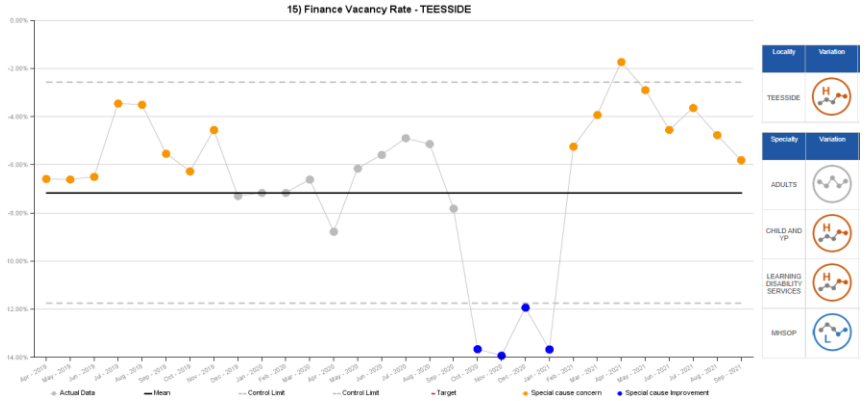
TD15) Finance Vacancy Rate – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

DETAILED ANALYSIS

We have a high number of vacancies across the Trust; the highest levels within North Yorkshire & York and Tees Localities. Further work has been completed to understand whether these are an area of concern.





Whilst there is a potential concern highlighted within **North Yorkshire & York** Children & Young People's Services (CYPS), work is underway across all specialities to review and address the significant number of vacancies that exist. A Project Manager for Recruitment and Retention has been appointed to facilitate this work.

Within **Tees** potential concerns are identified in CYPS and Adult Learning Disabilities (ALD). Whilst further investigation is required into CYPS, there is a significant campaign underway within ALD inpatient services in collaboration with the recruitment company, Indeed, to recruit new staff and facilitate their commencement in post as quickly as possible.

Whilst no concerns are indicated within Adult Mental Health or Mental Heath Services for Older People (MHSOP) in either Locality, or within **Durham & Darlington** or **Forensic** Services, vacancies are high in those areas and recruitment campaigns are underway, particularly within inpatient services where service models are being reviewed to ensure safe establishment levels. Additional funding is being allocated for new posts.

CONCLUSIONS	ACTIONS BEING TAKEN
There are a high number of vacancies within **North Yorkshire & York** CYP services and further work is required to identify whether this is an actual area of concern.	The Corporate Performance Team is to work with leads in People & Culture and Heads of Service within the Localities to understand in more detail specific actions that are in place and timescales around these actions. This work will be undertaken during October with findings and any actions to be undertaken reported in November 2021.
There are a high number of vacancies within **Tees** CYP services and ALD further work is required to identify whether these are actual areas of concern.	

TD16) Percentage of staff in post with a current appraisal (snapshot) – *Trust Standard 95%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

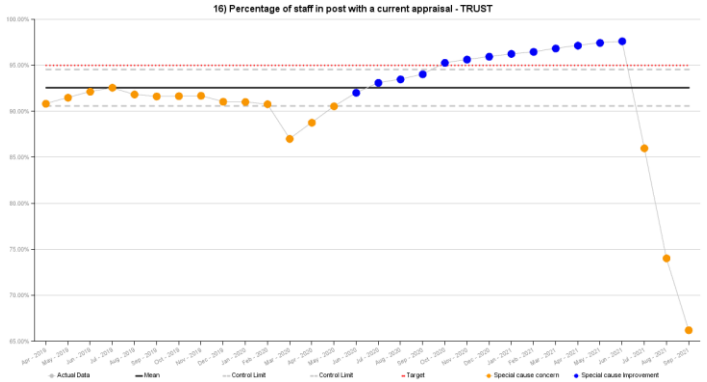
Of the **6278** eligible staff in post at the end of September; **4157 (66.22%)** had an up to date appraisal

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

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

Our system is expected to consistently fail the target/expectation

DQ ★ **100%**



Locality	Variation	Assurance
TRUST	L	F
DURHAM AND DARLINGTON	L	?
FORENSIC SERVICES	L	?
NORTH YORKSHIRE AND YORK	L	F
TEESSIDE	L	?

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that staff within our Localities have not received timely appraisals. To support business need during the pandemic, staff were given a series of extensions to ensure clinical care was prioritised. These grace periods started to expire in June and as a result we are starting to see the reduction in compliance.	Services to provide trajectories to be presented to the Locality Quality Assurance & Improvement (QA&I) Groups in October 2021.	**Ongoing.** Trajectories were provided for Forensic Services; however following discussion at the October Locality QA&I meetings, it was agreed that rather than focus on trajectories that the localities scope what time and resources are required to ensure all outstanding training is undertaken. This is to be presented to the November meetings.	No visible impact; however the actions are yet to start.

TD17) Percentage compliance with ALL mandatory and statutory training (snapshot) – *Trust Standard 92%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

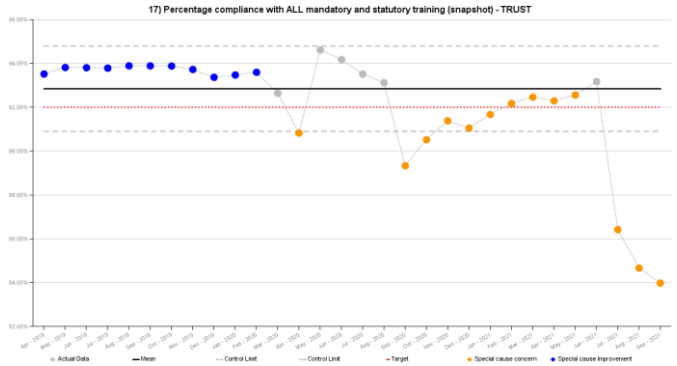
102,623 training courses were due to be completed for all staff in post by the end of September. Of those, **86,186 (83.98%)** courses were actually completed

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

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

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

DQ ★ **100%**



Locality	Variation	Assurance
TRUST	L	?
DURHAM AND DARLINGTON	L	?
FORENSIC SERVICES	L	P
NORTH YORKSHIRE AND YORK	L	?
TEESSIDE	L	?

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that staff within our Localities have not undertaken training in the required timescales. To support business need during the pandemic, staff were given a series of extensions to ensure clinical care was prioritised. These grace periods started to expire in June and as a result we are starting to see the reduction in compliance.	Services to provide trajectories to be presented to the Locality Quality Assurance & Improvement (QA&I) Groups in October 2021.	**Ongoing.** Trajectories were provided for Forensic Services; however following discussion at the October Locality QA&I meetings, it was agreed that rather than focus on trajectories that the localities scope what time and resources are required to ensure all outstanding training is undertaken. This is to be presented to the November meetings.	No visible impact; however the actions are yet to start.

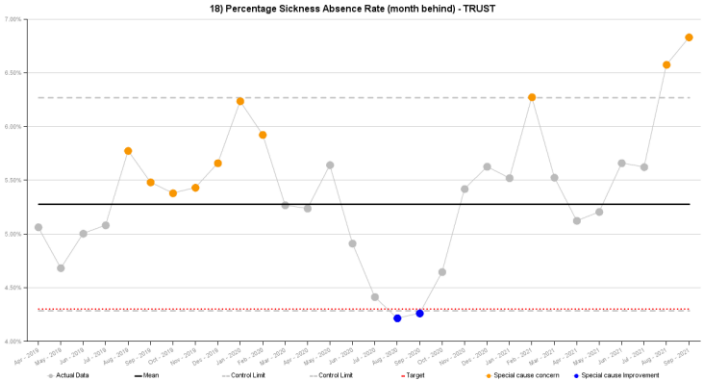
TD18) Sickness Absence – *Trust Standard 4.30%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work.

There were **211,863.76** working days available for all staff during August; of those, **14,472.55 (6.83%)** days were lost due to sickness.

- H — We're aiming to have low performance and we're moving in the wrong direction.
- ? — Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves
- ! — We need to investigate this to understand what's happened and/or take action
- DQ ✓ — **85%**



Locality	Variation	Assurance
TRUST	H	?
DURHAM AND DARLINGTON	H	?
FORENSIC SERVICES	H	F
NORTH YORKSHIRE AND YORK		?
TEESSIDE	H	F

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that more members of our staff have been absent from work due to sickness than we would like.	Actions are detailed overleaf and following for each locality.		No visible impact; however actions are still ongoing

TD18) Sickness Absence continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
This was first identified as a concern in May 2020 within our **Forensics** Services and issues identified included a number of long term sickness episodes and the impact of Covid-19.	An action plan is in place for Forensic Services.	**Ongoing.** There are 6 actions within the plan; 2 completed. A number of actions have been delayed due to staffing and business continuity pressures but revised deadlines are submitted for Board of Directors approval. • Review leaver information to establish if there are factors relating to sickness from staff leaving the teams. Proposed date October 21. • Review vacancy/use of bank staff. Proposed date October 21. • Quarterly reviews of any staff with restrictions to take place with managers and Human Resources. Proposed date October 21. • Review absences in Apr 20 – Mar 21 relating to anxiety / stress and other psychiatric issues to establish any themes. Proposed date October 21. • Review with Service if any additional support is required for staff with anxiety relating to COVID-19. Proposed date November 21. • Human Resources to carry out audits of staff personal files / sickness data to ensure sickness is being managing in line with the Trust Sickness Absence Management procedure. Proposed date November 21.	No visible impact; however actions are still ongoing.
A potential concern is now visible in **Durham & Darlington** Locality.	Analysis to be undertaken to identify any areas of concern.	**Completed.** The detailed findings are provided overleaf.	No visible impact; however actions are yet to be identified
A potential concern is now visible in **Tees** Locality; however there has been no previous concern identified.	Close monitoring to be implemented to confirm whether this is just monthly variation or further investigations are required.	**Not started.** Close monitoring will be undertaken during October and an update provided in November.	

TD18) Sickness Absence – Durham and Darlington locality

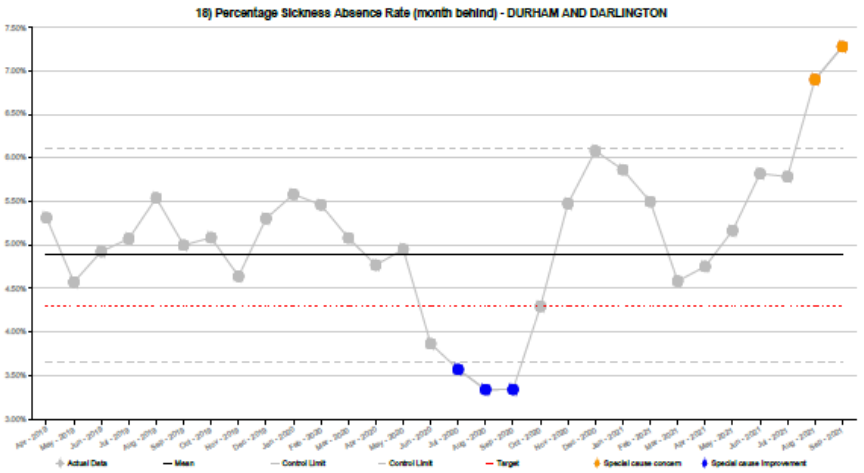
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

DETAILED ANALYSIS

More members of our staff in **Durham & Darlington** have been absent from work due to sickness than we would like. Analysis at speciality and team level has identified the following.

- Within Adult Mental Health Services (AMH) analysis has identified there may be concerns within North Durham Psychosis, Crisis team, Darlington Affective Disorders team and the Recovery College.

- Within Mental Health Services for Older People (MHSOP) analysis has identified that there may be a concern within Easington Community and Sedgefield Care Home Liaison Teams.



Locality	Variation	Assurance
DURHAM AND DARLINGTON	H	?

Speciality	Variation	Assurance
ADULTS	H	?
CHILD AND YP		?
LEARNING DISABILITY SERVICES		?
MHSOP	H	?

- Whilst sickness levels within Children & Young People's Services (CYPS) are within the range that we would expect, potential concerns are highlighted within the Darlington Community and Child Learning Disabilities North Durham Team that we would like to investigate further.
- Whilst most teams within Adult Learning Disabilities (ALD) are showing an improvement or no concern, there may be a potential concern within the South Durham Integrated team that we would like to investigate further.

CONCLUSIONS	ACTIONS BEING TAKEN
We are concerned that more members of our staff in the Durham & Darlington Locality have been absent from work due to sickness than we would like.	The Corporate Performance Team is to work with the Service Managers for CYP, MHSOP, AMH and ALD to investigate further to confirm whether these are actual areas of concern. This work will be undertaken during October with findings and any actions to be undertaken reported in November 2021.

Finance Measures

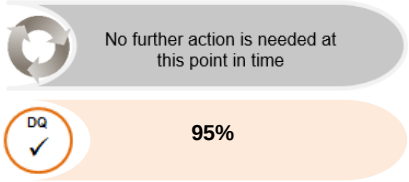
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

TD19) Delivery of our Financial Plan (I&E)

We are delivering a (**£5,441k)** surplus in September against a planned year to date surplus of **(£4,720k)**.

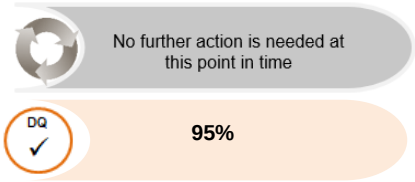
(£721k) Favourable variance from plan



TD 21) Cash against Plan

We have an actual cash balance of (**£83,584k)** against a planned year to date cash balance of (**£83,019k)**.

(£565k) Favourable variance from plan



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

SUMMARY

The Trust has an approved plan for the first 6 months of the financial year (H1) to achieve a surplus of £4,720k, and has delivered a surplus of £5,441k. This includes £420k of unplanned profits from a fixed asset disposal (land); which are excluded when assessing financial performance compared to plan. National guidance has been received for the second half of 2021/22 (H2; or October 2021 to March 2022) alongside Integrated Care System (ICS) and place-based allocations which are now being reviewed. A private update will be presented to the Board at its October meeting.

This review will continue to validate our monthly expenditure forecasts including:

- reconciliation of our anticipated income compared to forecast expenditures
- working with our place and systems partners to reconcile our anticipated income from national and local income streams
- agreeing key planning assumptions, including workforce recruitment, turnover, vacancy profiles and management of anticipated in-year inflation risk on funding mechanisms for nationally negotiated Agenda for Change
- agreeing key planning assumptions for subsequent financial years including risks associated with increased employer contributions for NHS Pensions, which are currently funded nationally, but for which recurrent funding arrangements are not known.

Planning guidance and financial allocations for 2022/23 are anticipated in December-January, once Comprehensive Spending Review discussions complete and as consequential allocations to systems are determined.

Financial performance and planning is discussed periodically at the Board of Directors, Financial Sustainability Board, Locality Management meetings and Strategy and Resources Committee.

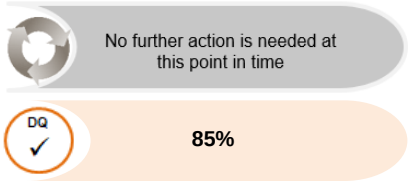
TD20) CRES Delivery

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

We have **£0k** Cash-Releasing Efficiency Savings planned in September and have identified **£0k** Cash-Releasing Efficiency Savings

£0k Variance to plan



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

SUMMARY

Cash-Releasing Efficiency Savings (CRES) requirements arise where NHS organisations need to balance expenditure within overall income, to deliver national efficiency expectations (set out in national tariff assumptions) and to deliver relevant organisational and / or system financial plan requirements. Tariff adjustments are usually applied to provider contracts annually and comprise:

- a national percentage uplift for estimated pay and price inflation
- a national percentage deduction for the required annual efficiency requirement

Providers receive the 'net' of an inflationary percentage uplift less the efficiency percentage deduction, meaning cash releasing efficiency savings are needed to maintain real terms funding levels. CRES requirements for organisations may exceed the national tariff efficiency level where other cost pressures need to be managed. The NHS seeks to find more cost efficient ways of delivering services and utilising resources. CRES might, for example include reviewing processes, staffing skills mix, premises utilisation, procurement and digital solutions.

As a result of national financial arrangements operating during the pandemic, the focus on CRES was initially suspended. More recently, the NHS has been asked to deliver CRES during 2021/22 with a view to returning to business as usual processes and arrangements from 2022/23. Nationally, 0.28% was targeted during H1 (April to September) with a national requirement of 1.1% during H2 (October to March).

It is anticipated that a higher level of CRES will be targeted nationally from 2022/23 as the NHS and wider public sector look to re-establish more normal financial flows. In preparation, the Trust is starting to focus on identifying 2022/23 recurrent efficiency or waste reduction schemes through annualised Business Planning arrangements and with Financial Sustainability Board oversight.

NHS Oversight Framework

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

SUMMARY

The majority of national standards within the NHS Oversight Framework have been achieved for Quarter 2 2021/22; however there is 1 exception to this:

1. **Inappropriate out of area placements for adult mental health services -** *This measure is contained within the Board Performance Dashboard (TD03) please see page 13 for further details.*

A new System Oversight Framework was released in June 2021, setting out NHS England and NHS Improvement's (NHSE/I) approach to the oversight of integrated care systems, CCGs and trusts, with a focus on system-led delivery of care. A review is underway to identify the requirements and work that needs to be undertaken to establish Trust assurance mechanisms. Pending the development of that report, monitoring of last year's Oversight Framework has continued.

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO.13

FOR GENERAL RELEASE

Board of Directors Meeting

DATE:	**Thursday 28th October 2021**
TITLE:	**NHS England Core Standards for Emergency Preparedness Resilience and Response**
REPORT OF:	**Russell Patton, Chief Operating Officer**
REPORT FOR:	**Consideration & Approval**

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

Executive Summary:

It is a requirement for all health organisations to undertake an annual Emergency Preparedness Resilience and Response (EPRR) self-assessment which is led by NHS England and NHS Improvement via Local Health Resilience Partnerships (LHRP).

The purpose of this process is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR Core Standards. Compliance with the standard gives assurance that NHS organisations in England can respond to emergencies and business continuity incidents and are resilient in relation to continuing to provide safe patient care.

Recommendations:

The Board of Directors are asked to review and approve this report which gives assurance that the Trust can effectively respond to emergency planning and business continuity incidents whilst maintaining services to patients.

MEETING OF:	**Board of Directors**
DATE:	**Thursday 28th October 2021**
TITLE:	**NHS England Core Standards for Emergency Preparedness Resilience and Response**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this paper is to provide the Board of Directors with appropriate levels of assurance that confirms that the Trust is complying with NHS England's Core Standards for Emergency Preparedness, Resilience and Response.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health and patient safety.

2.2 The Core Standards for EPRR aim to clearly set out the minimum standards which NHS organisations must meet to ensure that they can effectively respond to emergency and business continuity incidents whilst maintaining services to patients.

2.3 In addition they enable agencies to co-ordinate Emergency Preparedness, Resilience and Response activities and provide a framework for self-assessments and assurance processes.

3. KEY ISSUES:

3.1 The Core Standards for EPRR undergo a tri-annual review by NHS England to ensure they take account of best practice and remain fit for purpose. This review by the National Team was not possible due to the demands of the Covid-19 response. Hence the number of standards against which the Trust is required to self-assess this year has reduced from 54 to 37. The Trust still has a statutory responsibility to be compliant with the original standards; NHS England are not seeking to obtain assurance on compliance.

3.2 The self-assessment, attached as **Appendix 1**, shows the Trust to be fully compliant on 33 standards and partially compliant on 4. The evidence which was gathered in carrying out the self-assessment is attached as **Appendix 2**.

3.3 An action plan for the non-compliant standards is attached as **Appendix 3**. Progress against this plan will be monitored at the Emergency & Business Continuity Planning Working Group meetings.

3.4 This year's Deep Dive, which focuses on internally piped oxygen, does not require completion, as the Trust relies solely on bottled oxygen to support patient care.

3.5 The date for completion and presentation of the self-assessment, action plan and statement of compliance to Trust Board is Thursday 28 October.

3.6 The deadline for submission of the self-assessment, action plan and statement of compliance to the Head of EPRR for Yorkshire & the Humber is Friday 29 October 2021.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The EPRR Core Standards are not part of the CQC inspection framework, however they help us to plan and manage Trust arrangements to effectively deal with any internal or external incident and ensure continuity of our services.

4.2 **Financial/Value for Money:** None identified.

4.3 **Legal and Constitutional (including the NHS Constitution):** None identified.

4.4 **Equality and Diversity:** None identified.

4.5 **Other implications:** None identified.

5. RISKS:

There are no risks associated with this report, as the overall assessment shows that the Trust is substantially compliant with the Core Standards.

6. CONCLUSION:

This self-assessment gives assurance to the Board of Directors that the Trust can demonstrate it can effectively respond to emergency planning and business continuity incidents whilst still maintaining provision to service users.

7. RECOMMENDATIONS:

The Board of Directors are asked to note and approve this report.

Russell Patton
Chief Operating Officer

Supporting Papers:

Appendix 1	:	EPRR Core Standards Assessment
Appendix 2	:	Core Standards evidence
Appendix 3	:	Action plan
Appendix 4	:	Assurance process Statement of Compliance 21-22

Ref	Domain	Standard	Detail	Mental Health Providers	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
Domain 1 - Governance					
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	Fully compliant
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Fully compliant
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	Fully compliant
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	Partially compliant
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	Fully compliant
Domain 2 - Duty to risk assess					
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	Fully compliant
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	Fully compliant
Domain 3 - Duty to maintain plans					
11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Fully compliant
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Fully compliant
13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Fully compliant

14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Fully compliant
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Fully compliant
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Partially compliant
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Fully compliant
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Fully compliant
Domain 4 - Command and control					
24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	Fully compliant
Domain 5 - Training and exercising					
Domain 6 - Response					
30	Response	Incident Co-ordination Centre (ICC)	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y	Fully compliant
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	Fully compliant
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (Sitreps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	Fully compliant
Domain 7 - Warning and informing					
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	Fully compliant
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	Fully compliant
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	Fully compliant
Domain 8 - Cooperation					
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	Fully compliant
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	Fully compliant
Domain 9 - Business Continuity					
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Y	Fully compliant

48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	Fully compliant
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Fully compliant
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Partially compliant
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	Fully compliant
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	Fully compliant
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	Partially compliant
Domain 10: CBRN					
56	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Fully compliant
57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Fully compliant
58	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	Fully compliant
60	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Fully compliant
68	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Fully compliant
69	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y	Fully compliant

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance											
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Chief Operating Officer, Russell Patton, is the Board Level Director nominated as AEO. Trust decision not to have a non-executive board member in support.	Fully compliant				
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	EPRR Policy has been developed	Fully compliant				
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	The Core Standards Assessment presented to the Board of Directors in October. Future reports to include the debrief of the Microsoft printing incident response to demonstrate the ability to deliver services whilst responding to a number of concurrent disruptive events.	Fully compliant				
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	EPRR Policy defines roles of staff with key responsibilities. Due to recent retirements the cover for the EP&BC Manager is no longer in place.	Partially compliant				
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	EPRR Policy describes how Integrated Emergency Management (IEM) is used, together with capturing and sharing learning from incidents, exercises and regional meetings. Action plans from exercises are monitored by E&BCP Working Group.	Fully compliant				
Domain 2 - Duty to risk assess											
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	Risk Assessment template reviewed by E&BCP Working Group. Cross referenced to Datix. Individual NSRA Risk Assessment 2020 templates used as basis for shared risk working across all 4 LRFs. Outcomes are shared with the trust.	Fully compliant				
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	There is a BC sub category on Datix to allow reporting of local risks. High level risks are escalated to locality and trust risk registers. Risk assessment as part of the Integrated Emergency Management cycle is described in the EPRR Policy.	Fully compliant				
Domain 3 - Duty to maintain plans											
11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Internal Emergency Plan v 4.5, Business Continuity Command and Control Plan version 6, IT Incident Response Plan and Service Business Continuity plans.	Fully compliant				
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	External Major Incident Plan V9.8. The Therapies Staff Groups Business Continuity Plan outlines the process for providing a therapeutic intervention during a major incident.	Fully compliant				

13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	TEWV Summer and Winter Preparedness Plan 2021 - 2022 v2.1	Fully compliant				
14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	TEWV Summer and Winter Preparedness Plan 2021 - 2022 v2.1	Fully compliant				
18	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust will use the Business Continuity Command and Control Plan, v6 and the Therapies Staff Groups BCP (providing a therapeutic response) in conjunction with the relevant regional NHS England and Improvement mass casualty framework: Yorkshire & the Humber Mass Casualty Framework for Health or Mass Casualty Framework for Cumbria and the North East of England	Fully compliant				
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Decant facility at Roseberry Park for ward restoration and use of Activity Centre for evacuation. Evacuation facilities within Tees. Decant ward at Auckland Park being repurposed. Lack of formal decant locations within NYY.	Partially compliant				
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Appendix 2 of the Security Policy v8 - "Generic Building Emergency Lockdown" can be adapted for individual sites. Forensic BCP and all locality BCPs include lockdown action cards.	Fully compliant				
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	For Royal Visits Police will take the lead and NEAS or YAS will confirm ambulance and emergency attendance with acute trusts. For high profile patients coming from detained settings the Prison Service will liaise directly with service. High Profile Visitor and High Profile Patient on Leave action cards in Forensic BCP and locality BCPs.	Fully compliant				
Domain 4 - Command and control											
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	NHSE/I and CCGs have the 24/7 out of hours phone number to enable notification of incidents. Rotas in place and circulated for locality first on calls, trust wide second on call and Director on Call.	Fully compliant				
Domain 5 - Training and exercising											
Domain 6 - Response											
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y		Main ICC at West Park with back ups at Roseberry Park, Foss Park and Cross Lane. ICC most recently operationalised in July / August 2021.	Fully compliant				
32	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	Business Continuity Command and Control Plan and service business continuity plans	Fully compliant				
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (Sitreps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps	All BCPs have system failure sitrep for notification. Standard sitreps for ongoing incidents are held in Appendix 3 of BC Command and Control plan.	Fully compliant				
Domain 7 - Warning and informing											
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Communications Team Member is part of response team. Communications staff have a process to monitor and log information requests and inform via website and social media.	Fully compliant				
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	For internal incidents the Communications Team send emails, update InTouch and reach out via social media. For major incident NHSE Comms Team would take the lead. Trust team would retweet and share consistent messages.	Fully compliant				
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	Support to nominated directors with statements and preparing for media interviews.	Fully compliant				
Domain 8 - Cooperation											

42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Mutual aid through MOU in Forensic Services. There is a working partnership with Local authorities and LHRP. The trust could access voluntary services support during emergencies via the LRF. MACA can be requested through the relevant LRF but the trust must make the request via NHSE/I and show that all other alternatives have been exhausted. The request must be for a definite need and tasks explicit. Other options including mutual aid must have been discounted with the trust either lacks capability, or too expensive, not available or can't meet the scale and / or urgency. Recharge for this support.	Fully compliant				
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	Protocol outlined in section 4 in External Major Incident plan. Signatory to Durham and Darlington LRF Information Sharing Protocol	Fully compliant				
Domain 9 - Business Continuity											
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Business Continuity Policy	Fully compliant				
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	Business Continuity Policy	Fully compliant				
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	Comply with toolkit on an annual basis. Working towards Toolkit 2021/22 which has a final submission date of 30/06/2022	Fully compliant				
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Existing BCPs need to be updated and additional plans developed.	Partially compliant				
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	EPRR is in the audit plan. Audit being undertaken by Audit One in Sept / Oct. Report will be presented to Board.	Fully compliant				
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	BC Policy has been revised. Learning from Covid, inclusion of staffing escalation levels in plans shared. Plans tested and action plans implemented to ensure continual improvement - Exercise Gruber.	Fully compliant				
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Procedures need to be strengthened where appropriate	Partially compliant				
Domain 10: CBRN											
56	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	The trust does not have decontamination facilities. Patients will need to be taken to acute hospital by ambulance trust. Action cards	Fully compliant				
57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Action card in Hotel Services BCP on HAZMAT / CBRN for reception staff to follow in recognising the signs of potential contamination, escalation to manager, notification to emergency services and minimising spread.	Fully compliant				
58	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	Risk assessments have taken place to determine likely location, type of contaminant and associated treatment. Staff trained in recognising the signs of potential contamination, escalation to manager, notification to emergency services and minimising spread.	Fully compliant				

60	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• Completed equipment inventories; including completion date	Main receptions (including Forensic Control Room) maintain supplies of paper towels, plastic bags and disposable paper suits for re-robing, per Initial operating Response "Remove, Remove, Remove" advice. Tees card B8	Fully compliant				
68	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique	Action cards for reception staff to use are in Forensic, locality and Hotel Service BCP plans. Based on initial Operating Response and "Remove, Remove, Remove" guidance it emphasises getting patient outside or if not possible restricting contact with others until ambulance paramedics arrive to treat.	Fully compliant				
69	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		Resus Team members have been provided with fit testing, either in-house by IPC team or by acute hospital trainers. Masks are held in blue resus rucksacks.	Fully compliant				

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	EPRR Policy defines roles of staff with key responsibilities. Due to recent retirements the cover for the EP&BC Manager is no longer in place.	Partially compliant	Identify individuals to provide cover as set out in the BC Command and Control plan	Chief Operating Officer	Within 3 months of Board approval	
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Decant facility at Roseberry Park for ward restoration and use of Activity Centre for evacuation. Evacuation facilities within Tees. Decant ward at Auckland Park being repurposed. Lack of formal decant locations within NYY.	Partially compliant	Working with Directors of Operations, identify suitable facilities internally. Where none can be sourced agree mutual aid with local MH trust(s).	Chief Operating Officer	Within 6 - 12 months of Board approval	
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Existing BCPs need to be updated and additional plans developed.	Partially compliant	Agree the programme and milestones which services will meet to deliver fit for purpose business continuity plans.	Chief Operating Officer	Within 3 - 6 months of Board approval	
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Procedures need to be strengthened where appropriate	Partially compliant	Review of contract arrangements as they are awarded or renewed to ascertain if a business continuity plan is required for the provision of the service. If required providers are requested to share, reviewed by the Trust for completeness.	Contract and Commissioning Department	Within 3 - 6 months of Board approval	Start and then embed

Yorkshire and the Humber Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2021-2022

STATEMENT OF COMPLIANCE

Tees, Esk and Wear Valleys NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Tees, Esk and Wear Valleys NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

_____

Signed by the organisation's Accountable Emergency Officer

_____

Date signed

Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 14

FOR GENERAL RELEASE

Board of Directors Meeting

DATE:	**Thursday 28th October 2021**
TITLE:	**Winter Preparedness**
REPORT OF:	**Russell Patton, Chief Operating Officer**
REPORT FOR:	**Information and Assurance**

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

Executive Summary:

This paper provides a summary of the Trust's planned response to manage and respond to the predicted challenges in Winter 2021/2022. The paper and appendices describe actions in three key areas:

- escalation and contingencies for service delivery in the event of increased demand and system pressures
- the roadmap to maximising uptake of the flu vaccination
- emerging plans for the delivery of services that will support patient care over the extended Christmas and New Year period.

Recommendations:

The Board of Directors are asked to note the actions taken linked to the organisation's 'Winter Preparedness'

MEETING OF:	**Board of Directors**
DATE:	**Thursday 28th October 2021**
TITLE:	**Winter Preparedness**

1. INTRODUCTION & PURPOSE:

1.1 This paper outlines the Trust's plans to respond to increasing demands during Winter 2021/22 (**Appendix 1**). Specialty plans with clearly defined escalation and contingency measures for service delivery are provided in the event of increased demand and system pressures **(Appendix 2).**

1.2 Plans to maximise uptake of the flu vaccination campaign are provided in **Appendix 3** and the locality assurance summary statements in terms of staffing over the extended Christmas and New Year period is provided in **Appendix 4**.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Trust is required to develop a plan each winter to ensure that service delivery is maintained in the event of increased demand and system pressure.

2.2 To date the North Yorkshire and York services have been required to submit a locality plan as part of a system wide partnership approach within HCV ICS. We can reasonably expect that this request will made by the NENC ICS as part of their winter planning preparation. Appendix 1 & 2 would satisfy the requirements of this request. Other requests may be forthcoming from the Urgent &Emergency Care Network as well as local CCGs.

3. KEY ISSUES:

3.1 The plans enclosed are a key feature of the Trusts "winter preparedness" and build on existing arrangements to manage system and organisational pressure through partnership working, the use of Opel Framework and appropriate command and control measures.

3.2 In addition, the Trust's response to Covid is an integral element of these plans with IPC guidance, cohorting and staff and patient testing as key features.

3.3 Delivering a successful Seasonal Flu Campaign alongside measures to maximise uptake of the Covid booster are also an essential part of the winter preparedness plan for 21/22.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The Winter Preparedness Plan for 2021/22 is not part of the CQC Inspection Framework. However, it demonstrates a positive approach to organisational planning and confirms that the Trust is taking a pro-active approach to the potential challenges we are likely to face during Winter 2021/22.

4.2 **Financial/Value for Money:** None identified

4.3 **Legal and Constitutional (including the NHS Constitution):** None identified.

4.4 **Equality and Diversity:** None identified.

4.5 **Other implications:** None identified.

5. RISKS:

Our approach to "winter preparedness" goes some way to provide a level of mitigation and assurance for the organisation.

6. CONCLUSIONS:

This briefing has identified three key pieces of work that when actioned will support the organisation in its preparation for Winter 2021/22 and go some way to ensuring effective sustained service delivery.

7. RECOMMENDATIONS:

The Board of Directors are asked to note the content of this report and be assured because of the proposed actions.

Russell Patton
Chief Operating Officer
October 21

Supporting Papers:

Appendix 1 TEWV Winter Plan 2021-22
Appendix 2 Winter Response - Adult Mental Health
Appendix 2 Winter Response - Mental Health Services for Older People
Appendix 2 Winter Response – Child and Adolescent Mental Health Services
Appendix 2 Winter Response – Learning Disabilities

Appendix 3 Staff Flu Vaccination Campaign
Appendix 4 Locality Assurance of Community Services over the Christmas Period

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

TEWV - Winter Planning 2021/2022

journey to change

Themes for Winter Planning

- The same but different

- Covid is built into plans
  - IPC guidance now embedded
  - Cohorting arrangements in place
  - Outbreak management reporting
  - Applied learning from last year
  - Learning from socially distanced Seasonal Flu Campaign
  - Staff and patient testing operationalised

- Building and extending on existing arrangements
  - Partnership working
  - Sharing of OPEL via UEC RAIDR app
  - Promotion of consistent messaging in support of partners
  - Command and control arrangements (stepping up as required)
  - Cascade of alerts of adverse weather and Winter Preparedness Plan
  - Deliver successful Seasonal Flu Campaign + Covid booster

Plans for winter

- As previous years:
  - Daily monitoring of demand for acute liaison services with capacity to flex as needed
  - Daily monitoring of demand for crisis services with capacity to flex as needed
  - Proactive monitoring of community team caseloads across all specialties
- Good staff management plans in place to ensure all teams have adequate cover through rosters
- Plans which can flex to respond to anything that arises

What is currently in place

- 24/7 Crisis Service with hub and spoke model in place, leading to greater call handling capacity
- Single crisis number for whole Trust
- Acute Liaison services in place 24/7 with ability to flex capacity across acute sites depending on demand
- Daily monitoring of acute liaison KPIs (1 hour response time for A&Es) – currently performing well
- Close liaison between acute liaison and crisis services to minimise delays and re-work where admission to a TEWV bed from A&E may be required or where intensive home treatment may be helpful to prevent admission
- Close working with VCS to develop range of offers across wider crisis pathways
- Mechanisms in place to monitor any surge in COVID specific demand
- Mechanisms in place to re-establish business continuity arrangements as required for any further COVID waves

Plans to manage surge in activity

- Detailed forecasting and modelling work complete within Trust, linking to HIA, which will help us plan for any surge in advance of winter.
- COVID-specific plans for a subsequent wave include:
  - Cohorting arrangements for wards across all specialties
  - Embedded processes re PPE
  - Community team RAG rating of caseloads to allow more segmented management of clinical risk
  - Site management arrangements across 7 days if required
  - Specific support to care homes and the wider system in terms of managing mental health demand but also supporting staff
- Ability to step up additional crisis or liaison capacity, but this may risk drawing from community services. Contingencies being discussed internally
- Daily lean management in place in all services to allow timely responses and decision making across service areas

Other initiatives to manage activity

Staff resilience – the offer to our own staff and other partners staff via the Resilience Hub www.hcvresiliencehub.nhs.uk

TEWV Winter Plan Response Summary – Adult Mental Health

Primary aims	****Think twice?**
• To have a clear communicated plan to respond to patient /carer demand within workforce capacity; what we stop doing & what we offer as alternatives • To protect the wellbeing of staff & patient's at increased mental health risk • Support carers • To protect delivery of urgent response & inpatient care	• **Are you symptomatic?** (follow the NHS 111 coronavirus self-help to assist your decision) • **Are you or the household self-isolating?** • **Can you remain 2m away from patients in your contact? PPE required** • **Are you providing close clinical care within 1m? PPE required**

Service Line	**IAPT**	**Referral, access & brief intervention**	**Secondary mental health –** community, EIP, PNMH, Eating disorders	**Crisis response,** includes S136, FCR/Street Triage	**Home treatment**	**Inpatients**	**ALL Staff interactions**	**ALL Staff requirements/meetings**
STOP	• **All Group sessions** • **Face to face**	• **All Group sessions**	• **All Group sessions**			• * All **visiting stopped – other than for EoLC, LD & ASD acre planned need** • **No leave or placements supported** • **No base ward inpatient transfers**	• **Non-essential** team meetings • **Face to face** training • Access to **study** time • *** No purchase of additional annual leave**	• Non-essential training & eLearning • Performance reporting • QuAG • Job planning • Non- clinical facing meetings & QIS
REDUCE		• Face to face contacts • Domiciliary visits	• Face to face contacts • Domiciliary visits • Annual reviews	• Face to face contacts • Domiciliary visits	• Face to face contacts • Domiciliary visits	• Length of stay to reduce social contacts	• * Annual leave plans	
MAINTAIN	**MAINTAIN A LOCALITY RESPONSE; PRIORITISING AT RISK, CRISIS & URGENT RESPONSES & INPATIENT** **FACE-TO-FACE ONLY WHEN ESSENTIAL WITH PPE** **Diary management & Paris patient entries & activity recording**						**MAINTAIN STAFF WELL-BEING & COMMUNICATIONS**	
	• **Site & duty** response • Admin task support • **Daily triage** & **referral management** • **Screening & self help** • **Routine assessment** via phone • **Follow-up & intervention** • At risk; **Patient contact** through phone/video • **Computerised** contacts • *** Silver Cloud access**	• **Site & duty** response • Admin task support • **Daily triage** & **Referral management** • **Screening & Self help** • **Initial assessment** • **Follow-up & intervention** • At risk; **Patient contact** through phone/video	• **Site & duty** response • Admin task support • **Daily triage** & **Referral management** • **Screening & Self help** • **Initial assessment** • **Follow-up & intervention** • At risk; **Patient contact** through phone/video • **Mental Health Act** Assessment – only if considered critical • **Clozapine/lithium** • At risk **physical health** monitoring • Essential **medication** reviews • *** CAMHS** transitions • **Carer support** through phone/video contact • **CTO** management • *** ECT** via RPH swab prior	• *** All age mental health crisis & support line** • **Site & duty** response • Admin task support • **Crisis assessment** • **Gatekeeping** discussion recorded • **Patient contact** through phone/video • **Mental Health Act** Assessment – only if considered critical • Dialogue with **AMHP**s for rapid MHAA • *** New admissions** – swab against screening tool & admit to agreed cohort setting • Mgt support to **frequent attenders** via Skype or telephone • Co-work with **AHL & CAMHS** • **S136** presentations	• **Site & duty** response • Admin task support • **Crisis assessment** • **Patient contact** through phone/video when able • **Mental Health Act** Assessment - only if considered critical • Face to face when required	• * Plan to **cohort all** admissions & separate COVID +ve pts – swab screening tool • **IPC adherence;** isolate & swab of symptomatic patients • **PICU access** when essential • *** Discharge** planning, including leave • **DTOC** escalation with Local Authority service managers. • **Bed management** calls • Trustwide capacity-bed calls • **Carer & family** involvement via phone/tablets • **72hour & 7day** post discharge follow-up – via phone if clinically safe to do so • *** ECT** via RPH – swab prior	• **Work from home whenever able** • **Clinical huddles** with support of Skype for home workers • **Leadership** & **formulation** access with support of Skype • * Phone/video **recorded clinical supervision** • Phone/video **caseload support** • Raising concerns • **Appraisals** – capacity allowing vis Skype • **Debrief following incidents** • **Recruitment** using Skype support • *** Act on guidance not myths**	• **Keep in touch** with one another • **Long term sick** contact • **Maternity leave** contact • *** Reporting of sickness & COVID isolation, shielding & working social distancing** • Disciplinary actions • * Trust COVID -19 '**live' tracking** • **Incident reviews** • *** Managed annual leave** • Access to **computerised CBT** to emotionally support staff • **Potential to delay to stat/man** annual training for 6months • **Essential key skill training** for new staff & staff refreshers • *** Training to support COVID workforce mobilisation plans**
BCP Workforce flow	→	→	→	→	→	→		
Homeworking	• Supported for those confirmed vulnerable groups • Reduce social contact	• Supported for those confirmed vulnerable staff • Reduce social contact	• Supported for those confirmed vulnerable staff • Reduce social contact	• Supported for those confirmed vulnerable staff groups	• Supported for those confirmed vulnerable staff groups	• Supported for those confirmed vulnerable staff groups	• Supported for those confirmed vulnerable staff • Reduce social contact	
PPE requirements	• Hand hygiene • Alcohol gel & wipes • Social distancing	• PPE team access • Hand hygiene • Alcohol gel & wipes • Social distancing	• PPE Team access • Hand hygiene • Alcohol gel & wipes • Social distancing	• PPE Team access • Hand hygiene • Alcohol gel & wipes • Social distancing	• PPE Team access • Hand hygiene • Alcohol gel & wipes • Social distancing	• PPE Ward access • Hand hygiene • Alcohol gel & wipes • Social distancing	• Hand hygiene • Alcohol gel & wipes • Social distancing	• Hand hygiene • Alcohol gel & wipe • Social distancing
IT assistance	Laptop & Smart phone Microsoft Teams	Laptop & Smart phone Microsoft Teams	Laptop & Smart phone Microsoft Teams	Laptop & Smart phone Microsoft Teams	Laptop & Smart phone Microsoft Teams	Laptop & Smart phone Microsoft Teams	Laptop & Smart phone Microsoft Teams	Laptop &Smart phone Microsoft Teams

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TEWV Winter Plan Response Summary – Adult Mental Health

TEWV Winter Response Summary – Learning Disabilities

Primary aims	**Two Question approach**
• To have a clear communicated plan to respond to patient /carer demand within workforce capacity; what we stop doing & what we offer as alternatives • To protect the wellbeing of staff & patient's at increased mental health risk • Support carers • To protect delivery of urgent response & inpatient care	• **Are you symptomatic?** (follow the NHS 111 coronavirus self-help to assist your decision) • **Are you or the household self-isolating?** If yes, understand the clinical risk & plan for alternative contact wherever possible.

Service Line	**Secondary mental health –** Community	**Inpatients/ Outreach**	**ALL Staff interactions**	**ALL Staff requirements/meetings**
STOP	• Group sessions • Delivering training • Posture care assessments	• **All visiting** • **No inpatient transfers** • Carer visits in relation to discharge plans • Hotel services	• **All face to face team meetings** • **Face to face** training • Access to **study** time	• Non-essential training and eLearning • Performance reporting • QuAG • Job planning • Non- clinical facing meetings & QIS
REDUCE	• Face to face contacts • Domiciliary visits • Annual reviews • CPA • Moving and handling assessments • Health maintenance work	• Leave reduced		• Planned annual leave
MAINTAIN	**MAINTAIN STAFF WELL-BEING & COMMUNICATIONS**			
	• **Site & duty** response • Admin task support • **Daily triage** & **Referral management** • **Screening & Self help** • **Initial assessment** • **Follow-up & intervention** • At risk; **Patient contact** through phone/video • **Mental Health Act** Assessment – only if considered critical • **Clozapine/lithium** • **Physical and chest health** monitoring • Essential **medication and equipment** reviews • **Carer support** through phone/video contact • **CTO** management • **ECT** via RPH • **Huddles** • **Wellbeing checks** • **CTR/CETR** • **Activity engagement** • **Dysphagia assessments** • **Eating and drinking assessments** • **Communication aid repairs**	• Nominated **isolation** bungalow • IPC adherence; isolate & swab of symptomatic patients • PICU access when required • DTOC escalation with service managers • Trustwide capacity bed calls • Carer & family involvement via phone/tablets • 72 hour post discharge follow-up – via phone if clinically safe to do so	• **Work from home whenever able** • **Clinical huddles** with support of Skype/Teams for home workers • **Leadership** & **formulation** access with support of Teams • Phone/video **clinical supervision** • Phone/video **caseload support** • Raising concerns • **Appraisals** – capacity allowing via MSTeams • **Debriefs** • **Recruitment** using MST support	• **Keep in touch** with one another • **Long term sick** contact • **Maternity leave** contacts • **Abreast of local & national** guidance • **Reporting of sickness** • Disciplinary actions • '**live' tracking** & planning • **Incident reviews** • Access to **computerised CBT** to emotionally support staff • **Delay to stat/man** annual training for 6months • **Essential key skill training** for new staff & staff refreshers
BCP workforce flow	→			
Homeworking	• Supported for all • Psychological support available • To reduce social contact & in line with service offer	• Supported for shielded staff • To reduce social contact & in line with service offer	• Supported for all	• Supported for all
PPE requirements	• PPE Site access • Hand hygiene • Alcohol gel & wipes • Operating distance	• PPE Ward access • Hand hygiene • Alcohol gel & wipes • Operating distance	• Hand hygiene • Alcohol gel & wipes • Operating distance	• Hand hygiene • Alcohol gel & wipe • Operating distance
IT assistance	Laptop & Smart phone Microsoft Teams Attend anywhere	Laptop & Smart phone Microsoft Teams Attend anywhere	Laptop & Smart phone Microsoft Teams	Laptop &Smart phone Microsoft Teams

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TEWV Winter Plan Response Summary – Children and Adolescents Mental Health Services

Primary aims	Two Question approach
• To have a clear communicated plan to respond to patient /carer demand within workforce capacity; what we stop doing & what we offer as alternatives • To protect the wellbeing of staff & patient's at increased mental health risk • Support carers • To protect delivery of urgent response & inpatient care	• **Are you symptomatic?** (follow the NHS 111 coronavirus self-help to assist your decision) • **Are you or the household self-isolating?** If yes, understand the clinical risk & plan for alternative contact wherever possible.

Service Line	MHST	Single Point of Access	Generic Community MH/Emotional Wellbeing pathway (York)	Eating Disorders Team	**Crisis response,** includes FCR/Street Triage	Neurodevelopmental pathway (ADHD/ASC)	ALL Staff interactions	ALL Staff requirements/meetings
STOP	• Launch into schools/teams embedded in school sites		• Group sessions • School visits	• Group sessions		• New assessments • Initiating medication • Group interventions • School/home visits	• Non-essential team meetings • Face to face training	• Face to face training • Performance reporting • Job planning • Non- clinical facing meetings & QIS
REDUCE		• Face to face contacts	• Face to face contacts • Domiciliary visits • Transitions into AMH	• Face to face contacts • Domiciliary visits • Transitions into AMH	• Face to face contacts • Domiciliary visits	• Face to face contacts • Transitions into AMH	• Access to study time	• E learning (only mandatory) • QuAG meeting (quality assurance processed maintained)
MAINTAIN	**MAINTAIN STAFF WELL-BEING & COMMUNICATIONS**							
	• **Created low intensity intervention team – young people RAG rated as 'green' in generic pathway will be seen by this team.** • **EMHP training via universities** • **Patient contact through phone/video**	• **Daily triage** & **Referral management** • **Admin task support** • **Site & duty support** • **Screening & Self help** • At risk; **Patient contact** through phone/video • **Access to service assessments**	• **Site & duty** response • Admin task support • **Daily triage** & **Referral management** • **Screening & Self help** • **Initial assessment for at risk patients** • **Follow-up & intervention** • At risk; **Patient contact** through phone/video • Essential medication reviews • **Alternative DBT** provision • At risk **physical health** monitoring • **Carer support** through phone/video contact • **CTO** management	• **Site & duty** response • Admin task support • **Daily triage** & **Referral management** • **Screening & Self help** • **Initial assessment** • **Follow-up & intervention** • At risk; **Patient contact** through phone/video • Essential **medication** reviews • At risk **physical health** monitoring • **Carer support** through phone/video contact • **Supporting transitions to inpatient services**	• **Site & duty** response • **Crisis assessment –** telephone or face to face • **Patient contact** through phone/video • **Mental Health Act** Assessment – only if considered critical • Dialogue with **AMHP**s for rapid MHA • **New admissions virus symptoms** –admit to en-suite room • Mgt support to **frequent attenders** via skype/telephone conferencing • **Co-work with AHL/AMH** • **Negotiated A & E crisis assessment** away from A & E when no self-harm	• **Site & duty** response • Admin task support • **Crisis assessment** • **Patient contact** through phone/video • **Mental Health Act** Assessment - only if considered critical • **Physical health checks** as required • **Admin task support** • **Referral and triage** • **Telephone assessments** • **Follow up and monitoring (majority via telephone)** • **Patient contact through phone/video**	• **Clinical huddles** with support of Skype for home workers • **Leadership** & **formulation** access with support of Skype • Phone/video **clinical supervision** • Phone/video **caseload support** • Raising concerns • **Appraisals** – capacity allowing via Skype • **Debriefs** • **Recruitment** using Skype support	• **Keep in touch** with people that are • **Long term sick** contact • **Maternity leave** contacts • **Abreast of local & national** COVID-19 guidance • **Reporting of sickness** • Disciplinary actions • COVID -19 '**live' tracking** & planning • **Incident reviews** • **Planned annual leave** • **Delay to stat/man** annual training for 6months • **Essential key skill training** for new staff & staff refreshers
Homeworking	• Supported for all by requirement/staff needs • To reduce social contact & in line with service offer	• Supported for all by requirement/staff needs	• Supported for all by requirement/staff needs • To reduce social contact & in line with service offer	• Supported for all by requirement/staff needs	• To reduce social contact & in line with service offer	• Supported for all by requirement/staff needs • To reduce social contact & in line with service offer	• Supported for those vulnerable groups • To reduce social contact & in line with service offer	• Supported for those vulnerable groups • To reduce social contact & in line with service offer
PPE requirements	• Hand hygiene • Alcohol gel & wipes • Operating distance	• Hand hygiene • Alcohol gel & wipes • Operating distance	• PPE via local stocks • Hand hygiene • Alcohol gel & wipes • Operating distance	• PPE Site access • Hand hygiene • Alcohol gel & wipes • Operating distance	• PPE Site access • Hand hygiene • Alcohol gel & wipes • Operating distance	• PPE Site access • Hand hygiene • Alcohol gel & wipes • Operating distance	• Hand hygiene • Alcohol gel & wipes • Operating distance	• Hand hygiene • Alcohol gel & wipe • Operating distance
IT assistance	Laptop & Smart phone Microsoft Team		Laptop & Smart phone Microsoft Team	Laptop & Smart phone Microsoft Team	Laptop & Smart phone Microsoft Team	Laptop & Smart phone Microsoft Team	Laptop & Smart phone Microsoft Team	Laptop &Smart phone Microsoft Team

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TEWV Winter Response Summary – Mental Health Services for Older People

Primary aims

- To have a clear communicated plan to respond to patient /carer demand within workforce capacity; what we stop doing & what we offer as alternatives
- To protect the wellbeing of staff & patient's at increased mental health risk
- Support carers
- To protect delivery of urgent response & inpatient care

Two Question approach

- **Are you symptomatic?** (follow the NHS 111 coronavirus self-help to assist your decision)
- **Are you or the household self-isolating?**

If yes, understand the clinical risk & plan for alternative contact wherever possible.

Service Line	**Secondary mental health –** community, Memory services	**Crisis response**, RRICE and CHAD teams	**Acute Hospital Liaison Teams**	**Inpatients**	**ALL Staff interactions**	**ALL Staff requirements/meetings**
STOP	• Group sessions •			• Open visiting • **Socialisation leave** • Work/education placements • **Regular home leave**; plan for alternative contact • **Non-essential professionals/staff** attendance to wards	• Non-essential team meetings • Face to face training	• Face to face training • Performance reporting (to be reviewed) • QuAG (maintaining quality assurance processes) • Job planning • Non- clinical facing meetings & QIS
REDUCE	• Face to face contacts • Domiciliary visits (care homes included) • Annual reviews	• Face to face contacts • Domiciliary visits (care homes included, some of which has been instigated by care home mgt)	• Face to face contacts		• Access to study time (as required)	• eLearning (only as required)
MAINTAIN	**MAINTAIN A LOCALITY RESPONSE; PRIORITISING AT RISK, CRISIS & URGENT RESPONSES & INPATIENT** **FACE-TO-FACE WHEN REQUIRED WITH PPE** **Diary management & Paris patient entries & activity recording**				**MAINTAIN STAFF WELL-BEING & COMMUNICATIONS**	
	• **Site & duty** response • Admin task support • **Daily triage** & **Referral management** • **Screening & Self help** • **Initial assessment** • **Follow-up & intervention** • At risk; **Patient contact** through phone/video • **Mental Health Act** Assessment – only if considered critical • **Clozapine/lithium** • At risk **physical health** monitoring • Essential **medication** reviews • **Carer support** through phone/video contact • **CTO** management • **ECT** via Foss Park Hospital	• **Site & duty** response • Admin task support • **Crisis assessment** • **Gatekeeping** discussion • **Patient contact** through phone/video • **Mental Health Act** Assessment – only if considered critical • Dialogue with **AMHP**s • **Symptomatic new admissions** – admitted in isolation • **Co-work with CMHT**	• **Site & duty** response • Admin task support • **Crisis assessment** • **Patient contact** through phone/video • **Mental Health Act** Assessment - only if considered critical • **Advice, guidance and support to wards** through phone where possible • **Signposting and liaison** with other services	• Nominated **isolation** rooms • **Patient flow** • Restricted **visiting** • **Discharge** planning & accelerate, **DTOC** with service managers. • **Bed management** calls • Trustwide capacity-bed calls • **Carer & family** involvement and connection via phone/video • **72hour** post discharge follow-up – via phone if clinically safe to do so • **ECT** via RPH	• **Clinical huddles and leadership sessions** with support of Skype for home workers • **Leadership** & **formulation** access with support of Skype • Phone/video **clinical supervision** • Phone/video **caseload support** • Raising concerns • **Appraisals** – capacity allowing via Skype • **Debriefs** • **Recruitment** using Skype support	• **Keep in touch** with people that are • **Long term sick** contact • **Maternity leave** contacts • **Abreast of local & national** COVID-19 guidance • **Reporting of sickness** • Disciplinary actions • **Foss Park & Transformation** planning and mobilisation • COVID -19 '**live' tracking** & planning • **Incident reviews** • **Access to annual leave** • **Delay to stat/man** annual training for 6months • **Essential key skill training** for new staff & staff refreshers
BCP Workforce flow				**Phase 1: cross-cover within inpatients** **Phases 2-4: CMHT & Memory staff to Inpatients in order of experience/training** **Phase 5: AHLT to Inpatients**		
Homeworking	• Supported for those vulnerable groups and where social distancing is compromised • To reduce social contact & in line with service offer	• Supported for those vulnerable groups	• Supported for those vulnerable groups	• Supported for those vulnerable groups	• Supported for those vulnerable groups and where social distancing is compromised • To reduce social contact & in line with service offer	• Supported for those vulnerable groups and where social distancing is compromised • To reduce social contact & in line with service offer
PPE requirements	• PPE Site access • Hand hygiene • Alcohol gel & wipes • Operating distance	• PPE Site access • Hand hygiene • Alcohol gel & wipes • Operating distance	• PPE from local acute Trust/base with additional support from TEWV PPE supply • Hand hygiene • Alcohol gel & wipes • Operating distance	• PPE Ward access • Hand hygiene • Alcohol gel & wipes • Operating distance	• Hand hygiene • Alcohol gel & wipes • Operating distance	• Hand hygiene • Alcohol gel & wipe • Operating distance
IT assistance	Laptop & Smart phone Microsoft Teams	Laptop & Smart phone Microsoft Teams	Laptop & Smart phone Microsoft Teams	Laptop & Smart phone Microsoft Teams	Laptop & Smart phone Microsoft Teams	Laptop &Smart phone Microsoft Teams

NHS CORONAVIRUS PROTECT YOURSELF & OTHERS

TEWV Winter Response Summary – Mental Health Services for Older People

Appendix 3

Staff Flu Vaccination Campaign

- NHS England/Improvement continue to highlight vaccination as an essential component of the NHS response to seasonal influenza. A successful flu vaccination campaign with high uptake in identified priority groups will reduce the risk to individual patients, front line staff and their families of contracting the infection, both to reduce staff to patient transmission and to protect essential services from preventable staff absence.

- NHS England expect all Trusts to make the flu vaccination available to 100% of its staff (the flu vaccination remains voluntary at the current time though) and has set a target of Trust's achieving at least an 85% uptake within their organisations.

- The Trust have a dedicated Flu Project Manager and Project Assistant (sitting within the Staff Health & Wellbeing Team, part of the People & Culture Directorate) working all year round on delivering the Trust's annual staff flu vaccination campaign. Due to ever increasing internal and external reporting and data demands the Team have recently employed a Vaccinations Data Assistant to ensure the Trust can meet its requirement for National Immunisation and Vaccination System data updates.

- In the last two annual flu campaigns the Trust now delivers the campaign in full using internal Corporate and Clinical services (previously this was part of an Occupational Health contract delivered by a neighbouring Acute Trust, this is considered to be more in the control of the Trust in an operational sense.

- A monthly MDT Flu Group meets 11 months of the year to plan and deliver a successful campaign. Close partnership working with Heads of Nursing, Operational Localities and Teams such as Infection, Prevention & Control (IPC), Pharmacy and Communications is crucial.

- The Checklist sits alongside the staff Flu Operational Plan for the 2021-22 campaign which is in place to ensure all necessary steps in conducting a successful flu campaign are considered.

- The Trust's staff flu vaccination campaign sits alongside a programme to vaccinate all long stay and vulnerable inpatients. This aspect of the flu campaign is overseen by the central Pharmacy Team based at Roseberry Park Hospital and Operational Localities.

- The Trust's flu campaigns also sit alongside Public Health England's annual flu campaign which this year is using a message of being 'winter ready' and 'boosting your immunity' – a reference to the importance of not only protecting against flu, but also protecting against Covid-19 and other respiratory viruses that may be circulating. The Trust's Communications Team work closely with the Flu Team on planning and delivering an effective flu vaccination awareness raising message. This year we are pushing the message of 'don't be complacent, flu is still serious'

- The Trust's 2021-22 staff flu vaccination programme commenced on 4th October. The flu campaign team have been working on detailed delivery of the campaign since Spring 2021. At this early point in the 2021-22 campaign Trust progress against all aspects of the criteria set out in the best practice management checklist from NHS England/Improvement have been assessed as being current green or amber and no significant concerns raised. However, it is acknowledged the campaign will be a challenging one as ever.

- Financial resources, as yet unidentified by NHS England/Improvement (awaiting guidance) could be at risk should any set target vaccination rate not be achieved or if the Trust has been deemed not to undertake the required level of the proposed 100% 'offer' a vaccination to all staff and/or not achieving an 85% uptake of the vaccination by frontline staff. Early indications are showing that staff are taking up the offer of a flu vaccination in good numbers and many more staff at this early stage are informing the Trust if they have had a flu vaccination with their GP or local Pharmacy.

- Whilst the 2021-22 campaign will be a challenging campaign due to a number of factors, including the likelihood of a simultaneous Covid Booster campaign to be delivered (externally by partner organisations), every effort will be made by the flu campaign team to improve on the 2020-21 frontline healthcare vaccination uptake rate achieved in the Trust which was 71.5%. Uptake of a flu vaccination by staff has increased year by year since 2016 and has improved just over 30% since the 2016 rate of around 40%. The first flu vaccination uptake reports for Trust Localities and Services will be produced and circulated on Tuesday 19th October 2021.

- Challenges are always present to risk the uptake rate not increasing, especially as the crucial role of Chief Flu Fighters (Peer Vaccinators) is a voluntary role in addition to most staff's substantive roles and as Operational services continue to be stretched and very busy. The Trust's large geography is also an ongoing challenge to the efficient and timely distribution of flu vaccines and flu campaign equipment, however a successful staff flu campaign will contribute to the aim of having a healthy and responsive workforce staff within the Trust and lead to high quality of services being provided.

- Due to the current unpredictability of the implications of the Coronavirus pandemic it is acknowledged that the flu campaign team will need to be flexible and responsive to the situation and developments potentially occurring. Progress to deliver a successful campaign is on track.

Tees, Esk and Wear Valleys
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Assurance of Community Services Continuity over the Christmas Period

Durham & Darlington		
Speciality	Assurance Given	Mitigations
AMH	Yes	Prior to bank holidays, we will be working with patients and families to reiterate the arrangements for the holiday period. Each team has a VCB for depots and clozapine bloods. This is checked and appointment dates adjusted to accommodate the holiday period – with the date brought forward or delayed slightly depending on individual risk assessments). Cover on bank holidays is provided by MHST, IHT and/or Crisis Team if support is needed. Primary and secondary care services will not be open on bank holidays but will operate on usual working days. On usual working days we will have a core multi-disciplinary staff group covering the service, including Locality Manager or HoS. Community Matron, Team Managers, Social Workers, Nurses, Medics, AHPs, admin support.
MHSOP	Yes	Rota has been completed for the Christmas period – each cell in team, of which there are 4 operate their own duty system. There are 4 nurses to a cell (16 total) and no more than 2 can be off at any one time. On bank holidays and weekends there is 1 nurse on duty. Team has 6 support worker posts. Medics work to their own rota. OTs, Physio and Psychologists will have staff at work on normal working days but do not cover bank holidays and weekends. One duty nurse to cover per team on Bank Holidays 27th, 28th, 2nd and 3rd - usual weekend arrangements = 2 nurses on site from 2 different teams covering the 3 teams (Easington, Durham and CLS, and Derwentside) 24th and 31st December – normal working day
C&YPS	Yes	Annual leave is level loaded across all teams throughout the year CYPS Crisis and Intensive Home Treatment will provide cover 24/7 across the Christmas and New Year period. There is no CMHT cover on bank holidays. On usual working days we will have a core multi-disciplinary group covering the service, including Locality Manager or HoS. Community Matron, Team Managers, AHPs, admin.
ALD	Yes	There is no cover on bank holidays. On working days: We always have a Community Manager, usually aim for 2, in work (either one of the Health Team Managers or the Locality Manager or HoS). We also have one SLT, one physio, one OT available (these may be from other areas but contacts are shared prior to Christmas period.) We have one Medical Secretary in each day.

		Doctors work their on-call system I think – not 100% sure how they agree cover. We always create a table of who is in and when including contact details and these are shared around the service, including with LA colleagues. We intend to start collating volunteers for cover this month.
North Yorkshire & York		
Speciality	Assurance Given	Mitigations
AMH	Yes	Annual leave is being level loaded across community teams to match the approach of inpatients and CRHTT prior to Christmas and in between. Experience tells us people cancel these appointments however provides us greater capacity for a duty and rapid review for those on caseload. The week prior to Christmas will be to review and link with home treatment teams regarding those who need support over the extended weekend - this is normal practice. Crisis and home treatment will be staffed as per their rota We are looking to support a degree of additional staffing for the BH Monday and Tuesday as experience tells us these are more likely to be the busier days and additional capacity to support at home instead of admission.
MHSOP	Yes	Services are staffed and contactable within normal office hours and the number of people requesting Christmas leave is level loaded and safe staffing remains across all community teams. There are no requests for annual leave over the holiday period that would take services over the regular amount of annual leave that we would authorise for any other week of the year The service will pull from memory if required during that time because experience tells us that there is often a high number of DNA. The care home team in York (AKA CHAD) will be running a service supporting people in care homes and people with dementia in their own homes if needed across the whole period into the evenings including Christmas and bank holidays. All CMHTs will be triaging and planning for their most vulnerable patients and anticipating need ahead of going into the Christmas period as well as during. AHLS will continue to work closely with AMH Crisis to support need across as required.
C&YPS	Yes	Annual leave is level loaded across the service throughout the year. CYPS Crisis and Intensive Home Treatment will provide cover 24/7 across the Christmas and New Year period. There is no cover on bank holidays for the other CYPS community teams.
ALD	Yes	Learning Disability services have no crisis or 7 day community services to cover – standard operating process of referring to mainstream services remains in place Historically we have lower referral rates over the Christmas period and a lower demand All teams and professions are advised they must still be able to provide a full MDT service throughout the holiday period. This will be a challenge this year where there is only one professional at times in a team due to current vacancies

		To mitigate this a cross-locality cover system will be in place and will also ensure some degree of buffer in case of sickness Operational leadership will be in place from Locality Manager and Team Managers

Tees		
Speciality	Assurance Given	Mitigations
Tees Manag-ement	Yes	Site management and first manager on call will be coordinated across the Christmas and New Year period.
AMH	Yes	Annual leave is level loaded across all services throughout the year. Safe staffing will cover all inpatient and urgent care shifts 24/7. Cover across the extended weekends is provided by Tees Crisis Triage and Assessment Service, Intensive Home Treatment, and Liaison. The rosters are covered for these areas 24/7 throughout the Xmas/New Year period. Prior to bank holidays, we will be working with patients and families to reiterate the arrangements for the holiday period. Each team has a VCB for depots and clozapine bloods. This is checked and appointment dates adjusted to accommodate the holiday period – with the date brought forward or delayed slightly depending on individual risk assessments). Primary and secondary care services will not be open on bank holidays but will operate on usual working days and hours. On usual working days we will have a core multi-disciplinary staff group covering the service, including Locality Manager or HoS. Community Matron, Team Managers, Social Workers, Nurses, Medics, AHPs, admin support.
MHSOP	Yes	Annual leave is level loaded across all services throughout the year. Safe staffing will cover all inpatient and urgent care shifts 24/7 Tees Intensive Care Liaison Service (ICLS) operates daily throughout the year (8am-8pm) providing MHSOP advice and intervention for the community as required. 24th and 31st December 2021 – normal working days
CYPS	Yes	Annual leave is level loaded across all services throughout the year. Safe staffing will cover Baysdale shifts CYPS Crisis and Intensive Home Treatment will provide cover 24/7 across the Christmas and New Year period. There is no cover on bank holidays for the other CYPS community teams. On usual working days we will have a core multi-disciplinary staff group covering the service, including Locality Manager or HoS. Community Matron, Team Managers, AHPs, admin support.
ALD	Yes	Annual leave is level loaded across all services throughout the year. Safe staffing will be rostered for Bankfields Court and Thornaby Road 24/7 The mobile contact details will be provided across the extended weekends for LD Crisis, Community North, Crisis Nurse on Call, and Adult Consultant on Call.

Forensic Services	
Service/Assurance Given	Mitigations
Secure Outreach Transitions Team (SOTT) – Teesside & Durham Yes	Operational throughout with exception of Christmas day. Nurse on call cover is available from community teams.
Forensic Community Team (FCT) Yes	Patients will be seen in the run up to Christmas. Patients will be seen in the period between Christmas and New Year for regular appointments or as required, either by the care coordinator or prearranged with another member of staff. Safety summaries and plans will be up to date and reflect any crisis contingency plans – we are going to add that the crisis team can contact the H&J manager on call if required. Also, that any issues with conditionally discharged patients to contact the on call forensic psychiatrist. Staff will be at work in the period between Christmas and New Year.
CJLT Yes	Operational throughout with exception of Christmas day. Nurse on call cover is available from community teams.
SCFT Yes	Operational throughout with exception of Christmas day. Nurse on call cover is available from community teams.
NY Forensic Outreach Liaison Team (FOLS) Yes	Operational throughout with exception of Christmas day. Emergency Duty Team and Crisis Teams are available for emergency care / cover throughout the festive period for North Yorkshire Locality.
Liaison & Diversion (L&D) – Cleveland, Durham, North Yorkshire Yes	Staff in throughout the period. Support workers around during and after Christmas. They will come up with a process of identifying the most vulnerable service users who will need immediate welfare calls and make them a priority, working through them with their risk level in mind.
Psychologically Informed Consultation Service (PICS) Yes	At least one person is available throughout the week before and week after Christmas. Responsibility sits with the offender managers not the PICS team.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Item no 15

Quality Assurance Committee: Key Issues Report		
Report Date: 28th October 2021		**Report of: Quality Assurance Committee**
Date of last meetings: **2nd September 2021** **14.00 – 18.15pm** **7th October 2021** **14.00 – 17.04pm**		**Membership** Quoracy was met at both meetings. Apologies: September – 0, October – 4. **Summary of key issues:** This report captures the discussions, challenge, and debate in relation to the key risks, exceptions and matters presented to the Committee. Members consider the levels of assurance provided through reporting in relation to the mitigating actions in place to address concerns and make improvements.
1	**Agenda**	**Following a recess in August 2021, the Committee continues to meet monthly through to November 2021, following which there will be a Developmental Session on 2nd December 2021.** Both meetings considered the following regular items: **1. Update on progress in response to CQC Inspection and updates from NHSE/I and TEWV Quality Boards.** **2. Trust Level Quality Assurance & Learning Report.** **3. Service locality updates from Forensics, Durham & Darlington, Teesside, and North Yorkshire & York.** **4. Monthly Safe Staffing Exception Report.** Additional reports for 2nd September 2021 included: the six-monthly ***Research Governance Group*** update and the ***TEWV Umbrella Improvement Plan***, however this item was deferred for discussion at Board level on 7th September 2021. Additional reports for 7th October 2021 included: adopting the ***revised terms of reference for the Quality Assurance Committee***, the ***Board Assurance Framework*** (considered under confidential business), a new report to consider the ***Corporate Risks in relation to Quality and Safety*** and the ***Annual Reports for Safeguarding, PALS and Clinical Audit & Effectiveness***.
2a	**Alert (by exception)**	**Committee members alert the Board to the following:** **Corporate Risks Relating to Quality and Safety** This new report to the Committee, set out the risks relating to quality and safety from the Corporate Risk Register. • Whilst there has been some improvement on the review of risks, it was clear that there is further work required to address data quality issues, assignment of all risks with mitigating actions and regular updates. • Members challenged the methodology and ownership of the

		risks identified. Advise was given that a new risk management system will be implemented that will be in line with the Trust Board Assurance Framework. • Governance of risks is currently monitored through Senior Leaders Group with feedback to the risk owners. • There are plans to recruit a Band 8b Risk Manager to support taking this work forward. **Trust Level Quality Assurance and Learning** The Committee considered the data from the statistical process control information on the key areas of quality and safety for patient care, up to 13th September 2021. Matters which the Board should be alerted to are: ➢ There has been an ongoing issue with a backlog of unapproved serious incidents over the last couple of months. Significant progress was made during August 2021, leaving 216 outstanding unapproved incidents. All those that were moderate harm and above were extracted and approved. The Committee were informed that the backlog will be cleared by November 2021. ➢ Concerns were identified from statistical controls in relation to three measures of quality and safety - incidents per 1,000 OBD, mandatory training and appraisal. ➢ Of particular concern to members was the level of compliance with Basic Life Support and Positive Approaches Team training. A recovery plan has been put in place in order to try and make improvements. ➢ In light of the various deep dives and thematic reviews that are presented to QuAC, for example, the pilot on body worn cameras and sexual safety members agreed to consider at the QuAC Developmental Day, whether some of the recurring and ongoing concerns being found in the SPC charts relating to quality and safety should be reviewed in more depth and presented to Committee. The pending CQC report will also influence the discussions and content of the QuAC Development Day. **Cross Locality Issues:** The Board is to be alerted to the common themes and concerns across all four locality areas: • Unapproved serious incidents, resulting in the SPC data not providing a true reflection of the position at the time of writing reports. • Increasing levels of complex admissions and acuity – this has been a theme for a number of months, linked to post pandemic trends. • Business continuity arrangements ongoing across various wards. This continues to impact on patients and staff. • Staff health, wellbeing, and morale. This has been added to locality risk registers. Members suggested that a budget for staff support offering physical interventions might be helpful. • Increased bed occupancy Trust wide and out of area placements.

- Compliance with Basic Life Support Training, appraisals and mandatory training. This information triangulates with the data presented in the Trust Quality and Learning report.

Locality Updates

The Board is to be alerted to the areas reporting as a cause for concern through statistical process control (SPC), ongoing concerns for each locality, as well as any new issues.

Durham & Darlington

SPC data demonstrated concerns in relation to the following indicators: self-harm incidents, Friends and Family test, mandatory training, appraisals and ligature incidents.

No new risks were identified in August 2021. Current very high risks on the risk register are linked to, staffing challenges in Pharmacy, the Liaison Team's accommodation at UHND and a lack of Tier 4 beds for young people.

Ongoing concerns to note are:

- Patient acuity across all inpatient areas impacting on the need for high levels of observation and staffing levels.
- Staffing shortages and issues with timely recruitment and retention.
- Staff well-being. The service continues to provide well-being support.
- Low compliance with Basic Life Support Training. A series of bespoke local sessions will offer 108 places for staff during September 2021.
- Bed occupancy running at almost 100% in August 2021.
- Business continuity arrangements continue for the AMH Crisis Service. There have been some improvements with recruitment to some vacancies and staffing levels are stable. There are also notable improvements from a cultural perspective and some positive stories from staff.

Teesside

SPC data demonstrated concerns in relation to self-harm incidents and compliance with appraisal and mandatory training.

Ongoing Concerns to note are:

- Staffing shortages and recruitment and retention.
- Demand and capacity issues with bed occupancy in AMH acute inpatients remaining at over 100% and MHSOP functional ward at 99% in August 2021. ALD Bankfields was closed to admissions as it reached capacity due to acuity of care.
- Self-harm and aggression towards staff, particularly in ALD and AMH inpatients. LMGB are working to address areas of concern.

		• Low compliance with Basic Life Support Training. Training courses arranged over three days in September to improve uptake. This has been added to the risk register (risk 1142). **New concerns to note are:** • There were three incidents in August 2021, all classified as severe harm incidents. • Emerging risks around systems alignment to ensure IT systems reflect changes to pathways and safety and risk management processes. This is in relation to timing and accuracy of Visual Control Boards. A potential technology solution has been identified. **North Yorkshire & York** SPC data demonstrated concerns in relation to appraisals, which will decrease further once the Covid related extension is removed, statutory and mandatory training and FFT response numbers. **Ongoing concerns to note are:** • Increased complexity and demands on the service continue. • Recruitment and vacancy pressures continue with 169 current whole time equivalent (WTE) unfilled posts. Members were advised on the various recruitment measures underway. • Staff well-being. Teams have been referred to the Resilience Hub as part of Stop the Line planning. Staff are seeking employment opportunities outside TEWV. The risk register has been updated to reflect morale as a key risk factor. **New concerns to note are:** • The staffing model and sustainability with the current staffing establishment for ALD Holgate Ward and a single package of care. Part of a ward at Roseberry Park Hospital was used to support the individual. • AMH Perinatal has been placed under business continuity plans with several teams across the locality in stop the line processes because of staffing and service capacity issues. • Pressures in MHSOP services with lack of beds impacting on adult wards and out of area admissions. **Forensics** SPC data demonstrated concerns in relation to compliance with appraisal and mandatory training. Improvements demonstrated on SPC data were in relation to restrictive intervention incidents, seclusion incidents, medical errors and restraints. There were four positive Covid patients during August 2021, in secure IP services. All individuals were managed safely.

		Ongoing concerns are: • The service remains in business continuity plans due to continued staffing challenges. • At the time of the report to QuAC (13th September) there were three wards that remained collapsed (Thistle, Jay and Harrier Hawk). The impact on staff and patients was being carefully managed. • Staffing is a high risk on the risk register. Work is ongoing with the Safe Staffing Team to use Healthroster to support the service with staffing requirements. • Corporate support has been requested to streamline various action plans. **New concerns to note are:** • Six out of the seven seclusion rooms are vulnerable to vandalism. Work is ongoing with Estates. • Compliance with Basic Life Support training. Improving access to training will be key. • Reporting of clinical supervision. Some training is being arranged. • Increase in referrals to MH teams in prisons. • Some concerns were raised by NHSE about progress made against the action plan, following a 'Sit and See' on Thistle Ward in August 2021. This is being picked up and explored to see if any additional actions are required. **CQC Update/NHSEI and TEWV Quality Board** The Committee received verbal updates in September and October 2021, which included: • The Quality Board continued to monitor assurance on the work being done to address the actions following the CQC inspection. • A piece of work is underway to bring together the various reviews and action plans that have taken place in Forensic services over the last eighteen months, with a report and recommendations to be presented to the Quality Improvement Board for monitoring and oversight. • The action plan in relation to the re-inspection of acute inpatient wards has been submitted to the CQC. • The Trust is waiting to receive the formal independent review from Niche. • The final report following the CQC Well-led inspection is expected imminently to the Trust, following which there will be a ten-day period for any feedback on factual accuracy. • The TEWV 'Umbrella Plan' continues to be monitored.
2b	**Assurance**	**The Committee assures members of the Board on the following matters:** **Research Governance** The Committee was assured that the Trust is compliant with the UK

		Policy framework for Health and Social Care Research and there is sufficient evidence and ongoing work to actively promote research activity in the Trust. ➢ Members advised the Research Governance Group to include reference to 'Our Journey to Change' in the their revised terms of reference. **Monthly Safe Staffing Exception Report** The Committee received the monthly exception reports in relation to June and July 2021 (at the September 2021 QuAC meeting) and August 2021 (at the October 2021 QuAC meeting). • Members were assured that Gold Command is providing oversight and close monitoring of the business continuity protocols, which were implemented in June and July 2021 for secure inpatient services (SIS), Bankfields Court (Teesside Adult Learning Disabilities Services) and the Durham and Darlington Crisis Resolution Team. • That a new software product linked to the Health roster – 'Safe Care' is supporting the monitoring of daily staffing levels and patient acuity. • There has been high acuity on the two PICU wards – Bedale and Cedar, during August 2021, resulting in the need to increase the use of temporary staffing to support patient need. • Members of the Committee acknowledged that the shortfall of registered nurses continues to be a significant risk. They were advised that Health Care Support workers have backfilled when necessary. • Despite the challenges around recruiting nurses there has been some positive recruitment to Community Matrons and Practice Development Practitioners. The Committee can provide the Board with assurance that there are robust plans in place to monitor the staffing position which is being closely monitored by the Executive Team. **Board Assurance Framework (BAF)** The Committee held a confidential meeting on 7th October 2021 to consider the risks allocated to QuAC set out in the Board Assurance Framework. (BAF). The BAF has been refreshed in response to recommendations of the Well-Led (GGI) review and following on with Our Journey to Change. Members considered the profiles of the risks to calibrate and confirm the risk information and risk scores. ➢ Members suggested some minor changes to the names of the risk profiles to the relevant BAF risks: (i) "Quality" to be changed to "Experience" (Risk no. 4), (ii) "Learning" to be changed to "Safety" (Risk no. 6). (iii) The risk description of BAF reference Risk no. 11 should be changed to focus more on the line of sight

		between ward and Board, rather than on overly complex processes. ➢ Additional comments linked to BAF ref 2, the risk being focused on inpatient services, needed to be broadened to reflect rising levels of acuity for services, including in the community. ➢ Members agreed that at the present time the number of strategic risks within QuAC's remit was appropriate. **Annual Reports 2020/21** The Committee received for information the annual reports for Safeguarding, PALS & Complaints and Clinical Audit & Effectiveness.
2c	**Advise**	**The Committee would like to advise the Board of the following matters for information:** The revised terms of reference for the Quality Assurance Committee were received and adopted, following the refresh of all Committees reporting to the Board, in line with recommendations received from the Well-led (GGI) review, with effect from September 2021. **Positive news from the services:** Members were keen to advise the Board that despite the current challenges and pressures faced by all four locality areas there was a tremendous amount of positive work taking place. • The Prison Speech and Language Therapy Team have been awarded the Ruth Cranfield Award by NEPACS in recognition of them providing an excellent and progressive service to patients and families. • The MHSOP Inpatient Services have been shortlisted for Team of the Year in the Royal College of Psychiatry Awards. **Evaluation of QuAC** Members agreed that there had been a huge amount of information to digest and consider from both the meetings held in September and October 2021. They welcomed the attendance of Jill Haley, Non-Executive Director to the October meeting, for her challenge and questions.

Recommendation: The Board is asked to note the report following the Committee meetings held on 2nd September 2021 and 7th October 2021

3	**Actions to be considered by the Board**	There are no actions to be considered by the Board		
4	**Report compiled by**	Shirley Richardson, Acting Chair of Committee (Oct 2021) Donna Keeping, Deputy Trust Secretary, (Corporate)	**Minutes available from**	Donna Keeping, Deputy Trust Secretary (Corporate) Donnaoliver1@nhs.net

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 16

FOR GENERAL RELEASE

DATE:	**28th October 2021**
TITLE:	**Learning from Deaths – Dashboard Report Q 2 2021/22**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance**
REPORT FOR:	**Information**

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

Executive Summary:

The Learning from Deaths Dashboard Report sets out the approach the Trust is taking towards the identification, categorisation, and investigation of deaths in line with national guidance. The mortality dashboard for Q2 of the 2021/2022 financial year is included at Appendix 1 and includes 2020/2021 data for comparison.

During Quarter Q2 15 deaths were reported on StES. 14 of these deaths were community deaths and 1 was an unexpected in-patient death – cause of death to be determined. There were 5 physical health related in-patient deaths. 286 cases met the criteria for a mortality review. Of those 286 cases, under locally agreed criteria, 60 cases had a part 1 review. 12 of those cases were selected for a more detailed Part 2 Structured Judgement Review (SJR).

18 serious incident reviews were completed and discussed at Directors' panel. Five recurring lapses in care related to CPA/Care planning, risk assessment, record keeping, safeguarding and lack of compliance with clinical pathways.

New structures and processes for learning from deaths continue to be developed which include recommended improvements from the learning event 'Improving the Experience of Patients, Families, and Staff during Serious Untoward Incident Reviews' (SIR) and the Better Tomorrow Programme. These improvements will help to strengthen and demonstrate how we are capturing, actioning, and sharing learning to improve care for our service users and their families.

Recommendations:

The Board is requested to note the content of this report, the dashboard and the learning points and consider any additional actions to be taken.

MEETING OF:	**Trust Board of Directors**
DATE:	**28th October 2021**
TITLE:	**Learning from deaths - Dashboard Report Q2 2021/2022**

1. INTRODUCTION & PURPOSE:

1.1 The national guidance on learning from deaths requires each Trust to collect and publish specified information on a quarterly basis. This report covers the period of July to September 2021.The Board is receiving the report for information and assurance of the Trusts approach.

2. BACKGROUND INFORMATION AND CONTEXT:

It is expected that when people die in our care that the Trust reviews practice and works with families and others to understand what happened and what can be learned from the death to prevent reoccurrence where possible. All NHS Trusts are required to publish a dashboard (Appendix 1) highlighting the numbers of deaths that occur in the organisation on a quarterly basis, which are in-scope of the Learning from Deaths policy, and which 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.

There is now a full-time mortality reviewer in place to continue to develop and take new processes forward as well as a 0.2 WTE senior practitioner from MHSOP services who continues to assist with Structured Judgement reviews.

Recommendations have been accepted from the Quality Improvement learning event 'Improving the Experience of Patients, Families, and Staff during Serious Untoward Incident Reviews (SIRs)' which was held in July 2021. The Trusts participation in the National 'Better Tomorrow' Programme will provide feedback on current systems and processes for mortality reviews mid-November. In keeping with the Trust's Journey to Change, these improvements will help us to work in partnership with patients, carers/relatives, and staff.

3. KEY ISSUES:

3.1 Mortality Reviews and Learning

Further detail and criteria for Mortality reviews can be found in Appendix 2.

Mortality Review 2021/2022
In Q2 2021/2022, 286 cases met the criteria for a mortality review. Of those 286 reviews, 60 cases had a part 1 review. 12 of those cases were selected for a more detailed Part 2 Structured Judgement Review (SJR).

Month	Total Number of Deaths which met criteria for a review	Total Number of Deaths which has been reviewed under locally agreed criteria.	Total Number identified as requiring a Structured Judgement Review
July	116	27	7
August	102	19	3
September	68	14	2
Total	**286**	**60**	**12**

Mortality Reviews

Points of learning highlighted in completed SJRs in Q2 • Records lacking detail and rationale for clinical decisions made • Safeguarding: vulnerabilities not always being fully taken into consideration • Discharge planning: lack of clarity regarding pathways • Drug related deaths-motivation of people to make self-referrals to other support services
Points of Good Practice • Person-centred care planning • Evidenced-based care • Excellent physical health monitoring

3.2 Learning from deaths and serious incidents

During Quarter Q2 15 deaths were reported on StES. 14 of these deaths were community deaths and 1 was an unexpected in-patient death – cause of death to be determined. There were 5 physical health related in-patient deaths; these will be investigated via the mortality review process. 3 of these deaths occurred following transfer of patient to the acute Trust.

18 StEIS reportable serious incidents resulting in death were reviewed in the period. Key learning is summarised by themes and locality in the table below which illustrates the five most common lapses as:

- CPA/Care planning – care plans not reflecting needs, not developed in collaboration with patients and carers.
- Risk Assessment - safety summary not reflecting current and/or longitudinal risks, not exploring risks when concerns were raised by family/others.
- Record keeping – rationale for decision making not recorded, MDT discussions not reflected.
- Safeguarding – missed opportunities to identify safeguarding needs, not discussing with TEWV safeguarding Team, not following PAMIC process.
- Clinical pathways not being followed – examples include

i) Referral criteria not being followed
ii) Lack of compliance with DNA Pathway
iii) Lack of compliance with PIPA pathway

Serious incidents reports and associated findings are shared with services via Quality Assurance Groups however a number of wider, Trust wide pieces of work have been identified to address learning based on key themes and are detailed below although this is not an exhaustive list. All work streams that align to these key themes are aimed at improvement.

Formal action plans are in place for all incidents where lapses are identified which are actioned by services, closely monitored by the Patient Safety Team and Commissioners.

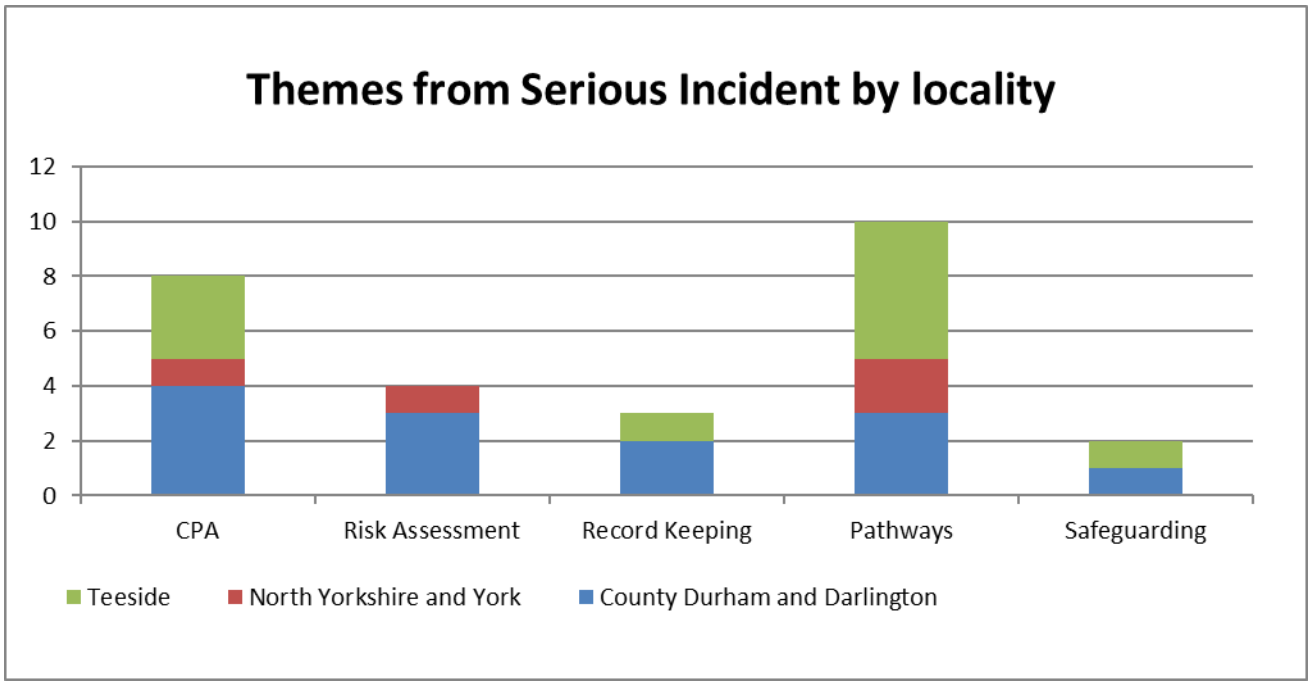

Table 1

In terms of learning in Q2 compared to Q1 CPA/care planning and risk assessments remain key areas for further development these are being actively worked on by the Practice Development Teams and the impact is being measured through the Quality Assurance reporting cycle. There has been learning for all localities in relation to pathways of care which is a new area of concern. Further work will be undertaken to look at these findings in more depth.

It is important to note, when considering the identified lapses above, that some of the serious incidents going through Directors' panel occurred prior to the CQC improvement event and the wider Trust programme developments.

3.3 Structures to support and embed learning

3.3.1 Practice Development Group (PDG)

The Practice Development Teams (PDTs) overseen by the PDG are addressing 3 key areas of learning as identified in table 1, namely CPA/care planning, risk assessments and documentation.

In-patient clinical areas are consistently achieving over 95% for completion of care documents; the PDTs are now able to focus on the quality of the documents and how they triangulate with Visual Display Boards, report out notes and clinical records. The current assessment tools utilised within the Trust wide Quality Assurance Programme have been amended to reflect this qualitative approach to ensure that there is clear documentation of the mitigation of any risks identified.

Practice Development Practitioners (PDP) are now in post and are offering a wide range of support to clinical staff, for example, MDT training in completion of safety summaries and safety plan documentation as well as improving the quality of Mental State Examinations (MSEs) undertaken and associated documentation. A training needs analysis will be undertaken across the MDT where required. The PDPs are creating resources to improve practice for all; these resources are to be included in the Learning Library.

There has been excellent progress in CMHTs completing safety summaries and safety plans. At the end of August, CMHTs met the target for completion of safety plans for patients under CPA and are making good progress for all other patients on caseloads.

A task and finish group was established to analyse care plans and to identify common problems/themes. This work was undertaken during July and August 2021.It was identified that care plans were not based on need and too generic. From this work a pilot project has been developed entitled, “Trying New Ways of Working”. The pilot, which is taking place on 5 wards, will commence on 04/10/2021 and end on 03/12/2021. It will apply to all admissions and incoming transfers. The aim is to move towards personalised plans based on need using DIALOG to support the care planning process. A ward information booklet will be introduced detailing non-personalised plans such as the right to privacy and dignity. The progress of the pilot will be reviewed frequently via the Quality Improvement Board (QIB) and the Clinical Leaders Group (CLG).

A standard supervision model has been introduced to monitor a range of record keeping standards within each clinician’s supervision session. A good practice audit has been developed and utilised to support safe risk management and subsequent care planning. Initial results indicate that ongoing embedding of expected standards are required.

The MDT walkabout tool in in-patient areas has demonstrated that staff have a good awareness of patient safety briefings and bulletins. It has also highlighted how staff are more confident in completing safety summaries and safety plans.

There has been positive feedback regarding the content of MDT discussions, an example being immediate actions taken to address newly identified environmental risks. These discussions have resulted in urgent patient safety briefings being disseminated to areas of concern.

3.3.2 Organisational Learning Group (OLG)

The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group. Over the reporting period learning from patient safety events has been shared through a range of mechanisms. There have been 8 patient safety briefings, two of these were in relation to identified ligature risks from window seals and en-suite doors in Covid isolation areas; these were both discussed in depth at the Trust’s Environmental risk group. 9 ‘Learning from Serious Incidents Bulletins’ were distributed across the Trust. The

bulletins have shared key learning and good practice highlighted in serious incident reports presented at the Directors' Assurance Panel. The OLG will shortly be producing an infographic report to capture and communicate learning, address themes and associated actions. A task and finish group is currently being established to take this forward. Significant progress has been made with the learning library and learning database.

3.3.3 Journey to Safer care

The Journey to Safer Care as part of the Trust's Journey to Change highlights four key patient safety priorities:

- Suicide Prevention and Self-harm Reduction
- Reducing Physical Restraint and Seclusion
- Harm Free care, Psychological Safety including sexual safety and a Safe Environment
- Promoting Physical Health

i) Suicide Prevention and Harm minimisation
A task and finish group from the Suicide Prevention and Harm Minimisation Group has developed a draft 'Preventing Suicide Plan' to ensure support in coordinating activities designed to reduce the risk of suicide and frequency of suicide attempts. In keeping with the Trusts Journey to change, next steps will be to undertake a period of engagement/consultation with all relevant stake holders.

The Trust now has two full time Preventing Suicide project leads in NY&Y and Teesside and a part-time lead in D&D. The Suicide Prevention Leads continue to build up and maintain effective partnership working with the suicide prevention taskforces/alliances and other agencies. These project leads are to work closer with the Patient Safety Team to look at potential themes and trends within localities.

ii) Harm Free Care - Safe Environment

The Environmental Risk Group receives monthly incident reports involving ligatures and other risks where environmental factors may have contributed to harm as well as progression of initiatives to reduce harm.

iii) Promoting Physical Heath

Work continues in relation to improving the physical health of people with mental health problems in keeping with ICS priorities when learning from deaths. This has included the appointment of physical health practitioners to support wards and teams. Training portfolios are in place for both registered and support staff within inpatient and community settings. Training includes recognition of the deteriorating patient and the Physical Health Intervention Framework for Serious Mental Illness (Lester Tool)

3.3.4 Safeguarding

Despite improvement work already undertaken to embed the principles of 'think family' and use of the PAMIC tool, it continues to be a finding in serious incidents investigations. Further webinars will be delivered and quality improvement approaches are being developed. An audit will then be undertaken of serious incidents to establish whether the webinars have had an impact on practice and whether learning is being embedded into practice. This information will be collated in the learning database and will be revisited on a 6-monthly basis.

Links between the patient safety team and the safeguarding team continue to be strengthened.

3.3.5 Serious Incident Investigation Process

The improvement event, commissioned by the Director of Nursing and Governance, built on existing work that had been already been carried out to improve the SI investigation process. Additional resources have been identified to ensure there is designated clinical leadership within the Nursing and Governance directorate to implement further improvement work as well as the wider PSIRF standards. In keeping with the Journey to Change there has been, and will continue to be, engagement with all relevant stakeholders.

3.3.6 Better Tomorrow Programme

The Better Tomorrow Team have been undertaking a desk top review of the Trust's current Mortality Review process to consider:

- Strategy and leadership
- Systems and processes
- Training and resources
- Data and information
- Governance
- Learning from Deaths

A feedback meeting will take place in November 2021 to discuss findings from the desk top review and next steps.

The Learning from Deaths policy will be reviewed to reflect improvements made in both the SI and mortality review processes.

Links have now been established with the regional LeDeR reviewers. A monthly meeting is held with the regional reviewers and the Trusts Mortality Lead to identify themes and to ensure that any learning is shared Trust wide. We are now part of a Mortality Leads Network which meets the first Thursday of every month. The aim of the network is to provide a supportive forum to share practical ideas for developing and delivering a high quality service and as an interested group to identify best practice and solutions to any areas of concern. It is facilitated by the Better Tomorrow Programme, who will provide national updates and take forward any issues that may require a national solution.

3.3.7 Thematic reviews

Two thematic reviews are currently being undertaken in relation to perinatal services and one of the Trusts Crisis Teams. The aim of these reviews is to identify any themes/service wide

learning from serious incidents. External input into both reviews will facilitate a sharing of expertise.

3.4 Gap analysis

Learning from deaths during Q2 has highlighted that patients with dual diagnoses are often not followed up proactively by mental health services. Further work is required to understand the various dual diagnosis initiatives already in the Trust – this work will be included as part of the Trust's clinical strategy. It has also been flagged at ICS level as it requires a system wide approach.

Further work is required to understand what the issues are in relation to learning and 'pathways' as this has been identified as a theme in all localities as detailed in Table 1 above.

3.5 The Learning from Deaths Dashboard

The learning from deaths dashboard is attached at Appendix 1 and includes 2020/21 data for comparison.

For Q2 the dashboard highlights the following:

- A total of 460 deaths were recorded (not including LD deaths). This is all deaths (including natural expected and unexpected) in relation to people who were currently open to the Trust's caseload.
- There were 18 StEIS reportable serious incidents resulting in death reviewed and 15 StEIS reportable serious incidents resulting in death reported.
- 23 learning points were identified from completed Serious Incident reviews.
- 286 cases were identified as meeting the mortality review criteria.
- 60 cases were reviewed (see appendix 2 for locally agreed criteria).
- 20 Learning Disability deaths were reported on Datix. All these cases were reviewed via the Trust mortality review process and have been reported to LeDeR.
- 6 in-patient deaths were reported over this period. There was 1 unexpected AMH inpatient death – cause to be determined. 5 other deaths occurred in MHSOP services; all 5 were related to physical health and will be reviewed via the mortality review process.
- In comparison for the same time frame in 2020/2021 Q2: there were 6 in-patient deaths. These deaths were all either expected or unexpected physical health deaths and were reviewed via the mortality view process.

4.0 IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
Improvements in the learning from deaths processes outlined will support the Trust to demonstrate the delivery of high quality, safe patient care in line with CQC Fundamental standards. The paper outlines how the Trust is strengthening its arrangements for organisational learning and the provision of assurance in the context of learning from deaths and embedding these to improve patient safety.

4.2 **Financial/Value for Money:**
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.

4.3 **Legal and Constitutional (including the NHS Constitution):**
CQC's Fundamental Standards in respect of Regulation 17 - Good Governance.

4.4 **Equality and Diversity:**
The Trusts learning from deaths reviews consider any issues relating to equality and diversity to ensure that any issues of discrimination are addressed.

4.5 **Other implications:**
No other implications identified.

5. RISKS:

There is a risk that if we fail to embed key learning from deaths that patient safety and quality will be compromised.

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

6. CONCLUSION:
This paper sets out the Trust's approach to Learning from Deaths in line with national NQB guidance. Themes have been identified as well as structures in place to carry out actions and embed learning to drive improvements in the quality and safety of patient care. Significant progress has been made in relation to organisational learning and how this is being triangulated Trust-wide via the OLG and the PDG . Plans are in place to identify gaps in workstreams from learning identified and to strengthen assurance regarding the impact of actions taken on patient safety themes.

7. RECOMMENDATIONS:
The Board is requested to note the content of this report, the dashboard and the learning points and consider any additional actions to be taken.

Background Papers:

Learning From Deaths Framework
https://www.england.nhs.uk/?s=Learning+from+Deaths

Southern Health Report
https://www.england.nhs.uk/2015/12/mazars/

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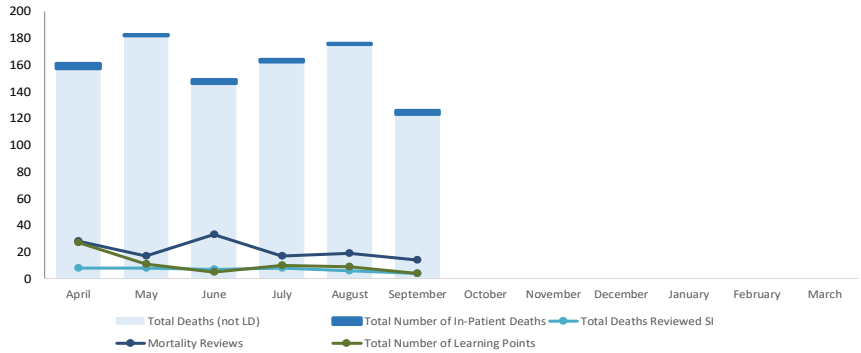
Appendix 1 Dashboard

Learning from Deaths Dashboard - Data Taken from Paris and Datix
Reporting Period - Quarter 1 -April- June 2021

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

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

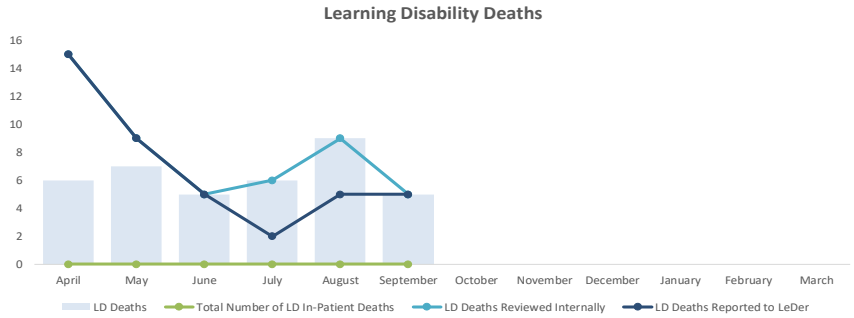
	Total Deaths (not LD)		Total Number of In-Patient Deaths		Total Deaths Reviewed SI		Mortality Reviews		Total Number of Learning Points	
	2021/22	2020/21	2021/22	2020/21	2021/22	2020/21	2021/22	2020/21	2021/22	2020/21
Q1	485	↘ 979	8	↘ 14	23	↘ 29	78	↘ 337	43	↗ 18
Q2	460	↘ 486	6	↔ 6	18	↘ 43	60	↘ 194	23	↘ 30
Q3		731		5		35		126		29
Q4		691		7		22		98		18
YTD	945	↘ 2887	14	↘ 32	41	↘ 129	138	↘ 755	66	↘ 95



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

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

	LD Deaths		Total Number of LD In-Patient Deaths		LD Deaths Reviewed Internally		LD Deaths Reported to LeDer	
	2021/22	2020/21	2021/22	2020/21	2021/22	2020/21	2021/22	2020/21
Q1	18	↘ 34	0	↔ 0	29	↘ 34	29	↘ 34
Q2	20	↗ 13	0	↔ 0	20	↗ 12	12	↔ 12
Q3		28		1		25		25
Q4		32		1		36		36
YTD	38	↘ 107	0	↘ 2	49	↘ 107	41	↘ 107



Mortality Reviews 2021/2022

Appendix 2

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 carried out.

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

- Family, carers, or staff have raised concerns about the care provided
- Diagnosis of psychosis or eating disorders during the last episode of care
- Psychiatric in-patient at the time of death, or discharged from care within the last month (where the death does not fit into the category of a Serious Incident)
- Under Crisis Resolution and Home Treatment Team at the time of death (where the death does not fit into the category of a Serious Incident)
- Patient had a Learning Disability. These cases will also be referred to LeDeR
- Prescribed Clozapine or high doses of anti-psychotic medication

This criterion allows for greater learning from a more suitable selection of cases reviewed. In order to prioritise the most significant cases for learning from unexpected and expected physical health deaths throughout Q1, taking into consideration capacity issues, the following actions have been taken for those deaths reported on datix:

- All in-patient deaths have either had a Structured Judgement Review completed or are in the process of having one completed.
- All LD deaths 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 have also been referred to LeDeR for review.
- All community deaths for patients aged 64 and under 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.
- 20% of community deaths for patients aged between 65 and 75 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 between 76 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.

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NHS Foundation Trust

ITEM NO 17

Mental Health Legislation Committee: Key Issues Report		
Report Date: 28 October 2021		**Report of: Mental Health Legislation Committee (MHLC)**
Date of last meeting: 21 October 2021		The meeting was quorate, there were no apologies for absence
1	**Agenda**	**The Committee considered the following agenda items during the meeting:** • Discharges from Detention Quarterly Report • Section 136 Quarterly Report • Section 132 b Quarterly Report • Section 18 Absent without Leave (AWOL) • Section 5 Mental Health Act (Holding Powers) Report • Seclusion Report • Mental Capacity Act (MCA) Deprivation of Liberty Safeguards (DoLS) Report • CQC Mental Health Act Inspections • Update on Mental Health Act Legislation
2a	**Alert**	**The Committee alerts members of the Board that:** Members of the Committee challenged how the levels of assurance were provided throughout the reports. They questioned how the data and information, provided over the quarter or six-monthly period, could provide members with firm assurance that demonstrated the Trust is not only adhering to MHA legislation and guidance, but also making a positive impact on patient care. A request was made that, where possible within reports, a narrative assurance statement should be provided, to demonstrate that patient care is within legislative guidance. **Absent without Leave (AWOL)** There was a long debate about the data presented for those patients that are absent without leave. There were 64 patients over the quarter that were AWOL, however the data includes not only people that do not return from authorised leave, but also those that might return late. Members queried where the data about AWOL is presented and discussed, in terms of any themes or ward hot spots and environmental issues that need to be considered. The Committee had requested at a previous meeting that the data be shared operationally, and it had subsequently gone to the Quality Assurance Improvement Group. Members felt that there should be a better understanding of the risks around patients that abscond or fail to return, for triangulation of the data and in order to try and prevent any possible harm to an individual.

		Members agreed that a report should be provided to the Quality Assurance Committee on the details behind the data for those patients that are absent without leave.
2b	**Assurance**	**The Committee assures members of the Board that:** **Discharge from Detention Quarterly Report** The Mental Health Legislation Department (MHLD) monitor all discharges by the Tribunal service and by Hospital Managers (HM), to identify any pattern or similarity between reasons for discharge for patients from the same team. The process is managed by a member of the MHL Team being present at all HM Hearings. There are a minority of cases where the Tribunal and clinical team disagree about discharge of an individual. The Trust can clearly demonstrate that the processes supporting discharges from detention are robust, the criteria is being met and comprehensive reports are submitted to ensure the best outcome for individuals. From review of all discharges by the Tribunal and Hospital Managers in the last quarter there were three patients out of 117 first-tier Tribunals discharged from their section. None of these patients were re-admitted or re-sectioned at the time the report was written for Committee. There were 155 Hospital Manager meetings and no patients were discharged. The assurance from this information comes from the evidence that there have been 155 HM reviews and 117 First Tier Tribunals, which demonstrates that patients are being given their rights and accessing these services. **Section 136** The Trust places of safety are situated at West Park Hospital, Darlington, Roseberry Park, Middlesbrough, Lanchester Road, Durham, Cross Lane Hospital, Scarborough and Foss Park, York. From the data considered over Q2 there were no instances where an individual was taken to a police station and TEWV was chosen as a place of safety for assessments. TEWV is currently breaking the national trend and is seeing a reduction in the use of S136. There was a drop in the use of S136 in North Yorkshire (63 > 49) and in Middlesbrough (65 > 49). There were six individuals who exceeded the 12-hour stipulated time under S136, with one lasting 19 hours where a PICU bed had been required. Members were advised that Middlesbrough has historically been an outlier for the use of S136, thought to be attributable to the high deprivation in the area and also that the place of safety in Middlesbrough is the Crisis Assessment Suite at Roseberry Park Hospital, which provides support twenty four hours a day. The Committee had requested at a previous meeting some comparative data to be provided on anyone under the age of 18 years old, for inclusion in the S136 data. There was no evidence of any concerns from the data in the reporting period, with five individuals placed in different locality places of safety.

		Assurance of the monitoring of S136 demonstrates that there is a process in place, which includes the maintenance of electronic records for the use of Section 136 and the Trust's 'Places of Safety'. This is monitored and managed by an escalation process, overseen by the MH Legislation Team to ensure completion of paperwork within the required timeframe. **Section 132 – Information to Detained Patients** Over Q2 there was good compliance in regards to providing patients with their rights at the point of admission, (when detained under the Mental Health Act 1983), however compliance is not at 100%. Where compliance is not reached there are robust escalation processes and this occurred on 11 occasions in Q2, (20 in the previous quarter), with one escalated to the MHL Team Manager (Overdale Ward). All escalations resulted in the necessary documentation of S132b forms being received. Members were concerned that this is a vulnerable area for the Trust and something that the CQC closely monitor. Assurance was provided that this area of compliance no longer features in the top five concerns from MHA Inspections and this was attributed to the introduction of the closely managed escalation processes. Members sought further assurance on how improvements would be made on those wards where due process were not being followed. For the visual control boards situated on the wards, a prompt will be added to remind staff to return the S132 forms. **Section 18 Absent without Leave (AWOL)** The Committee considered the data for quarter 1 and 2 for 2021/22. During that period there were 64 episodes of AWOL. The episodes increased from five in April to 12 during September 2021. There are repeat AWOL episodes, with seven patients who were absent twice and three patients on four occasions. Assurance was provided that all AWOL episodes are checked and reported to the CQC if the individual is from a low, medium or high secure environment. As already mentioned, the Committee has requested the Quality Assurance Committee to review a short summary paper on AWOL following consideration by the Quality Assurance Improvement Group. **Section 5 MHA 1983 (Holding Powers)** The MHL Team monitor information on the use of Section 5 holding powers and any issues are then investigated. The Committee were informed on the use of Section 5(2) Doctors or ACs Holding Power and Section 5(4) Nurses Holding Power. This is in relation to detaining a patient that is already in hospital. There MHL team reported exception data where Section 5 had been allowed to lapse, or where the outcome was not usual or lawful. There were 37 uses of section 5(4) and 226 uses of section 5(2) in

		Q1 and 2. Over that period one section 5(2) had been allowed to lapse where ward staff had not arranged the assessment. The AMHP had recorded that the request for assessment had only been one hour before the section 5(2) was due to expire. The matter was raised with the ward manager. **Seclusion and Segregation** The MHL Team continue to monitor the use of seclusion and segregation. During Q2 there were 48 episodes of seclusion (52 in previous quarter). There were six episodes of segregation (four in previous quarter) including four episodes of flexible segregation, of which three were ongoing at the time of writing the report to Committee. All seclusion episodes were over 12 hours, including 32 that were over 24 hours. The longest completed seclusion was 471 hours. Members sought further assurance on how appropriate the actions taken in the use of seclusion and segregation were appropriate for the individuals involved. Advice was provided that through the Restrictive Practice Programme monitoring of the restrictive practices, which includes seclusion and segregation is also reported to the Quality Assurance Committee. **Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) Report** The Committee were briefed on the work that continues to embed the Mental Capacity Act in preparation for the introduction of the Liberty Protection Safeguards (LPS) – which will replace DoLS, (expected in around April 2022). The implementation of LPS is an operational issue, which will require collaborative working with the clinical and governance teams, in terms of obtaining compliance within the legislation and the provision of accurate statistical information. Due to the closure of two respite units following the pandemic many DoLS authorisations have ended. There are currently 13 in place. Members were reminded that the Local Authority is the supervisory body for managing DoLS until this is replaced with the new system. This will be made explicit in future reports, as there are some areas of legislation that are not within the control of the Trust.
2c	**Advise**	**The Committee advises the Board that:** **Update on Mental Health Act Legislation** There is nothing new to update the Board on the pending changes to the MHA legislation, since the consultation and the Government's response and some working parties that were set up. **Seclusion Clinical Audit** The Committee had considered that it would be useful to undertake a clinical audit in relation to compliance with the completion of medical reviews. This had initially been raised at Committee in October 2020 as there were some concerns

		around compliance in Teesside and Forensics and whether there were enough junior Doctors to meet the needs of the patients. The audit was then put on hold due to the pandemic. This will now be re-visited and the audit included in the Clinical Audit Plan. **Annual Clinical Audit Plan** The Annual Clinical Audit Plan was circulated to members of the Committee, following the meeting, for assurance that legal and regulatory requirements are included in the Plan. **CQC Quarterly Report** Members considered a presentation on the outcomes of Mental Health Act Inspections – the unannounced visits to wards. One of the things that had been evidenced from the inspections was a positive improvement for compliance with completing Section 17 leave forms. There were some areas of improvement that had been identified associated with co-production, care plans and safety plans. **Case Study** Due to resource and capacity issues in Nursing & Governance the case study was deferred to the next meeting in January 2022. **Revised Policies** To reduce the amount of paperwork being considered by members at each meeting, it was agreed to circulate five revised Trust policies outside the MHL meeting, to gain approval before they are ratified at Senior Leaders Group. Most of the policies had been due for a three-year revision, with minor amendments and all now included reference to Our Journey to Change. The policies are: • Advance decisions and statements • S117 • Missing Persons • S135 • Consent to examination		
2d	**Review of Risks**	There were no new risks that were identified during the meeting for inclusion on risk registers or the Board Assurance Framework.		
Recommendation: The Board is asked to note the contents of this report.				
3	**Actions to be considered by the Board**	There are no matters to escalate to the Board:		
4		Donna Keeping ***Deputy Trust Secretary (Corporate)*** Pali Hungin ***Non-Executive Director (Committee Chair)*** Elizabeth Moody ***Director of Nursing & Governance***	**Minutes are available from:**	*Donna Keeping* ***Deputy Trust Secretary (Corporate)***

ITEM NO.18

Trust Board of Directors

DATE:	**19th October 2021**
TITLE:	**Guardian of Safe Working Quarterly Report October 2021**
REPORT OF:	**Dr Jim Boylan - Guardian of Safe Working**
REPORT FOR:	**Assurance**

This report supports the achievement of the following Strategic Goals:	✓
A great experience for patients, carers and families	
A great experience for staff	✓
A great experience for partners	✓

Executive Summary:

It is the responsibility of the Guardian of Safe Working to provide annual & quarterly reports to the Trust Board for assurance that Junior Doctors are safely rostered and working hours that are safe and in compliance with Terms and Conditions of Service.

There has been a continuing major impact on working conditions by the CoVID 19 pandemic for all staff, including Junior Doctors, over the past year and more recently a significant escalation of positive cases has meant an increase in the number off work due to self isolation or sick leave.

Following recent expressed concerns a visit has been made to the 136 suite at Lanchester Road Hospital which reassured the Guardian that the suite is not physically so remote from other clinical space, especially as the crisis team office is close by - but it remains clear that the key issue is the level of staffing within the Crisis Team so that support for 136 assessments can be reliably provided. As previous reports have also identified other junior doctor concerns regarding section 136 assessments, the medical director is pursing a Trust-wide quality improvement event to obtain baseline data and develop standard operating procedures to ensure the quality and staff / patient safety.

There continue to be a notable number of exception reports emanating from the Scarborough (in particular) and Teesside localities where there are Non-Residential On Call Rotas. These have continued to persist over many months now and are of particular concern in the Scarborough area where the pressure is being felt at all levels among medical staff and suggest a real need to address the elevated work intensity in this area. Where Guardian fines are levied these continue to be largely due to the breach of the 5 hours continuous rest rule.

We continue to monitor and review the process for exception reporting to try to ensure timely reporting by Junior Doctors and accurate intelligence of work intensity across all localities.

Recommendations:
The Board are asked to read and note this Annual report from the Acting Guardian of Safe Working.

MEETING OF:	**Trust Board**
DATE:	**28th October 2021**
TITLE:	**Quarterly Report by Guardian of Safe Working for Junior Doctors**

1. INTRODUCTION & PURPOSE:

The Board receive Annual & quarterly reports from the Guardian of Safe Working as a requirement of the 2016 terms and conditions of service for Junior Doctors. This report contains both annual and quarterly data in the appendices and includes aggregated data on exception reports, details of fines levied against departments with safety issues, data on rota gaps/vacancies/locum usage and a qualitative narrative highlighting good practice and/or persistent concern. This will provide assurance to the Board and if needed, ask for approval for action to rectify a safety concern.

2. BACKGROUND INFORMATION AND CONTEXT:

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours and during negotiation, agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS doctors in training to oversee the process of ensuring doctors are properly paid for all their work and ensure they are not working unsafe hours. It is a requirement that all doctors on the contract have an individualised schedule of work for each placement, variation from which requires them to place an exception report, based on hours of work and/or educational experience.

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

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

The work of the Guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission and by the continued scrutiny of the quality of training by Health Education England.

3. KEY ISSUES:

- **Appendices 1 and 2** provide more details for North (Durham & Teesside) and South (York and North Yorks) sectors respectively for the quarter July to September (inclusive) 2021 with a short narrative explaining the data from the relevant medical staffing officer for each area. The relevant appendices are shared with the corresponding Health Education England body for the different sectors.

- From these appendices the data is clear that there remain concerns about the continuing level of exceptions being reported particularly in the Scarborough locality which has had the highest number of exceptions reported by some margin (47 in this quarter) and also in York (23) and Teesside (31). All of these are related to Non-Residential On Call Rotas and are once again the areas which have incurred fines for breach of contract. The trainees in Scarborough report regular very intense workloads on call – mostly related to out of area admissions, which is a particular issue at Weekends. Monitoring during this quarter has demonstrated this escalated work intensity in Scarborough and discussions continue between locality medical management and Junior Doctors and medical to improve the situation. The continuing influx of out of area patients with rapid turnover are the probable main drivers for the increased intensity. One option being considered is to employ a further Physician Associate on the Cross Lane site to offset some of the routine ward work which has added considerably to the workload. A split weekend system with allocated days rest is the currently operating model and this has improved the situation.

- An agreement has been reached to maintain two middle tier NROC rotas in County Durham rather than merge into 1 rota across the county. This requires an increased frequency of on-call among participant to make this serviceable but was the favoured choice for middle tier doctors. There is a current pilot and planned review of this arrangement in the near future.

- Over the past quarter we have witnessed the continuing impact of CoVID 19 in the workplace and a national upsurge in new cases as relaxation of distancing measures has occurred. This has caused an escalation of staff absences in TEWV through infection and the need for self isolation, which has impacted on available staffing levels.

- We continue to monitor access to the Web Ice clinical results service out of hours and overall this has improved in most localities, but during this quarter there have been reports of difficulties in accessing lab results in the Teesside locality and staffing have had difficulties in eliciting a response from the South Tees Trust to expedite licences for our trainees.

- Over recent months there have been concerns expressed regarding a reduced availability of Crisis Team staff, and therefore available support for the Section 136 suites during out of hours assessments in County Durham. As reported in the last quarter, there remain particular staffing pressures for the Durham and Darlington Crisis Team (which is ,to my knowledge, still being managed through

business continuity arrangements). Following assurances that this is being looked into – we are continuing to monitor the situation through the locality junior doctor reps and the Forum. I visited the site at Lanchester Road along with the Associate Director of Medical Development and satisfied myself that the 136 suite is not geographically isolated and is suitably appointed. It also has the Crisis Team office very close. The key issue is having adequate staffing resources to support out of hours assessments. We also continue to monitor for reports by Higher Trainees of pressure to discharge patients from section 136 without an AMHP having been in attendance. I have not received any specific reports of this during the last quarter.

- I viewed the Junior Doctors on call room at Lanchester Road in the company of our associate Director of Medical Development and we saw that it is isolated from the main hospital block in a deserted building at the end of several corridors. Junior Doctors have been choosing the medical students room in the Bowes Lyon unit which is more comfortable and much closer with shower facilities close by. We are looking into relocating the on call room to this location and finding an alternative for medical students.

- Medical Development have continued to deliver a fortnightly webinar meeting for all Junior doctors to provide updates and support and also regular on-line teaching sessions. I link in with this when possible and try to make myself responsive and available for requested consultation and coaching / support sessions for junior doctors to access by phone or video-link.

- Over this quarter I am satisfied that all exception reports submitted by doctors on the new contract have been actioned within specified and reasonable timeframes. The medical staffing department have supported doctors' supervisors to action these appropriately and maintain a log that enables trends to be spotted and reports submitted to locality forums.

- There have been no evident rota gaps of concern during this quarter and the internal locum system appear to function well with no reported use of Agency locums on Junior Doctors rotas.

- The Trust continues to monitor and provide compensatory rest arrangements that match or exceed requirements set out in the contract.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

The work of the guardian will help to inform CQC in the areas of Safety, Good Governance, Staffing and Duty of Candour. This report evidences maintenance of these standards.

4.2 Financial/Value for Money:

The new contract is underpinned by the principle that junior doctors are paid for the work they do. Implementation of the contract has cost the organisation a significant amount of money. It is necessary that the Board understands that extra costs will be incurred for additional anti-social hours work and breaches of hours and rest agreements. It is vital that broader resources are effectively utilised to ensure work passed to junior doctors is necessary and appropriate.

4.3 **Legal and Constitutional (including the NHS Constitution):**
The Learning and Development Agreement signed by the Trust with Health Education England clearly sets out the expectations on placement providers. The organisation must ensure that the work schedules in the new contract allow junior doctors to fulfil their curriculum needs within a sound learning environment.

4.4 **Equality and Diversity:**
The revised 2016 terms and conditions included the responsibility of the guardian to oversee issues relating to Equality & Diversity. The Head of Equality and Diversity has therefore been invited to the quarterly trustwide Junior Doctor Forum. An Equality Impact Assessment has been completed and is updated within the forum. The Champion of Less Than Full-time Working is a core member of the Junior Doctor forum and holds an additional forum / network for less than full time doctors.

4.5 **Other implications:**
It is important that our junior doctor colleagues continue to believe that we are supporting them in providing an appropriate and safe learning environment.

5. RISKS:

The ongoing and developing situation with Covid 19 and the recent escalation of cases resulting in staff vacancies and shortages in key areas has compromised safety for Junior Doctors in some localities for urgent out of hours assessments and it is important that monitoring of this situation continues.

Pressure upon Junior doctors to assess section 136 patients without the presence of an AMHP does not constitute best practice and may compromise the level of assurance for decisions made about these patients and pose a professional risk for Junior Doctors.

Continuing pressure from out of area admissions and work intensity is having a negative effect upon morale for all grades of medical staff in the Scarborough locality with the risk of staff departures in an area which is historically hard to recruit to.

Failure to anticipate the impact on Junior Doctors working situations of any major service changes remain a generic risk for a large and dispersed organisation such as the Trust and may lead to a Junior Doctor being placed in an unsafe situation.

The Trust rightly encourage high levels of necessary exception reporting and with current levels of negative media attention – these may be misunderstood and be reported in the media without adequate understanding of Trust policy and processes – which may lead in turn to reputational risk.

In the context of the current requirements for social distancing our normally robust structures for Junior Doctor Forums and meetings between senior medics are potentially more challenged, although there is continuing evolution in the availability and use of technology for remote linkage.

6. CONCLUSIONS:

The continuing challenges of the Covid19 Pandemic manifested more recently through staff shortages have impacted upon safe working practices for Junior Doctors in acute out of hours situations in some parts of the trust. There is a need to further assess and respond to this situation pro-actively.

There continue to be issues around work intensity in Non-Residential Rotas around the trust and this is of most concern in the Scarborough locality. There continues to be close monitoring of the situation but no noticeable change in intensity of work. This will have a negative effect upon retention and recruitment if allowed to continue.

Junior Doctors are appropriately submitting exception reports but continuing review of how to maintain and improve the efficiency of this process is important. Medical staffing are processing the exception reports in an appropriate and fair way. I am satisfied that reasonable processes continue to be in place to identify and rectify issues of safety despite the stringencies of safe distance working.

Appropriate alternative measures continue to be taken to provide ongoing training and support for Junior Doctors through regular webinars and video conferencing.
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7. RECOMMENDATIONS:

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

Author: Dr Jim Boylan
Title: Guardian of Safe Working for Junior Doctors

Background Papers:
Appendices 1 & 2: detailed information on numbers, exception reports and locum usage- North and South Sectors respectively - third quarter 2021.

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

High level data

Number of doctors / dentists in training (total):	74
Number of doctors / dentists in training on 2016 TCS (total):	72
Amount of time available in job plan for guardian to do the role:	1.5 PAs
Admin support provided to the guardian (if any):	4 Days per quarter
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st July 2021 up to 30th September 2021

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Teesside & Forensic Services Juniors	0	2	2	0
F1 –North Durham	0	0	0	0
F1 – South Durham	0	0	0	0
F2 - Teesside & Forensic Services Juniors	0	4	4	0
F2 –North Durham	0	0	0	0
F2 – South Durham	0	0	0	0
CT1-2 Teesside & Forensic Services Juniors	0	17	17	0
CT1-2 –North Durham	0	0	0	0
CT1-2 – South Durham	0	7	7	0
CT3/ST4-6 – Teesside & Forensic Services Seniors	0	7	7	0
CT3 – North Durham	0	0	0	0
CT3 – South Durham	0	0	0	0
ST4-6 –North & South Durham Seniors	0	2	2	0
Trust Doctors - North Durham	0	0	0	0
Trust Doctors - South Durham	0	0	0	0
Trust Doctors - Teesside	0	1	1	0
Total	**0**	**40**	**40**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services Juniors	0	26	26	0
Teesside & Forensic Senior Registrars	0	5	5	0
North Durham Juniors	0	0	0	0
South Durham Juniors	0	7	7	0
South Durham Senior Registrars	0	1	1	0
North Durham Senior Registrars	0	1	1	0
Total	**0**	**40**	**40**	**0**

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Teesside & Forensic Services Juniors	3	7	16	0
Teesside & Forensic Senior Registrars	0	2	3	0
North Durham Juniors	0	0	0	0
South Durham Juniors	0	3	4	0
South Durham Senior Registrars	0	1	0	0
North Durham Senior Registrars	0	0	1	0
Total	**3**	**13**	**24**	**0**

Narrative for Exception Reports

In Teesside and Forensics, there were 6 reports from new starters shadowing 4 hour resident shifts prior to their first one, 4 educational reports as doctors were required to stay on the ward and miss teaching due to no resident doctor being available and 2 reports of staying late to complete work.

In Durham & Darlington, the number of exception reports remains low due to the fact that both Junior Doctor rota's are now resident.

Work schedule reviews

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

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

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Teesside & Forensics	F2	11	11	0	87.5	101.5
	CT1/2/GP	37	27	0	435	333.5
	CT3	3	5	0	41	104
	Trust Doctor	0	2	0	0	18.5
	SPR/SAS	7	7	0	124	124
North Durham	F2	8	8	0	40.5	40.5
	CT1/2/GP	28	28	0	264	264
	CT3	3	3	0	37.5	37.5
	Trust Doctor	0	0	0	0	0
	SPR/SAS	6	6	0	104	104
South Durham	F2	3	3	0	37.5	0
	CT1/2/GP	22	22	0	156.5	156.5
	CT3	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
	SPR/SAS	58	58	0	1060	1060
Total		**184**	**180**	**0**	**2387.5**	**2344**

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Compassionate Leave	3	3	0	29	29
COVID isolation	21	21	0	247	247
Maternity leave	0	0	0	0	0
On call cover	109	109	0	1572	1572
Vacancy	15	15	0	110.5	110.5
Sickness	38	38	0	448	448
Increase in workload	0	0	0	0	0
Total	**186**	**186**	**0**	**2406.5**	**2406.5**

On call cover results in most of the locum cover. This is where a doctor is present at work but exempt from the rota due to occupational health reasons.

Vacancies

Vacancies by month						
Locality	**Grade**	**July 2021**	**August 2021**	**September 2021**	**Total gaps (average)**	**Number of shifts uncovered**
Teesside & Forensics	F1	0	2	2	0	0
	F2	0	2	2	0	0
	CT1	0	1	1	0	0
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	1	0	0	0	0
	Trust Doctor	0	0	0	0	0
North Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	0	0	0	0
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	2	0	0	0	0
	Trust Doctor	0	0	0	0	0
South Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	0	0	0	0
	CT2	0	0	0	0	0
	CT3	0	1	1	0	0
	ST4 -6	3	1	1	0	0
	GP	1	0	0	0	0
	Trust Doctor	0	0	0	0	0
Total		**7**	**7**	**7**	**0**	**0**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Teesside & Forensic	2	£459.71
North Durham	0	£00.00
South Durham	0	£00.00
Total	2	**£459.71**

Fines (cumulative)			
Balance at end of last quarter	**Fines this quarter**	**Disbursements this quarter**	**Balance at end of this quarter**
£4098.10	**£459.71**	**£00.00**	**£4557.81**

Purchases: None made this quarter

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

High level data

Number of doctors / dentists in training (total):	71
Number of doctors / dentists in training on 2016 TCS (total):	71
Amount of time available in job plan for guardian to do the role:	1.5 PAs
Admin support provided to the guardian (if any):	4 Days per quarter
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st July 2021 up to 30th September 2021

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Northallerton	0	0	0	0
F1 - Harrogate	0	0	0	0
F1 - Scarborough	0	10	10	0
F1 - York	0	0	0	0
F2 - York	0	0	0	0
CT1-2 - Northallerton	0	4	4	0
CT1-2 - Harrogate	0	0	0	0
CT1-2 - Scarborough	0	24	24	0
CT1-2 - York	0	7	7	0
CT3/ST4-6 – Northallerton	0	1	1	0
CT3/ST4-6 – Harrogate	0	0	0	0
CT3/ST4-6 – Scarborough	0	6	6	0
CT3/ST4-6 – York	0	8	8	0
Trust Doctors - Northallerton	0	0	0	0
Trust Doctors - Harrogate	0	0	0	0
Trust Doctors - Scarborough	0	7	7	0
Trust Doctors - York	0	3	3	0
Total	**0**	**70**	**70**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Northallerton/ Harrogate/ York	0	23	23	0
Scarborough	0	47	47	0
Total	**0**	**70**	**70**	**0**

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Northallerton/ Harrogate/ York	7	8	7	0
Scarborough	26	12	7	0
Total	**33**	**20**	**14**	**0**

Work Schedule reviews

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

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

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Northallerton/ Harrogate/ York	F2	6	6	0	73.5	73.5
	CT1/2/GP	28	28	0	422.5	422.5
	CT3	7	7	0	105.5	105.5
	Trust Doctor	0	0	0	0	0
	ST4-6/SAS	18	18	0	324	324
Scarborough	F2	1	1	0	16	16
	CT1/2/GP	88	73	0	782	738
	CT3	1	1	0	24	24
	Trust Doctor	0	0	0	0	0
	ST4-6/ SAS	83	83	0	1544	1544
Total		**232**	**217**	**0**	**3291.5**	**3247.5**

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	42	42	0	798	798
Sickness	13	13	0	190.5	190.5
Other	177	167	0	2303	2259
Total	**232**	**222**	**0**	**3291.5**	**3247.5**

Vacancies

Vacancies by month						
Locality	**Grade**	**July 2021**	**August 2021**	**September 2021**	**Total gaps (average)**	**Number of shifts uncovered**
Northallerton/ Harrogate/ York	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1/2/GP	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
Scarborough	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1/2/GP	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
Total		**0**	**0**	**0**	**0**	**0**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Scarborough	4	£540.34
North Yorkshire & York	6	£933.06
Total	10	**£1473.4**

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£852.14	**£1473.4**	**£00.00**	**£2325.54**

Purchases

No purchases this quarter

Tees, Esk and Wear Valleys
NHS Foundation Trust

PUBLIC

Item 19

BOARD OF DIRECTORS

DATE:	28th October 2021
TITLE:	To approve the Annual Report and Accounts of the Charitable Trust Funds for submission to the Charity Commission.
REPORT OF:	Liz Romaniak, Director of Finance and Information
REPORT FOR:	Assurance and Information

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

Executive Summary:

The Charitable Trust Fund (CTF) accounts and report were accepted and recommended to the Board for submission at Audit Committee on 9th September 2021.

In year the CTF increased by £179k in net resources mainly due to grants received from NHS Charities Together. The overall balance of the funds as at 31 March 2021 was £618k.

An independent review completed by Mazars found no material matters to draw attention to, or to suggest that the accounts have been compiled incorrectly.

Once approved, the CTF annual report and accounts will be uploaded to the Charities Commission website.

Recommendations:

The Board of Directors is requested to receive the report, to note the conclusions in section 6 and to raise any issues of concern, clarification or interest.

The Board of Directors is requested to approve the submission of the Annual Report and Accounts of the Charitable Trust Fund, as shown in appendix A.

DATE:	28th October 2021
TITLE:	To approve the Annual Report and Accounts of the Charitable Trust Funds for submission to the Charity Commission.
REPORT OF:	Liz Romaniak, Director of Finance and Information
REPORT FOR:	Assurance and Information

1. INTRODUCTION & PURPOSE:

This report sets out the closing financial position of the Charitable Trust Fund (CTF) for the financial year 2020/21, prior to upload to the Charities Commission.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This report will enable the Board of Directors to approve the submission of the CTF accounts and report for upload to the Charities Commission.

3. KEY ISSUES:

3.1 Appendix A contains the CTF annual report and accounts. In year the fund increased by £179k, and had a closing balance of £618k.

3.2 An independent review was completed by Mazars, which found:

- accounts have been prepared in line with standards
- no matters require additional disclosure

This report is attached as appendix B.

3.3 The Charitable Trust Fund (CTF) accounts and report were accepted and recommended to the Board for submission at Audit Committee on 9th September 2021.

3.4 Following approval from the Board, the CTF accounts and report will be uploaded to the Charities Commission website. The deadline for upload is 31 January 2022.

4. IMPLICATIONS:

4.1 There are no direct CQC, quality, legal or equality and diversity implications associated with this paper.

5. RISKS:

5.1 There are no risks arising from the implications identified in section 4.

6. CONCLUSIONS:

6.1 In year the CTF increased by £179k, and had a closing balance of £618k.

6.2 An independent review completed by Mazars found no material matters to draw attention to, or to suggest that the accounts have been compiled incorrectly.

7. RECOMMENDATIONS:

7.1 The Board of Directors is requested to receive the report, to note the conclusions in section 6 and to raise any issues of concern, clarification or interest.

7.2 The Board of Directors is requested to approve the submission of the Annual Report and Accounts of the Charitable Trust Fund, as shown in appendix A.

Liz Romaniak
Director of Finance of Information

ARC Papers 9th September

Appendix A

Item 17 CTF Annual Account 2020-21.pdf Item 17 CTF ANNUAL REPORT 20

Appendix B

Item 16 Summary report of findings 20:

CHARITABLE TRUST ACCOUNT - TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST - 2020-21	
Data entered below will be used throughout the workbook:	
This year	2020-21
Last year	2019-20
This year ended	2021
Last year ended	2020
This year beginning	1 April 2020
This year name	31 March 2021
Last year name	31 March 2020

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 2011, 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 1-9 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 ……

INDEPENDENT EXAMINER'S REPORT TO THE TRUSTEE OF TEES, ESK AND WEAR VALLEYS NHS TRUST GENERAL CHARITABLE FUND

Independent Examiners Report to be added here once approved.

Statement of Financial Activities for the year ended 31 March 2021

	Note	31 March 2021 Unrestricted Funds £000	31 March 2021 Restricted Funds £000	31 March 2021 **Total Funds £000**	31 March 2020 Total Funds £000
Incoming resources					
Income and endowments from:					
Donations		2	8	**10**	5
Legacies		-	2	**2**	5
Grants received	5.1	208	-	**208**	-
Income from investments	5.2	-	1	**1**	1
Other trading activities	5.3	-	128	**128**	91
Total income and endowments		**210**	**139**	**349**	**102**
Resources expended					
Expenditure on:					
Raising funds	3.3	(9)	(111)	**(120)**	(81)
Charitable Activities	3.1	(25)	(25)	**(50)**	(66)
Total resources expended	4	**(34)**	**(136)**	**(170)**	**(147)**
Net expenditure		**176**	**3**	**179**	**(45)**
External transfers	6	-	-	-	57
Total transfers	6	**0**	**0**	**0**	**57**
Net movement in funds	6	**176**	**3**	**179**	**12**
Reconcilliation of funds:					
Fund balances brought forward at 31 March 2020		141	298	**439**	427
Fund balances carried forward at 31 March 2021		**317**	**301**	**618**	**439**

There were no other recognised gains or losses in the year.

Balance Sheet as at 31 March 2021

	Notes	Unrestricted Funds £000	Restricted Funds £000	**Total at 31 March 2021 £000**	Total at 31 March 2020 £000
Current assets					
Debtors		-	2	**2**	-
Short Term Deposit Investment		318	304	**622**	450
Total current assets		318	306	**624**	450
Current liabilities					
Creditors: Amounts falling due within one year	7	(1)	(5)	**(6)**	(11)
Total current liabilities		(1)	(5)	**(6)**	(11)
Total current assets less current liabilities		317	301	**618**	**439**
Total net assets		**317**	**301**	**618**	**439**
Funds of the Charity					
Income Funds:					
Restricted	8.1	-	301	**301**	298
Unrestricted	8.2	317	-	**317**	141
Total funds		**317**	**301**	**618**	**439**

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 2020-21 and throughout the comparators shown for the previous reporting year 2019-20.

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 2020-21. These costs are apportioned across the funds using the appropriate classification of fund. During 2020-21 the classification split was:

Restricted 49%, Unrestricted 51%.

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 (2019-20, £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.

Mrs M Harte
Mr C S Martin - left 29th June 2020
Mr B Kilmurray - started 29th June 2020
Mr P McGahon - left 5th August 2020
Mrs L Romaniak - started 19th October 2020
Dr A Khouja
Mrs E Moody
Mrs R Hill
Mr D Jennings - left 31st August 2020
Mr R Simpson - left 31st August 2020
Mr H Griffiths
Mr P Murphy
Mrs Shirley Richardson
Mr Pali Hungin
Mrs Beverley Reilly
Mr John Maddison

3 Details of resources expended on charitable activities

3.1 Activities in furtherance of charities objectives

	Unrestricted Funds	Restricted Funds	**Total 2021**	Total 2020
	£000	£000	**£000**	£000
Patients welfare and amenities	(7)	(15)	**(22)**	(34)
Staff welfare and amenities	(14)	(6)	**(20)**	(14)
Governance costs (see 3.2 below)	(4)	(4)	**(8)**	(18)
	(25)	**(25)**	**(50)**	(66)

3.2 Analysis of governance costs

	Unrestricted Funds	Restricted Funds	**Total 2021**	Total 2020
	£000	£000	**£000**	£000
Establishment costs	(3)	(3)	**(6)**	(6)
Internal / External audit fee*	(1)	(1)	**(2)**	(2)
Professional fund review	-	-	**-**	(10)
	(4)	**(4)**	**(8)**	(18)

*Independent examination of the accounts cost £480

3.3 Details of costs incurred in raising funds

	Unrestricted Funds	Restricted Funds	**Total 2021**	Total 2020
	£000	£000	**£000**	£000
Purchasing goods for re-sale	-	(98)	**(98)**	(81)
Fund Raising Support	(9)	(13)	**(22)**	-
	(9)	**(111)**	**(120)**	(81)

4 Analysis of total resources expended

	Costs of raising funds	Costs of activities for charitable objectives	**Total 2021**	Total 2020
	£000	£000	**£000**	£000
Internal / External audit fee	-	(2)	**(2)**	(2)
Compliance costs for Trust Funds	-	(6)	**(6)**	(6)
Professional fund review	-	-	**-**	(10)
Fund Raising Support	(22)	-	**(22)**	-
Charitable activities	(98)	(42)	**(140)**	(129)
	(120)	**(50)**	**(170)**	(147)

5 Analysis of income

5.1 Grants received

	Unrestricted Funds	Restricted Funds	**Total 2021**	Total 2020
	£000	£000	**£000**	£000
NHS Charities Together	181	-	**181**	
Other Grants Received	27	-	**27**	-
	208	**-**	**208**	-

5.2 Income from investments

Income from investments of £1k (restricted) 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 £128k income from other trading activities was delivered from the re-sale of goods purchased at a cost of £98k, and training provided that generated £1k income.

6 Changes in resources available for charity use

	Unrestricted Funds	Restricted Funds	**Total 2021**	Total 2020
	£000	£000	**£000**	£000
Net movement in funds for the year before transfers	176	3	**179**	(45)
External transfers	-	-	**-**	57
Net decrease in funds for the year	**176**	**3**	**179**	12

7 Analysis of creditors	Balance at 31 March 2021 £000	Balance at 31 March 2020 £000
Trade creditors	(6)	(11)
Total amounts falling due within one year	**(6)**	**(11)**

8 Details of material funds

8.1 Restricted funds	Balance 1 April 2020 £000	Incoming resources £000	Resources expended £000	**Balance 31 March 2021 £000**	Description of the nature and purpose of each fund
CHIME Fund	49	127	(112)	**64**	To provide funds for the well being of patients within Ridgeway
Allinson Bequest	29	-	(1)	**28**	To provide funds for epilepsy services in the Durham area
Acomb Garth	14	2	(1)	**15**	To provide funds for activities for patients of Acomb Garth
Learning Disabilities	15	-	(1)	**14**	To provide funds for activities for patients with Learning Disabilities in York and Selby
Epilepsy Fund, Bankfields Court	12	-	(1)	**11**	To provide funds for epilepsy services in the Middlesbrough area
Learning Disability Medical Staff	10	-	-	**10**	To provide funds for Patient activities, comforts, diversional equipment
North of Tees MHSOP Charitable Account	10	-	(1)	**9**	To provide funds for Patient activities, comforts, diversional equipment
Others (99 Funds)	159	10	(19)	**150**	
Total	298	139	(136)	**301**	

8.2 Unrestricted funds	Balance 1 April 2020 £000	Incoming resources £000	Resources expended £000	**Balance 31 March 2021 £000**	
Foss Park Fund	57	78	(5)	**130**	To provide general purpose funds for the patients being cared for in Foss Park Hospital
CDDPS General Fund	14	132	(23)	**123**	To provide general purpose funds for the patients being cared for in the Durham area
St Mary's General Fund	13	-	(1)	**12**	To provide general purpose funds for the patients being cared for at St Mary's Hospital
Others (41 Funds)	57	-	(5)	**52**	
Total	**141**	**210**	**(34)**	**317**	

9 Connected organisations

	2020-21		2019-20	
	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	**423,265**	**(16,741)**	385,665	(16,119)

* The deficit for 2020-21 includes expenditure for unanticipated impairments of fixed assets totalling £25,841k. Excluding these non operation items would result in a surplus of £9,100k.

** The deficit for 2019-20 includes expenditure for unanticipated impairments of fixed assets totalling £27,628k. Excluding these non operation items would result in a surplus of £11,509k.

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.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Trust

General Charitable Fund

Fund Number: 1061486

Annual Report 2020-21

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 2020-21

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 Resources Committee receives and examines reports on Charitable Trust Funds at three month intervals. The membership of this committee was:

Mr C S Martin, Chief Executive – left 29 June 2020
Mr B Kilmurray, Chief Executive – started 29 June 2020
Mr P McGahon, Director of Finance and Information – left 5 August 2020
Mr D Kendall, Acting Director of Finance and Information – 5 August 2020 to 19 October 2020
Mrs L Romaniak, Director of Finance and Information – started 19 October 2020
Mrs R Hill, Chief Operating Officer
Mrs S Dexter-Smith, Director of People and Culture – started 15 February 2021
Mrs M Harte, Chairman of the Trust
Mr M Hawthorn, Non-Executive Director – left 31 March 2020
Mr D Jennings, Non-Executive Director – left 31 August 2020
Mr P Murphy, Non-Executive Director
Mr J Maddison, Non-Executive Director – started 1 September 2020

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 Financial Controller has overall responsibility for the administration of the funds, supplying regular reports to the 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:

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 £109k in year due to grants received from NHS Charities Together.

Foss Park Hospital
The purpose of this fund is to benefit the service users of Foss Park Hospital by providing amenities, activities and events. The fund increase by £73k due to grants received (£50k from NHS Charities Together).

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 funds increasing by £15k last year.

Rowan Lea Nurses Fund
This fund is for staff on Rowan Lea ward; the fund increased by £2k due to donations.

West Park Cedar
The purpose of this fund is to provide amenities, activities and events for service users / carers at Cedar Ward. The fund increased by £2k due to donations.

Mulberry Centre Psychology
This fund is to be used for training for staff and to develop existing resources to meet the needs of young people at the Mulberry Centre. This fund decreased by £2k due to expenditure on hand painted murals and Christmas gifts.

5. Review of activities

There was one new fund set up during the year, and one fund closed due to no further funds being available.

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.

6. Financial activity

A full set of accounts for the financial year 2020-21 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 £179k in net resources mainly due to grants received from NHS Charities Together, for which expenditure is ongoing. The overall balance of the funds as at 31 March 2021 was £618k.

Income is derived from grants, donations, legacies, raising funds and investment income. Income from raising funds is 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 2020 to 31 March 2021 total investment income was £1k which was in line with 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 received £208k in grants during the financial year, £181k from NHS Charities Together to support employees and service users during the Covid pandemic. Grants were made available to support the wellbeing of NHS staff, volunteers and patients impacted by

Covid-19 during the pandemic.

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 two bids approved by the Trustee in 2020-21, to develop a therapy garden and to support 10 service users complete a leg of a sailing journey around the UK.

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	£150,076	99	£1,516
Unrestricted	£51,941	41	£1,267

6.2 Incoming resources

Total income for the year was £349k, an increase of £247k on last year. Actual figures were:

	2020-21 £000	**2019-20 £000**
Donations	10	5
Legacies	2	5
Other trading activities	128	91
Income from investments	1	1
Grants received	208	0
Total	**349**	**102**

See Appendix 1 for chart showing the split of income sources.

6.3 Material donations and legacies

The Charitable Fund received legacies totalling £2k in 2020-21, and received donations of £10k to various funds.

6.4 Resources expended

Expenditure for the year was £170k, an increase of £23k when compared with £147k spent in the previous year. Analysis of Expenditure:

	2020-21 £000	**2019-20 £000**
Purchasing goods for resale	98	81
Patients' welfare	22	34
Staff welfare	20	14
Fund raising support	22	0
Governance costs	8	18
Total	**170**	**147**

Expenditure has increased from the previous financial year, mainly due to increased trading activities within the Ridgeway café / shop, and LD Forensic Day Services. Fund raising support was also commissioned during the financial year.

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, fund raising support and the Trust cost of administering the funds. Charity Commission guidelines state that if a charity does not exceed £250k gross income in a financial year or 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 Charitable Funds (e.g. in excess of £5k) in 2020-21 from any single fund. Expenditure on fund raising support of £22k was apportioned based on individual fund balances.

6.7 Going concern

The funds activities, together with the factors likely to affect its future development, performance and position are set out in the annual accounts on pages 3-9.

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 accruals and creditors as disclosed in the balance sheet which reports £6k of debt compared to £622k of cash in hand.

The return on deposit account investments 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 £317k; as this is not material in comparison with the Trust's turnover of £423,961k 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 Yorkshire Bank PLC at an agreed interest of 0.15%, with a minimal balance in a lower interest bearing account at Barclays Bank PLC.

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 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:
Mrs M Harte (Chairman)
Mr D Jennings – left 31 August 2020
Mr R Simpson – left 31 August 2020
Mr H Griffiths
Mr P Murphy
Mrs Shirley Richardson
Prof. Pali Hungin
Mrs Beverley Reilly
Mr John Maddison

Executive directors
Mr C S Martin – left 29 June 2020
Mr B Kilmurray – started 29 June 2020
Dr A Khouja
Mrs Ruth Hill
Mrs E Moody
Mr P McGahon – left 5 August 2020
Mr D Kendall – started 5 August 2020, left 19 October 2020
Mrs L Romaniak – started 19 October 2020

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

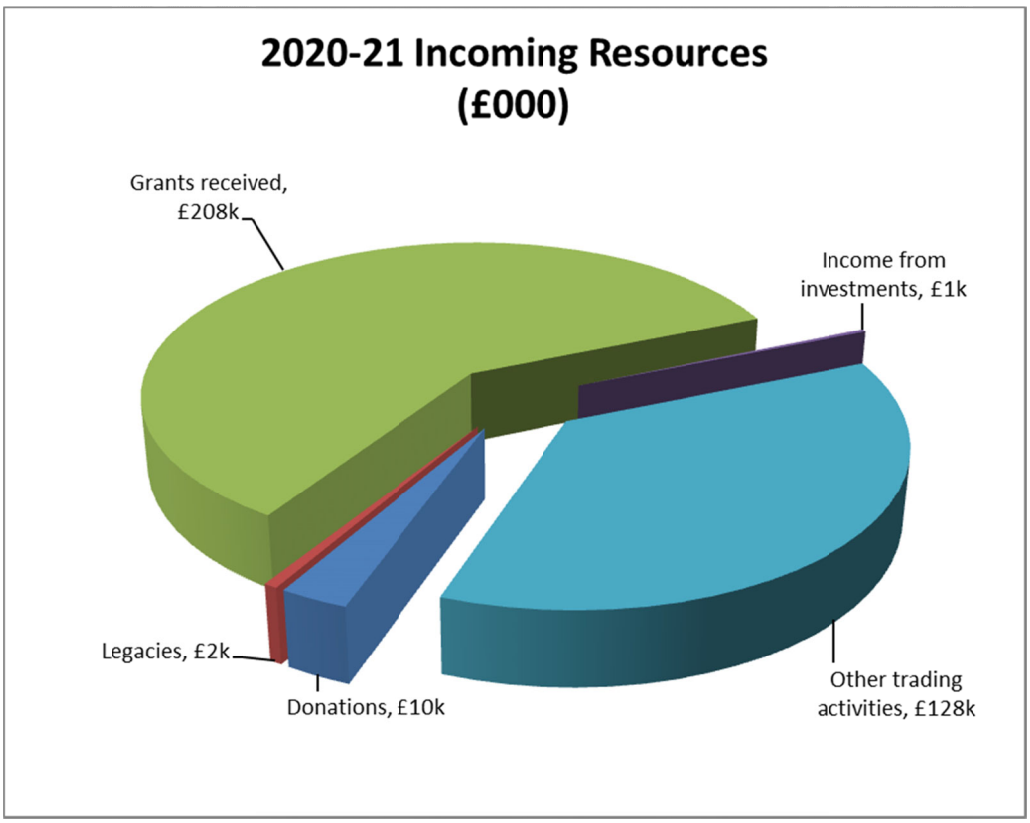
Legal advisors
Ward Hadaway
Sandgate House
102 Quayside
Newcastle upon Tyne
NE1 3DX

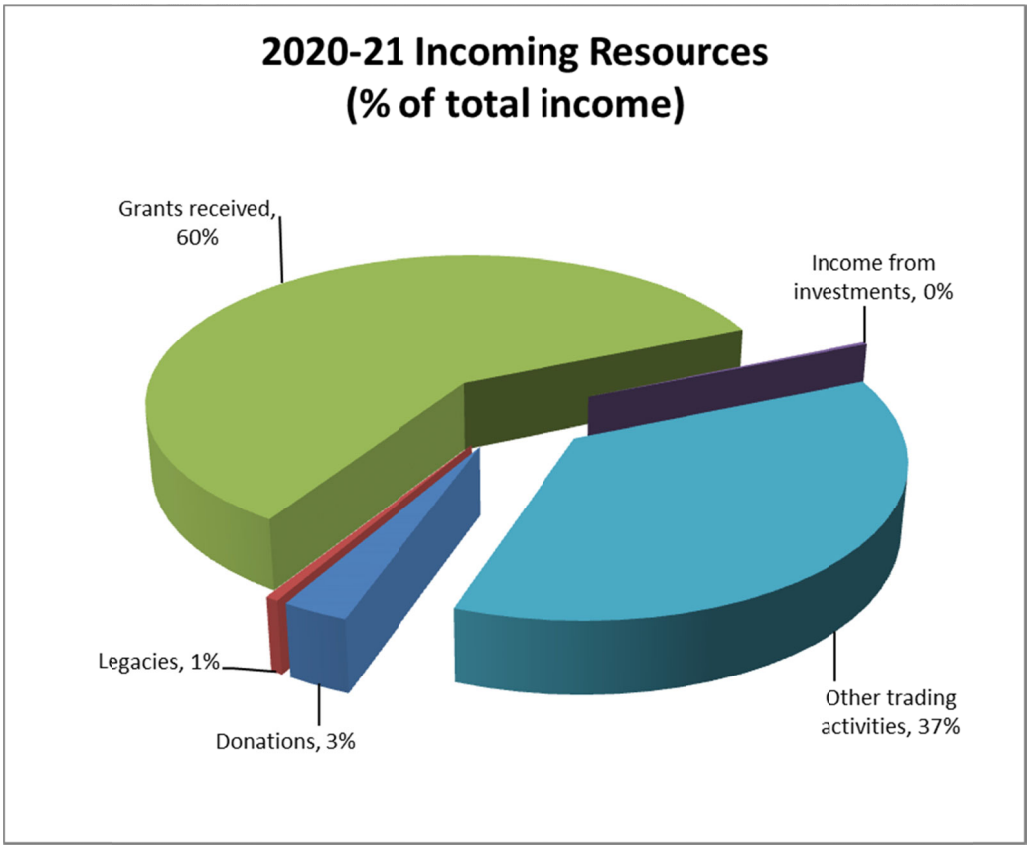
Bankers

Yorkshire Bank PLC
7 Linthorpe Road
Middlesbrough
TS1 1RF

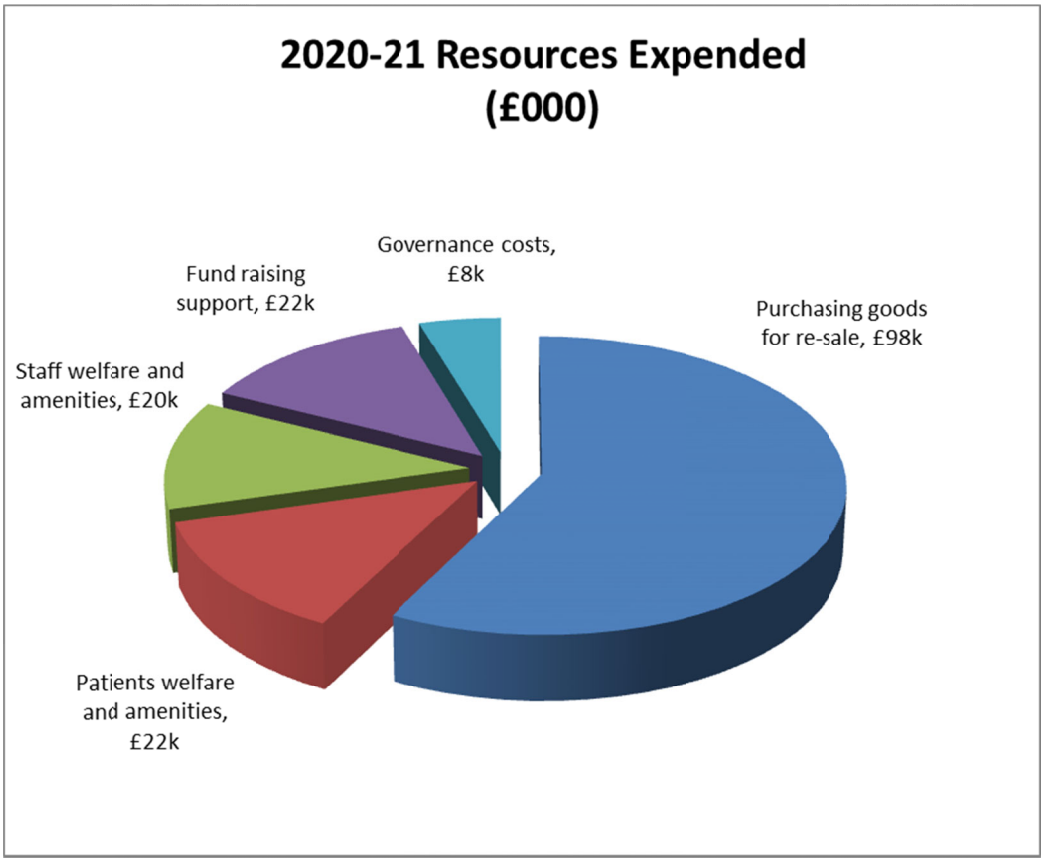
Barclays Commercial Bank
PO Box 190, 2 Floor,
1 Park Row,
Leeds, LS1 5WU

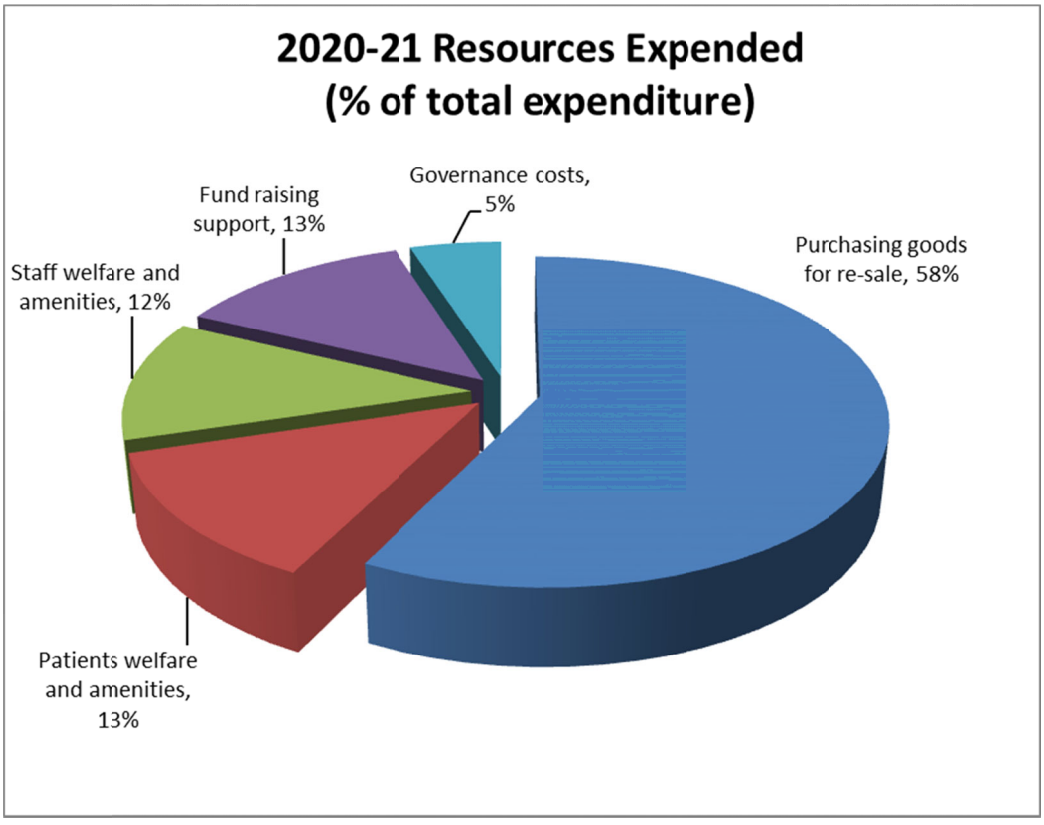
Analysis of incoming resources **Appendix 1**





Analysis of resources expended **Appendix 2**





Summary Report of Findings

Tees, Esk and Wear Valleys NHS Trust General Charitable Fund

Year ending 31 March 2021

mazars

Contents

1. SUMMARY REPORT

Purpose of this report

This document is to report the findings from our Independent Examination of Tees, Esk and Wear Valleys NHS Trust General Charitable Fund (the Charity) for the year ended 31 March 2021. It is addressed to Tees, Esk and Wear Valleys NHS Foundation Trust (the Trust) as corporate trustee of the Charity.

Our work has been undertaken in line with our Engagement Pack dated 1 December 2020, which we previously agreed with the Trust.

Our work is not an audit of the Charity's statements, and as such our work is limited to the procedures for Independent Examiners set down by the Charity Commission.

Status of our work and overall findings

At the time of issuing this report, we:

- anticipate issuing a standard unmodified independent examiner's report; and
- have not identified any significant matters from our independent examination of the Charity's financial statements for the year ended 31 March 2021 which we need to bring to the Trust's attention.

Our review identified a small number of minor issues for which management has amended the Financial Statements/Annual Report:

- The split of expenditure on the face of the SOFA between 'Raising funds' and 'Charitable Activities' and the analysis of expenditure in Notes 3.1, 3.2, 3.3 and 4 was not consistent with the ledger and supporting workings. The following amendments were made:
  - Expenditure on Raising funds amended from £98k to £120k; Unrestricted funds from £nil to £9k and Restricted funds from £98k to £111k; and
  - Expenditure on Charitable activities amended from £72k to £50k; Unrestricted funds from £34k to £25k and Restricted funds from £38k to £25k

We also identified a small number of minor consistency, presentation and disclosure matters, all of which management has agreed to amend.

Fees

Our fees are in line with those set out in our engagement pack dated 1 December 2020, being £400 plus VAT.

APPENDIX: DRAFT INDEPENDENT EXAMINER'S 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 2021, 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 trustee 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 trustee 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: Cameron Waddell (CPFA) for and on behalf of Mazars LLP
Relevant professional qualification or body: CPFA
Address: The Corner, Bank Chambers, 26 Mosley Street, Newcastle upon Tyne, NE1 1DF
Date: xx xxx 2021

CONTACT

Cameron Waddell

Partner

Phone: 0191 383 6314

Mobile: 07813 752053

Email: cameron.waddell@mazars.co.uk

Joanne Greener

Manager

Phone: 0191 383 6353

Mobile: 07881 252444

Email: joanne.greener@mazars.co.uk

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 21

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th October 2021**
TITLE:	**Appointment of the Non-Executive Chairs and Members of Committees of the Board of Directors**
REPORT OF:	**Paul Murphy, Interim Chair**
REPORT FOR:	**Decision**

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

Report:

The appointment of the Chairs and Members of the Board's committees is a reserved matter under Standing Order 6.7.

The appointments have been reviewed in response to the approval of new committee structure, and the related terms of reference, earlier in the year.

The Board is asked to approve the appointments as set out in Annex 1 to this report.

In doing so, the Board is also asked to agree the following matters:

- That Associate Non-Executive Directors should be granted full voting rights when appointed as members of the Board's committees.

  Board Members will be aware that consideration is being given to the appointment of up to two Associate Non-Executive Directors to bolster capacity on the Board. Under Standing Order 6.7 they will need to be granted voting rights (when attending meetings as either full or deputy members) in order for the committees to operate effectively.

- That the terms of reference of the Strategy and Resources Committee should be amended to increase the number of seats for Non-Executive Directors to two.

  On reflection, there are considered to be benefits, in terms of maintaining continuity and expertise and supporting sustainability, for the Non-Executive Director membership of the Committee to be increased.

Recommendations:

The Board is asked to:

(1) Agree that the terms of reference of the Strategy and Resources Committee be amended to increase the number of seats for Non-Executive Directors to two (excluding the Chair).

(2) Agree that Associate Non-Executive Directors, appointed as members of the Board's committees, be granted full voting rights.

(3)	Approve the appointments to the Board's committees as set out in Annex 1 to this report.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Non-Executive Director/Associate Non-Executive Director Committee Membership from 1st November 2021

	Audit & Risk Committee	Commissioning Committee	Mental Health Legislation Committee	Quality Assurance Committee	People Culture & Diversity Committee	Strategy & Resources Committee	West Lane Project Committee
Number of Non-Executive Director seats	*Cttee Chair plus 2 NEDs*	*Cttee Chair plus 1 NED*	*Cttee Chair plus 1 NED*	*Cttee Chair plus 2 NEDs*	*Cttee Chair plus 1 NED*	*Cttee Chair plus 2 NEDs*	*Cttee Chair plus 1 NED*
Paul Murphy						**Chair**	
Charlotte Carpenter	✓					✓	
Jill Haley		✓			✓		
Prof. Pali Hungin			**Chair**	✓			
John Maddison	**Chair**	**Chair**				✓	✓
Bev Reilly			✓	**Chair**			
Shirley Richardson				✓	**Chair**		**Chair**
Assoc NED 1	✓						
Assoc NED 2							

(Note: All Non-Executive Directors are members of the Board Nomination and Remuneration Committee)

ITEM NO. 22

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th October 2021**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Company Secretary**
REPORT FOR:	**Information**

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

Report:

The Board is asked to note the use of the Trust seal, as set out in Annex 1 to this report, in accordance with standing order 15.6.

Recommendations:

The Board is asked to receive and note this report.

Annex 1

Seals Register - Extract

Ref.	Date	Document	Sealing Officers
404	28.07.21	Licence for alterations (minor works) relating to Woodside Resource Centre, Cavendish Road, Middlesbrough	Liz Romaniak, Director of Finance and Information Phil Bellas, Trust Secretary
405	28.07.21	Lease relating to the Hartlepool Centre for Independent Living, Burbank Street Hartlepool	Liz Romaniak, Director of Finance and Information Phil Bellas, Trust Secretary
406	28.07.21	Deed of Variation of restaurant and hospitality services agreement relating to Roseberry Park Hospital, Middlesbrough	Liz Romaniak, Director of Finance and Information Phil Bellas, Trust Secretary
407	28.07.21	TR1 form in relation to land on the east side of Beckwith Head Road, Beckwith, Harrogate	Liz Romaniak, Director of Finance and Information Phil Bellas, Trust Secretary
408	28.07.21	Overage Deed relating to land on the east side of Beckwith Head Road, Beckwith, Harrogate	Liz Romaniak, Director of Finance and Information Phil Bellas, Trust Secretary
409	07.09.21	Settlement Agreement	Brent Kilmurray, Chief Executive Phil Bellas, Trust Secretary
410	30.9.21	Lease relating to part of St Margaret's House, Crossgate, Durham	Brent Kilmurray, Chief Executive Phil Bellas, Trust Secretary
410	30.9.21	Licence to underlet relating to part of St Margaret's House, Crossgate, Durham	Brent Kilmurray, Chief Executive Phil Bellas, Trust Secretary