MEETING OF THE BOARD OF DIRECTORS
Thursday 31st March 2022
at 1.00 p.m.

The meeting will be held via MS Teams

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

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

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

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

The timings provided in the agenda are indicative only.

AGENDA

Standard Items (1.00 pm – 1.15 pm):

1	Apologies.	**Chair**	**-**
2	Chair's welcome and introduction.	**Chair**	**Verbal**
3	To approve the minutes of the last meeting held on 24th February 2022.	**-**	**Draft Minutes**
4	To receive any declarations of interest.	**-**	**Verbal**
5	Board Action Log.	**-**	**Attached**
6	Chair's Report.	**Chair**	**Verbal**
7	To note any matters raised by Governors.	**Board**	**Verbal**

Strategic Items (1.15 pm – 1.45 pm):

8	Chief Executive's Report.	**CEO**	**Report**

9	To consider the report of the Chair of the Audit and Risk Committee.	**Committee Chair (JM)**	**Committee Key Issues Report**
10	To consider the Finance Report as at 28th February 2022.	**DoF&I**	**Report**
11	To consider the Performance Dashboard Report as at 28th February 2022.	**ACEO**	**Report**

Goal 1: To Co-create a Great Experience for our Patients, Carers and Families (1.45 pm – 1.55 pm):

12	To consider the report of the Acting Chair of the Quality Assurance Committee	**Acting Committee Chair (SR)**	**Committee Key Issues Report**

Goal 2: To Co-create a Great Experience for our Colleagues (1.55 pm – 2.20 pm):

13	To consider the report of the Chair of the People, Culture and Diversity Committee.	**Committee Chair (SR)**	**Committee Key Issues Report**
14	To consider a report on the outcome of the establishment reviews.	**DoN&G**	**Report**

Governance (2.20 pm – 2.35 pm):

15	On the recommendation of the Council of Governors to consider amendments to the Trust's Constitution in regard to the classes of the Staff Constituency and the composition of the Council of Governors.	**Chair**	**Report**
16	On the recommendation of the Audit and Risk Committee to approve the revised Standing Financial Instructions.	**DoFI**	**Report**

Matters for Information (2.35 pm – 2.40 pm):

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

Exclusion of the Public (2.40 pm):

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

Paul Murphy
Chair
25th March 2022

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 24 FEBRUARY 2022 COMMENCING AT 1.00 PM via MS Teams

Present:
Mr P Murphy, Interim Chair
Mrs S Richardson, Non-executive Director/Senior Independent Director/Interim Deputy Chair
Dr C Carpenter, Non-executive Director
Ms J Haley, Non-executive Director.
Prof P Hungin, Non-executive Director
Mr J Maddison, Non-executive Director
Mrs B Reilly, Non-executive Director
Mr J Preston, Associate Non-executive Director (Non-voting)
Mr B Kilmurray, Chief Executive
Mrs A Bridges, Director of Corporate Affairs and Involvement (Non-voting)
Mrs E Moody, Director of Nursing and Governance/Deputy Chief Executive
Mrs S Pickering, Assistant Chief Executive (Non-voting)
Mrs L Romaniak, Director of Finance, Information and Estates
Dr S Wright, Interim Medical Director

In Attendance:
Mr P Bellas, Company Secretary
Dr J Boylan, Guardian of Safe Working
Ms L Hughes, Interim Corporate Governance Advisor
Mr D Williams, Freedom to Speak Up Guardian

Observers/Members of the Public
Mr P Scott, Managing Director (Designate)
Ms S Baxter, Public Governor (Redcar and Cleveland)
Ms M Booth, Public Governor (Middlesbrough)
Ms H Griffiths, Public Governor (Harrogate and Wetherby)

22/02/1/196 APOLOGIES

1.1 Apologies were received from Roberta Barker, Associate Non-executive Director and Dr. Sarah Dexter-Smith, Director of People and Culture.

22/02/2/197 CHAIRMAN'S INTRODUCTION

2.1 The Interim Chair welcomed everyone to the meeting.

22/02/3/198 MINUTES OF PREVIOUS MEETING

3.1 **Resolved:** the minutes of the previous meeting held on 27 January 2022 were approved as a correct record and agreed to be signed by the Chairman.

22/02/4/199 DECLARATIONS OF INTEREST

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

22/02/5/200 PUBLIC BOARD ACTION LOG

5.1 It was noted that there was one open action on the Action Log (222/01/09/185/9.1.6.1); the ICO Audit report was on track to be presented to the next Strategy and Resource Sub-Committee and the Audit and Risk Sub-Committee meetings. It was agreed to leave this action on the log until completed.

22/02/6/201 CHAIRMAN'S REPORT

6.1 The Interim Chair reported on activities since the last meeting, drawing reference to the following of note:

6.2 There had been a total of four Locality Governor meetings; he had chaired two and Shirley Richardson had chaired two. The Governors had found the meetings informative to gain an understanding of local issues in the areas they represent.

6.2 A useful briefing from the Director of HR at Merseycare on their approach to a restorative just culture.

6.3 His Secure Inpatient Services ward visit at Roseberry Park had enabled him to spend time on the wards with patients and staff, with a second visit planned to take place during week commencing 28 February 2022.

6.4 The Interim Chair and Shirley Richardson had attended a Community Hub, PACT House, in Stanley, which was recommended to them by a local MP. The Community Hub is run by local heroes and supports people who have experience of domestic violence, mental health, alcohol issues, etc. The service is independent from the NHS and the Trust and a most valuable support to the community it serves. The Trust is keen to form connections with such services within its locality areas.

6.5 Bev Reilly, Non-executive Director, queried if it would be beneficial for Non-executive Directors to support Locality Governor meetings going forward. The Interim Chair welcomed this suggestion and explained there would be an open invitation for all Board members to attend future meetings.

6.6 **Resolved:** the Interim Chair's verbal report was noted.

22/02/07/202 MATTERS RAISED BY GOVERNORS

7.1 The Interim Chair provided an update on the briefing meeting held with Governors prior to the Board meeting that day. He explained that Governors had expressed their disappointment with regards to the negative publicity in a recent Teesside Live/Gazette Live article, but he had pointed out that the article did contain balancing comments from the Trust.

7.2 Some Governors had requested that Council of Governor meetings continue to be held via MS Teams; others preferred face-to-face. The Interim Chair explained that consideration would be given to the future arrangements for Council of Governor and Board of Director meetings, including the feasibility of a balance of face to face and MS Teams meetings.

7.3 **Resolved:** Matters raised by Governors were received and noted.

22/02/08/203 CHIEF EXECUTIVE'S REPORT

8.1 The Chief Executive's Report was received and noted with reference drawn to the following matters:

8.1.1 Since the Trust received the Care Quality Commission's (CQC) Section 29A Warning Notice on 6 August 2021 considerable progress had been made to deliver the improvement plans across Secure Inpatient Services and Community CAHMS to address the CQC's concerns. Progress had continued to be monitored by the Quality Improvement Board and the NHS England and Improvement Quality Board. The Trust continued to liaise with the CQC and a further meeting is scheduled to take place on 9 March 2022.

8.1.1.2 The Chief Executive explained that progress is being made within Forensic services with several internal investigations taking place.

8.1.2 North Yorkshire and York Children's Emotional Health Summit - the Trust assisted the gathering of key professionals involved in the leadership of children's mental health and care services on 14 February 2022. The Summit was very well attended, and it was pleasing to see there were representatives from primary care, education, and the voluntary and community sector. There was strong support to ensure earlier intervention for children and families to access multi-agency support, which should be available to them based on needs. There was also agreement that there needs to be an improved offer to children across all stages of the pathway, which should include accessing tier four inpatient services and secure social care settings.

8.1.2.1 In addition to the progress made at the Summit discussions have also taken place to extend this offer for children's services across County Durham and the Tees Valley areas.

8.1.3 Covid PPE arrangements continued within the Trust's premises, which is standard across the NHS and anticipated to be in place for the foreseeable future. Work continues with clinical teams to address the continued clinical activity pressures experienced with high bed occupancy and referrals and waiting list pressures. There was a noted improvement with staff absences with sickness absences less than 8% (7.85% as of 16 February 2022).

8.1.4 Vaccinations and Vaccination as a Condition of Deployment – since the last Board meeting the government has paused the mandatory Covid vaccination legislation, with consultation taking place to repeal this legislation. The Trust had worked hard and compassionately with colleagues through the process to date and will continue to do so to provide support to teams. Colleagues will be encouraged to have the fourth booster, which will be offered and available in the coming months.

8.2 Bev Reilly, Non-executive Director commended the work taking place to improve the offer available across the children's mental health services and asked about the arrangements to provide assurance to the Board on the improvements to these services. In response, the Chief Executive explained that monitoring of Business Plans will provide evidence and assurance on this area of work.

8.3 Bev Reilly, Non-executive Director queried if the additional beds in place had resulted in additional pressure on staff. In response, the Chief Executive explained that due to the pressure in the system the additional beds were required as an interim emergency arrangement and plans are in place to revert to the Trust's original bed base.

8.4 Shirley Richardson, Interim Deputy Chair commended the multi-agency work taking place and queried if this had been shared widely with teams. In response, the Chief Executive explained a joint statement will be produced to share across teams.

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

22/02/9/204 FINANCE REPORT

9.1 Liz Romaniak spoke to the Finance Report as of 31 January 2022, which reflects financial performance within the national financial arrangements supporting the NHS to sustain the Covid pandemic response. Liz Romaniak drew reference to the following of note:

9.1.1 The Trust predicts a year end surplus of £5.9m, which is £0.8m ahead of the planned £5.1m for 2021/22, which reflects the receipt of unplanned income, including the prior year final pay control provisions.

9.1.2 Capital expenditure is £1.8m below plan with one asset sale delayed (with the auction planned to take place during February 2022) and one other asset sale no longer proceeding. The Trust expects to generate £0.2m underspend against the £13.6m allocation but is aware of some uncertainty in relation to the timing and quantum of VAT recovery and assumes that the IT infrastructure supplies are received as planned by the end of March 2022.

9.1.3 Statement of Comprehensive Income - the year-to-date position is an operational surplus of £5.0m, which is £0.5m ahead of the planned £4.5m surplus. This is before £0.5m additional unplanned profit from disposal of fixed assets, which is excluded from assessing NHS provider's financial position.

9.1.4 Cash Balances of £87.8m, which equates to £6.5m ahead of plan.

9.1.5 NHS Improvement Agency Cap had not applied during the Covid pandemic but the Trust's internal monitoring established that this would equate to an equivalent cost cap of £7.0m year to date, which continues to be challenging.

9.1.6 The Use of Resources Risk Rating (UoRR) is impacted by the Covid pandemic with national monitoring suspended. Despite this, the Trust continues to assess the UoRR on planning submissions and actual performance. The Trust's internal assessment of its UoRR is that this has dropped to 3, which has been affected by the increased use of bank and agency staff. The Trust plans to revisit and refresh its controls to develop alternative staff arrangements as the infection rates from the Omicron variant subside.

9.1.7 Within the Integrated Care System (ICS) work continues to understand individual organisation and sub-ICS (place) level impacts for 2022/23 through the finance groups, which are focussing on draft revenue and capital allocations. Contract offers have been received from commissioners in the Tees Valley with contract offers yet to be received from other commissioners. There is significant residual uncertainty regarding Service Development Funding nationally, locally and at organisational level.

9.2 Pali Hungin, Non-executive Director drew reference to the CRES targets and funding allocations querying views on how this will work in 2022/23. In response, Liz Romaniak explained that it has been a different arrangement for services during the Covid pandemic with a disruption to business as usual. During 2022/23 the arrangement will include assessing performance against plan in the ICS through Place through the Integrated Care Board (ICB) arrangements in place, which aims to ensure risk is shared across providers.

9.3 Jules Preston, Associate Non-executive Director queried the contract arrangements when transitioning from CCGs to ICBs. In response, Liz Romaniak explained that contracts will be for the full year, and they will novate from the CCG to the ICB.

9.4 Jules Preston, Associate Non-executive Director referred the number of vacancies and queried if the Trust has plans to recruit additional agency staff to support the additional pressures. In response, Liz Romaniak explained that there has been a concerted effort to fill vacant positions on a permanent and temporary basis and work is under way to market the Trust as a good place to work to attract staff going forward.

9.5 John Maddison, Non-executive Director queried what measures the Trust planned to take to fill the vacant positions in the interim period. In response, Liz Romaniak explained

that arrangements would be made to seek support through the Provider Collaborative arrangement the Trust has with CNTW. She highlighted that CNTW had its own staffing pressures, but arrangements will be explored over the financial position to fill vacancies on a permanent arrangement wherever possible going forward.

9.6 The Interim Chair reminded the Board that unlike other Trusts the Trust had increased its headcount by 800 staff, which impacts on the current position.

9.7 It was noted that the Strategy and Resource Committee had approved the quarter three performance remotely to support the development of the Trust's Business Plan.

9.8 **Resolved:** the Finance Report as of 31 December 2022 was received and noted.

22/02/10/205 PERFORMANCE DASHBOARD

10.1 Sharon Pickering spoke to the Performance Dashboard. It was noted that the sickness absence information included in the report was as of 31 December 2021; the remainder of information was as of 31 January 2022. Reference was drawn to the following of note:

10.1.1 Out of the 21 key performance measures, 11 areas were of concern and had plans in place which being closely monitored. The key concerns remained within quality, activity and workforce with challenges continuing in relation to staff sickness absences. Waiting times continue to be longer than the Trust would like patients to experience and the pressures on inpatient services remained a significant concern. Work is taking place across localities to address bed availability against length of stay and it was noted there had been 11 patients placed outside of the Trust's locality areas.

10.2 Pali Hungin, Non-executive Director queried if there were alternative arrangements in place during OPEL 4 or if the Trust was required to continue to work toward the achievement of performance targets. In response, Sharon Pickering explained that the performance targets had continued but had been adjusted during the Covid pandemic.

10.3 Bev Reilly, Non-executive Director queried reference to the actions in place and impact. In response, Sharon Pickering explained that actions had been put in place and were being monitored and in some instances such as Forensics services the workforce plans were adjusted to take into account the impact on the sickness absence position.

10.4 Jules Preston, Associate Non-executive Director drew reference to the appraisal position and the importance of appraisals to support staff during the Journey for Change. With reference to page 16 of the report, Children's referrals removed, he queried the arrangements in place for those children. In response, Sharon Pickering explained that the Trust carries out the assessment and diagnosis for those children, but their treatment is provided by an alternative provider.

10.5 **Resolved:** the Performance Report as of 31 January 2022 was received and noted.

22/02/11/206 REPORT OF THE QUALITY AND ASSURANCE COMMITTEE CHAIR

11.1 Bev Reilly, Non-executive Director/Chair of the Quality and Assurance Committee spoke to the report following the meeting held on 3 January 2022 with no risks to be escalated to the Board. Reference was drawn to the following of note:

11.1.1 The efforts of staff working in exceptionally pressured circumstances under OPEL 4 were commended with reports still provided to the Committee in the tight turnaround since the previous meeting. Lead Directors of localities were given the opportunity to report by exception to replace the full locality report.

11.1.2 The Committee noted that work was progressing to move to the revised governance structure in April 2022 including the two Care Group Boards, which was seen as a positive move to assist with the streamlining of information and assurance provided to the Committee.

11.1.3 The Chief Executive had provided an update report from the last Quality Improvement Board meeting.

11.1.4 The CQC and NHS England and Improvement Quality Board update was provided. It was agreed that the Committee would receive a copy of the CQC Core Service and Well-led Action for review and scrutiny at its 3 March 2022 meeting.

11.1.5 The delays of taking forward the quarter two and three Quality Account actions were noted, which was because of the redeployment of staff to support front line services as a result of staffing pressures. Work had been deferred to quarter three and four as a result of this, however, the Committee were pleased to note that 64% of actions had been completed or were on track for completion by the target dates.

11.1.6 Positive practice was commended of a nurse who had responded to a CPR incident and had successfully resuscitated a patient following a cardiac arrest on Northdale ward; and the Trust's Community Transformation Report demonstrated collaborative working with five local Healthwatch teams through the use of a survey designed to gain insight into people's experiences of accessing mental health and well-being services.

11.2 The Board thanked Bev Reilly for her update and there were no queries raised.

11.3 **Resolved:** the Report of the Quality and Assurance Committee Chair from the meeting held on 3 January 2022 was received and noted.

22/02/12/207 LEARNING FROM DEATHS REPORT

12.1 Elizabeth Moody spoke to the Learning from Deaths Quarter three report as of 31 December 2022. It was noted that the report set out the approach the Trust is taking towards the identification, categorisation, and investigation of deaths in line with national guidance. Reference was drawn to the mortality dashboard (Appendix 1), which included 2020/21 data for comparison including natural deaths.

12.1.2 During the quarter period 23 deaths were reported on StEIS, 22 in relation to community deaths and one an unexpected in-patient death, which is now known to be related to a physical issue. There had been 15 serious incident reviews completed and discussed at Directors' panels with 12 cases found to have lapses in the care and/or treatment provided. Recurring lapses related to CPA/care planning, risk assessment/harm minimisation, with other lapses due to lack of carer support/engagement, meaningful patient engagement and issues with referrals/triage.

12.1.3 Following the quality improvement event (Improving the Experience of Patients, Families, and Staff during Serious Untoward Incident Reviews) a project plan was put in place with the aim of making improvements that will strengthen and demonstrate how the Trust is capturing, actioning and sharing learning to improve care for service users and their families. This work is being monitored closely and the Trust ensures the regulators are updated on progress. The policy relating to learning from deaths had been reviewed to reflect the improvement work and work continued with the Better Tomorrow Programme.

12.1.4 It was noted that as part of the Co-creation work a Care Planning Event has been arranged to take place on 7 March 2022 with Elizabeth Moody and Dr Ahmed Khouja as the Clinical Sponsors supporting this event.

12.2 Jill Haley, Non-executive Director drew reference to the 15 serious untoward incidents with 12 of those found to have lapses in care and/or treatment provided and queried if this will concern the CQC and if it is anticipated that there will be an improvement made next time when the Board is updated. In response, Elizabeth Moody explained that the themes are complex and multi-factorial. It is expected there will be an improvement monitoring the impact, but she was unable to confirm the outcome of serious untoward incidents reported to the next Board at that time due to the time lag between incidents occurring, the subsequent review and evaluation of the learning being put into practice. Bev Reilly, Non-executive Director and Chair of the Quality Assurance Committee added that improvements should be noted in future, but they may not be within the next quarter.

12.3 **Resolved:** the Learning from Deaths Quarter three report as of 31 December 2022 was noted including the learning points and actions being taken forward.

22/02/13/208 REPORT OF THE MENTAL HEALTH LEGISLATION COMMITTEE CHAIR

13.1 Pali Hungin, Non-executive Director and Chair of the Mental Health Legislation Committee spoke to the report from the meeting held on 17 February 2022, which had been deferred from January 2022 due to staffing pressures. It was noted that the following was agreed to be escalated to the Board:

131.1 Data in relation to Absent Without Leave (AWOL) patients for review of patient safety and quality of care is currently reviewed by the Quality Improvement Board and Quality Assurance Sub-Committee; an update report is planned to be presented to the next Committee meeting in May 2022.

13.1.2 An update has been requested for oversight and assurance on a patient cared for by Durham and Darlington to ensure the Trust is meeting the patient's needs and human rights, whilst in long-term segregation.

13.1.3 Increased challenges to find beds for under 18 year olds were noted and the availability of beds for detained patients also continued to be challenging.

13.1.4 Progress had been made against the CQC Action Plan but the Committee recognised further improvements are still required to be made.

13.1.5 A half-day Committee development session was being explored with the aim of gaining assurance that the Committee is working in accordance with its Terms of Reference and that Mental Health legislation were being applied to each individual patient and that practice is compliant with statutory and regulatory requirements.

13.2 **Resolved:** the Report of the Mental Health Act Legislation Committee Chair from the meeting held on 17 February 2022 was received and noted.

22/02/14/209 FREEDOM TO SPEAK UP GUARDIAN HALF YEARLY REPORT

14.1 Dewi Williams, Freedom to Speak Up Guardian (FTSUG) spoke to the half yearly report to the period ending 31 December 2021. He drew reference to the following of note:

14.1.1 Development work continues to embed the Speaking Up Culture and Barry Speak, Head of the Employee Psychology service/Consultant Clinical Psychologist continues to act as the Deputy FTSUG. The local network continues to meet on a regular basis to share intelligence and offer peer support; and the regional network for FTSUG to meet is held on a quarterly basis. The National Guardians Office continues to offer guidance on best practice through a weekly newsletter; and it was noted that the Trust is working towards relaunching the FTSUG Champions initiative and will encourage a diverse range of staff to volunteer.

14.1.2 The highest reported speaking up concerns were in relation to patient safety, with a reduction of bullying and harassment speaking up concerns noted. A member of staff had raised a patient safety concern direct with NHS England and Improvement instead of taking it forward through the Trust's internal processes. On receipt of the concern, Sarah Dexter-Smith engaged an independent manager to undertake a review resulting in a central point identified to receive FTSU concerns, which also provided feedback to those people who raised concerns on the progress/outcome. Dewi Williams noted the increased time commitment required to support the FTSUG role, which is planned to be discussed further with Sarah Dexter-Smith outside the meeting.

14.1.3 A three-day Quality Improvement event had been held which helped to develop a range of standard processes, a training plan for reviewers, and a revised communication statement.

14.1.4 Jill Haley, Non-executive Director shared her experience of speaking up arrangements within a housing association and queried if there were similar arrangements in place for the FTSUG to meet with managers and/or Executive colleagues monthly. In response, Dewi Williams explained that there is a monthly meeting in place within the Trust and any themes and concerns are shared with teams across the Trust. The Chief Executive added that in addition to the monthly meeting there is additional development taking place within Forensic services to support colleagues speaking up; and there are virtual Coffee Events and Schwartz Rounds, which provide a protective space for staff from all disciplines to share experiences and their vulnerability in a safe space.

14.4 **Resolved:** the Freedom to Speak Up Guardian half yearly report covering the period to 31 December 2021 was received and noted.

22/02/15/210 GUARDIAN OF SAFE WORKING QUARTERLY REPORT

15.1 Jim Boylan spoke to the Guardian of Safe Working quarter three report covering the period to 31 December 2021, which aimed to provide assurance that Junior Doctors are safely rostered and working hours are safe in compliance with Terms and Conditions of Service. He drew reference to the following of note:

15.1.1 Over the reporting period as a result of the Covid pandemic many staff, including Junior Doctors, had seen an increase of sickness leave.

15.1.2 A concern had been received in relation to Lanchester Road Hospital, Durham, which initiated a visit by the Guardian of Safe Working. It was found that the staffing levels within the Crisis Team made it difficult to support the completion of 136 assessments. As a result of this and other concerns raised by Junior Doctors previously regarding Section 136 assessments the Medical Director is carrying out an organisational quality improvement event to obtain baseline data with the aim of developing a Standard Operating Procedure.

15.1.3 Exception reports continued to be received in relation to Non-residential On-call Rotas in Scarborough and Teesside localities. It was noted that these were more of concern in Scarborough where there is pressure amongst medical staff with Guardian fines levied; this is mainly due to a breach of the 5 hour continuous rest rule.

15.1.4 Work continues to review the process for exception reporting with the aim of receiving timely reporting by Junior Doctors.

15.1.5 Plans are in place for the re-provision of On-call accommodation and education facilities for Junior Doctors on the Roseberry Park site, which has the highest number of trainees

in the Trust. It was noted that this is most positive to support Junior Doctors and in the longer term should help to support recruitment and retention.

15.2 Liz Romaniak explained that the Guardian of Safe Working had an open invite to contact her directly with any estates concerns raised by Junior Doctors

15.3 **Resolved:** the Guardian of Safe Working quarterly report to the period ending 31 December 2021 was received and noted.

22/02/16/211 USE OF THE TRUST'S SEAL

16.1 **Resolved:** in accordance with Standing Order 15.6 the Board noted the use of the Trust seal on three occasions since the last Board meeting.

22/02/17/212 CONFIDENTIAL MOTION

17.1 **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 2.45pm.

Paul Murphy
Chair
31 March 2022

Board of Directors

Public Action Log

RAG Ratings:

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

Date	Ref No.	Action	Owner(s)	Timescale	Comments	Status
27/01/22	**22/01/09/185/9.1.6.1**	Agreed that the outcome of the ICO Audit would be presented to the next Strategy and Resource Committee; and the next Audit and Risk Committee. Agreed at the February Board meeting to leave this action open until completed.	Co Sec/DoF	~~March/~~April/May 22	Noted for inclusion on agendas	Open (Consideration by the Audit and Risk Committee deferred until May 2022 due to operational pressures - see agenda item 9)

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 8

PUBLIC

BOARD OF DIRECTORS

DATE:	**Thursday, 31 March 2022**
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 (CQC)

Good progress is being made in the delivery of the Section 29A action plans. To some extent the ability to embed certain aspects of the work has been hampered by the two month period where absences peaked due to Omicron. The team is proud of the progress made however, and there have been "significant improvements" achieved in all of the key areas raised through the CQC's enforcement actions.

Secure Inpatient Services – this continues to be a service under pressure. Staff absences are reducing and we are now relying on fewer bank shifts to deliver the service. The service launched a new model of care on 14 February (attached at Appendix 1) which is designed to embed a sustained improvement in the quality of service, improved engagement of staff leading to a better patient experience.

Key deliverables to note are:

- A review of safety plans and safety summaries and how these are used to optimise patient safety.
- Improvements in safety summary, safety plan and observation and engagement compliance.
- Improved compliance with safeguarding training.
- Implemented SafeCare to ensure we have safe staffing levels.
- Improved flow of patient safety information through revised governance structures.
- Launched a new model of care and model of professional practice (February 2022)
- Recruitment and retention.
- Continuation of the cultural work.
- Reviewed the reduced use of restrictive practices.
- Further work undertaken to embed the use of safety summaries and safety plans.
- Launch of healthcare assistant council (March 2022) .
- Launch of ward manager development programme.
- Improvements in compliance with level 3 safeguarding training, with a safeguarding lead based on site.
- Further work to support e-rostering in the service.

Key impacts to note are:

- Only 3% of leaves were cancelled in January due to staffing.
- Over recruited in some roles such as healthcare assistants.
- No ward manager vacancies.
- 55 staff in offer stage of recruitment.
- Increased to five matrons.
- A reduction in bank staff since Feb 2022.
- A detailed induction programme including autism training now in place (trajectory to reach 95% compliance by end of April).
- OT screening and triaging increased by 50% from January to February.

Community Child and Adolescent Mental Health Services (CAMHS) – Again this is a service under pressure. There has been less concern regarding absence, however more of an issue on recruitment and filling vacancies. The focus on keeping young people safe and their families informed and engaged whilst they wait for treatment is now starting to see positive patient and carer feedback. Work continues on roll out and embedding of the caseload management approach.

Key deliverables to note:

- Reviewed all young people waiting for treatment.
- All young people and/or families waiting are being contacted regularly and in-line with individual risk.

- New system in place for Keeping in Touch processes and ongoing review of potential risk**.**
- Daily monitoring of waiting lists, progress and issues.
- Caseload analysis to 'level load' between teams or clinicians and identify additional resource that may be required.
- Workforce development strategy in development, reviewing alternative roles such as apprenticeships and peer support.
- Trust-wide staffing establishment exercise undertaken.
- Working closely with partners to develop joint working processes that are sustainable.
- Caseload refresh.
- Developed a capacity and demand framework.

Key impacts to note:

- Oversight of every young person waiting.
- Stockton CAMHS caseload reduced by approximately 37%, this model will be rolled out to all teams by September 2022.
- Teesside average wait:
    - 1st appointment - 6 days
    - 2nd appointment - 20 days
- Reduced waiting times for treatment.
- 111 staff in offer stage of recruitment (due to start in post by June 2022).
- Increased training compliance across the teams. Safeguarding and whistleblowing currently at 91% average – 1% from target.

Engagement with the CQC – The team has continued to maintain a positive relationship with the CQC inspection team. On 9 March there was an extended relationship meeting where members of the executive along with senior operational and clinical colleagues presented progress around the S29A and updated on key thematic work including:

- Observations and engagement
- Restrictice practices
- Sexual safety
- Standards of care and safeguarding

The CQC team were unable to pass comment at the meeting, but did say that it had been helpful to have a deeper dive into the work and could see the hard work that had gone on. It will only be through re-inspection that they will be able to fully determine whether the significant progress required has been made. We are aware that the CQC will most likely re-inspect these services by the summer.

Well Led and Core Services action plan – As colleagues will recall the action plan was submitted to the CQC at the end of January. You will note that progress is being reported through the QUAC and risks, issues and exceptional concerns will be

flagged through the QUAC report. The team will periodically bring the full report through confidential board.

Scrutiny – As colleagues are aware following a motion proposing a public inquiry, the Stockton Adult Social Care and Health Select Committee invited the Trust to present progress with our CQC plans on 15 February. The Chairman and I attended with Elspeth Devanney, interim Director of Operations for Teesside and several of our senior clinical and operational colleagues. We were also invited to the Joint Tees Valley Health and Care Scrutiny committee on 18 March. Stockton scrutiny deferred a decision on their motion until after the Joint Scrutiny committee. Stockton councillors met again on 22 March where they supported the motion to write to the Secretary of State requesting a public inquiry.

Vaccinations

The Covid vaccination as a condition of deployment has now been formally revoked. The legal situation is therefore changing around the data that we can ask and hold about staff. We have a couple of months leeway to work this through but are stopping asking new starters about their vaccination status and working with Information Governance and national guidance on what we do collect and how, as part of an employee's contract and how this becomes part of a broader vaccination approach with occupational health. We are also planning on an assumption that there will be annual Covid as well as flu vaccinations on offer and are working up a service model of how we will offer these ourselves rather than relying on external partners. We have been incredibly grateful for partners' support with this but the evidence (from us and other Trusts) is that when we offer this ourselves the uptake is greater.

We have ended this reporting year with 62% flu uptake and 85% Covid vaccine including booster. We think the flu in particular might be an under-representation given that people over 50 were asked to go to external providers for a different vaccination and we were reliant on them telling us about this.

Organisational Structure

The clinical restructure is now largely in place. The Managing Director for NYY&S has been offered following a strong round of applications and interviews for the Medical Director post will take place in early April. The medical posts throughout the structure have now started to be populated and the therapies posts are being interviewed for in the next two weeks. The corporate restructure is well underway with People and Culture appointing their senior tier last week and other services entering interview and other organisational change processes this week following a period of consultation.

The development programme has started with a series of CEO briefings supported by the executives and OD. We are also being supported by Inspiring Leaders Network who will be leading the Care Group Boards through a shadow board type piece of work within the overall development programme. The three tiers will begin

their collective programme at the end of June and individual development needs are being mapped in the meantime with staff attending the self as leader module and values workshops. We are also revisiting the way that the ThinkOn coaching masterclasses are nestled within this programme so that all offers build on each other.

Well-Led (GGI) Implementation Plan/Board Development Programme

These two key pieces of improvement work are reaching their conclusion.

As Board Members are aware all the substantive workshops under the Board Development Programme have now been delivered by Deloitte LLP. Board and Committee effectiveness surveys will now be undertaken to inform the final workshop in May on future development opportunities. The Executive Directors have also held discussions on Board and Committee reporting to support the provision and consideration of assurance, and a broader training programme for staff is planned.

A report on the Implementation Plan is due to be considered in the private session. The Board is being asked to consider the closure of the Plan in view of the good progress made on its delivery. Monitoring of the CQC Action Plan will enable oversight to be maintained on relevant ongoing work.

Secure Inpatient Services Model of Care

2021 - 2023

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Service mission statement: *To help people to lead safer, healthier, meaningful and hopeful lives*

Professional excellence

Compassion focused trauma informed care

- Open to the reality of suffering and aspire to its healing
- Curious and responsive to the impact of childhood and adult adversity on mental health

Safety, stabilisation & containment

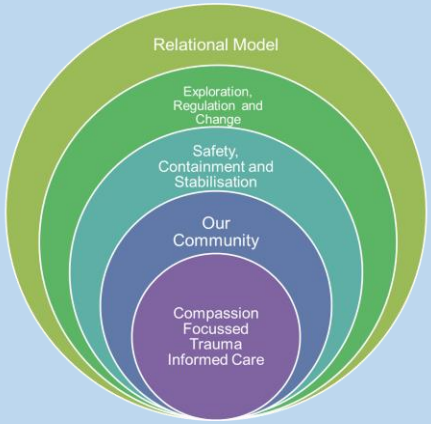
- Provide a common pathway for intervention across all services, ensuring continuity and consolidation of skills for service users.

Exploration, regulation and change

- Evidence based care and availability of consistent, boundaried and nonjudgmental support.

Avoidable harm

- Preventing harm by ensuring proportionate and patient-centered care planning



Our community–collective leadership

Shared governance

- Staff have collective ownership to improve practice; placing staff at the centre of decision making

Empowerment

- Inclusivity and diversity - your voice is heard
- Psychological contract

Professional councils

- Staff led forums, enabling collective leadership

Investing in our people

Education

- All staff can reach their full potential

Innovation and Service Improvement

- Designing workforce models around patient need

Research and Development

- Supporting staff at all levels to be curious

Wellbeing and Resilience

- Looking after you & helping you when you need it

Safe staffing

- Optimising skill mix and establishments to deliver excellent care

Improved patient outcomes & experience and a highly motivated workforce who have the competence and confidence to work with complexity and feel valued and respected

Ward Accreditation

Committee Key Issues Report

Report Date: 31 March 2022		**Report of: The Audit and Risk Committee**
Date of last meeting: 17 March 2022		**Membership Numbers: 4** Quoracy met -100%
1	**Agenda**	The Committee considered the following matters: ▪ Reports on the Corporate Risk Register (CRR) and the development of the Board Assurance Framework (BAF). ▪ The Quality Assurance Programme for 2022/23 and resources available for its delivery. ▪ An update on improvements to Freedom to Speak Up processes. ▪ A progress report on the delivery of Internal Audit recommendations to improve clinical waste management. ▪ A Counter Fraud Progress Report. ▪ An Internal Audit Progress Report and the draft Annual Report and Head of Internal Audit's Annual Opinion (HoIAO). ▪ Arrangements for the 2021/22 Trust Audit including the refreshed three-year External Audit Strategy; the External Audit Strategy Memorandum; the External/Internal Audit Protocol for Liaison; and the TCWG request. ▪ The draft Going Concern Statement. ▪ Revisions to Standing Financial Instructions. ▪ Losses and Special Payments for Write-off. ▪ The fees for External Audit services for the 2021/22 and 2022/23 audits. ▪ Future meeting arrangements taking into account the published submission dates for the Annual Report and Accounts.
2a	**Alert**	The Board is alerted to the following matters discussed at the meeting: ▪ The number of outstanding counter fraud recommendations that have not been implemented by their due dates. The Committee will be seeking explanations from managers if they do not provide updates to the LCFS. ▪ Potential risks to the delivery of a robust HoIAO. Delays to the completion of ongoing work are continuing caused by late responses to requests for supporting evidence during audit testing and to requests for initial meetings to commence audits. The Chair has asked to be notified if issues arise with the completion of planned audit assignments. ▪ Disappointment that the report on the CRR did not, as previously requested at the January meeting, reflect the role of the Committee in gaining assurance on the adequacy and robustness of risk management processes. The Company Secretary has been asked to convene a meeting involving members of the Committee and the Director of Quality Governance to consider the assurances required from future reporting. ▪ The need for further assurance that the Quality Assurance Programme for 2022/23, as well as mandatory audits, also covers key areas of risk.
2b	**Assurance**	The Committee wishes to draw the following positive assurances to the attention of the Board: ▪ The arrangements for the 2021/22 Trust Audit recognising that there are no identified threats to the independence and objectivity of the External Auditors and robust arrangements are in place for liaison between the External and Internal Auditors. ▪ The direction of travel on the development of Board Assurance Framework. ▪ The significant work being undertaken to improve Freedom to Speak Up processes. ▪ The action being taken to improve clinical waste management processes following the limited assurance report provided by Internal Audit, subject to the completion of the audit recommendations.

		▪ The report from the Internal Auditors that no issues have been identified from their completed work, or work in progress, that would significantly impact on the HoIAO (subject to the risks identified in section 2a above). ▪ The changes proposed to Standing Financial Instructions to reflect the new operational and governance arrangements and to improve compliance with procurement regulations. ▪ Notwithstanding the absence of national financial allocations, there is sufficient assurance for the Board to agree that the Trust should be considered as a 'going concern' and that the annual accounts should be prepared on that basis.		

2c	**Advise**	The Committee wishes to advise Members of the Board that:
		▪ The planned update on the position on patient property, money and valuables and the report on the findings of the recent audit conducted by the Information Commissioners Office (in accordance with Board minute 22/01/09/185/9.1.6.1) have been deferred to its next meeting, due to current operational pressures.
		▪ In regard to External Audit:
		  ▪ Gavin Barker has replaced Cameron Waddell as the Mazars LLP's Engagement Lead with the Trust.
		  ▪ A Quality Report is not required by NHS E/I for 2021/22; however, a Quality Account, which is not subject to audit, will need to be prepared and submitted.
		  ▪ There are no material changes to the key audit risks to be reviewed by the External Auditors.
		  ▪ Arrangements to respond to the TCWG request from the External Auditors have been agreed.
		▪ Reports will be sought from the Chairs of the Board's Committees to provide assurance on the extent that they have met their terms of reference and that clear work plans, aligned to the BAF, are in place.
		▪ Impaired receivables in the sum of £104k have been written off for 2021/22 as there is no reasonable prospect of recovery.
		▪ The planned TRA audit, LAN Refresh, has been deferred to Q3, 2022/23 due to slippage on the project which is outside the Trust's control.
		▪ Updates will be sought, either directly or through the People Culture and Diversity Committee, on the implementation and embedding of the revised Freedom to Speak Up processes.
		▪ Arrangements for the meetings of the Committee are being changed following receipt of the submission dates for Annual Report and Accounts. It is also likely that a Special Board meeting will be required in mid-June to align with the reporting requirements.
		▪ The External Audit fees for 2021/22 were agreed and the increases for 2022/23 were noted.		

2d	**Review of Risks**	The role of the Committee is not to scrutinise individual risks but to gain assurance that risk management processes are operating effectively. Further and ongoing assurance is required on the development of the Trust's risks management processes, with the implementation of the new governance arrangements, and reports will be scheduled A risk to the provision of a robust HoIAO has been identified and will be kept under review.		
3	**Actions to be considered by the Board**	Following consideration at the meeting the Board is asked to approve: ▪ The revised Standing Financial Instructions (see agenda item 16) ▪ That the Trust should be classed as a 'going concern' and the annual accounts should be prepared on that basis (see private agenda item 8)		
4	**Report compiled by**	*John Maddison, Chair of Committee* *Phil Bellas, Company Secretary*	**Minutes available from**	*Angela Grant* *Senior Administrator*

Tees, Esk and Wear Valleys
NHS Foundation Trust

Item 10

PUBLIC
BOARD OF DIRECTORS

DATE:	**31st March 2022**
TITLE:	**Month 11 Finance Report - 1 April to 28 February 2022**
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 11 report reflects performance within the context of national financial arrangements supporting the NHS Coronavirus Pandemic response.

The Trust submitted a plan to deliver a surplus of £47k for the second 6 months of 2021/22 (H2), and a composite annual surplus of £5.1m when added to confirmed performance for the first 6 months of the year. The Trust projects a 2021/22 probable case surplus of £5.9m, or £0.8m ahead of plan. This reflects receipt of unplanned income, including national funding for prior year Final Pay Control costs.

- **Statement of Comprehensive Income:** The year to date position is an operational surplus of £4.9m, which is £0.3m ahead of the planned £4.6m surplus. This is before £0.5m additional unplanned profit from the disposal of fixed assets, which is excluded in assessing NHS provider financial performance.
- **Capital Programme:** 2021/22 capital requirements were prioritised to set a programme that was affordable within the Trust's £13.6m capital allocation. Schemes were impact assessed to inform the final plan. Expenditure is £1.8m below plan at Month 11, but adjusting for disposal impacts, net expenditure is £0.8m below plan. No further disposals are anticipated this year. The Trust's Month 11 reports and returns reflect an outturn of £0.9m above the Trust's £13.6m plan and reflect ongoing liaison on VAT recovery via HMRC (and passported via the Trust's construction partner) beyond 31st March. It assumes that IT infrastructure supplies are receipted as planned. Full recovery was confirmed after Month 11 close, giving a favourable variance to plan. Regional colleagues have been alerted and an upside will be reported at month 12.
- **Cash Balances** are £93.5m, or £13.7m ahead of plan, with details in section 3.7.

2022/23 planning work continues below Integrated Care System (ICS) level to develop draft (March) and final (April) organisation and 'place' level financial plans, using indicative revenue and capital envelopes. National arrangements are targeted to support the NHS to navigate a phased return, or 'glidepath', towards capitation-based revenue allocations. Final plans are due for submission in April 2022. A draft financial plan update is being discussed in the Private session of the Trust Board.

Recommendations:

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

1. INTRODUCTION & PURPOSE:

This report sets out the financial position for month 11 of 2021/22; 1st April to 28th February 2022 against a planned surplus for the period of £4.6m.

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 block funding mechanisms have continued throughout 2021/22, supporting the NHS in responding to the Covid-19 pandemic. The Trust supported the submission of high-level systems plans that would deliver a H1 surplus of £4.7m for the Trust and to deliver a breakeven plan for the Tees Valley 'place' and wider North East and North Cumbria Integrated Care System (NENC ICS). The Trust delivered a surplus of £5,441k for the period April to September 2021 (H1). When adjusted to remove profits from fixed asset disposals of £420k, this gave a £5,021k surplus and surpassed the H1 operational plan by £301k.

2.4 The Trust submitted its financial plan in November with an anticipated surplus position of £47k for H2. This gave a composite (H1 plus H2) planned surplus of £5,068k for the financial year. Included within this plan is a national efficiency requirement of £1.8m.

2.5 Month end processes now include system partner consideration of best, probable, and worst-case forecasts. The level of variability between best and worst case in aggregate means we have informally considered the collective ICS and Place probable case outturn forecasts.

Ongoing iterative run rate, balance sheet and forecast reviews suggest a current Trust probable case forecast that is £0.8m ahead of our planned surplus of £5.1m, i.e., a full year £5.9m surplus. This deteriorated at Month 10 due to increased rostered staffing costs and independent sector bed utilisation.

Variability in the forecast is reducing as the Trust's more significant end of year accounting issues relating to annual leave accruals, provisions, and central guidance (including on Spending Review /other income) crystallise.

The surplus arises due to:

- Unplanned income and anomalies in planned nationally block income arrangements (based on higher 2019/20 outturn values);

- Changes in the national approach of charging providers for Final Pay Control via NHS Pensions (generating the reimbursement of prior year liabilities); offset by
- Independent Sector bed costs and shift incentive payments linked to inpatient staffing pressures.

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

2.7 Operational planning guidance for 2022/23 was issued on 24th December 2021, followed by supporting technical guidance in various tranches after 14th January 2022. Indicative contract envelopes (ICE) and agreement on income allocations continued to be pursued during February and into March, with some challenges due to cross-ICS funding flows and varying system timetables. The impact was that, at draft submission stage, there was residual uncertainty around levels of service development and new investment funding available in 2022/23. Commissioner income assumptions in aggregate were finalised in mid-March, leaving financial planning activities compressed around a reduced planning window before final plan submission in April.

2.8 Detailed draft organisation plans, reflected in 'place' and ICS level plans, were submitted on 17th March 2022. The focus now is working through confirmed funding envelopes to agree final plan assumptions that support a final ICS plan submission on 28th April. Key activities include:

- Agreeing key workforce assumptions, including inpatient and community staffing.
- Assessing options for cash releasing efficiencies, including medical and inpatient rostered agency staffing alternatives and rate reductions.
- Commissioner discussions on individual high-cost packages of care and pressures on collaborative arrangements.
- Review of prioritised planned discretionary expenditure and non-recurrent run rate variation.
- Place and ICS-level discussions to ensure consistency of approach and key common assumptions.

3.1 <u>Key Performance Indicators (KPIs)</u>

Appendix 1 provides a summary of KPIs for the year to date.

3.2 <u>Statement of Comprehensive Income – Year to date</u>

The year to date position is a surplus of £4.9m, which is £0.3m ahead of plan. This excludes £0.5m unplanned profit from fixed asset disposals, which is excluded when assessing NHS provider financial performance, and is therefore

included as a 'below the line' adjustment at Table 1. Performance is summarised in table 1:

Table 1

	Year to Date			Last Month	Forecast		
	Plan	Actual	Variance	Variance	Annual Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000
Income From Activities	359,904	370,310	-10,406	-8,599	407,495	416,254	-8,759
Other Operating Income	18,036	19,818	-1,781	-670	19,699	19,763	-64
Total Income	**377,940**	**390,127**	**-12,187**	**-9,268**	**427,194**	**436,017**	**-8,823**
Employee Operating Expenses	-301,074	-308,008	6,934	6,400	-343,543	-348,141	4,599
Operating Expenses Excluding Employee Expenses	-68,586	-73,293	4,708	2,095	-74,558	-77,651	3,093
Non Operating Expenses	-3,671	-3,929	257	243	-4,024	-4,324	300
Surplus / (Deficit)	**4,609**	**4,897**	**-288**	**-531**	**5,069**	**5,901**	**-832**
Profit on sale of Assets	0	509	-509	-509	420	509	-89
Surplus / (Deficit) incl adjustments	**4,609**	**5,406**	**-797**	**-1,040**	**5,489**	**6,410**	**-921**

Income from patient care activities was £8.6m higher than plan due to additional income, including for Mental Health spending review allocations, to support investment by the Trust in adult acute inpatient ward staffing, and from National pay award funding (£4.2m) where allocations were clarified after plan submission. The Trust discussed additional Mental Health income with Partnership Boards and Commissioners, with a focus on progressing external (including Voluntary and Community Sector) schemes to alleviate capacity and winter pressures.

Other operating income is £0.7m above plan due to salary recharges, research and development and non-patient care income not anticipated at plan.

Pay expenditure was higher than planned by £6.9m due to:

- £4.2m nationally determined pay award not confirmed at plan;
- £6.6m higher than planned temporary staffing expenditure, including costs relating to the Gold Command decision to offer incentives to support acute and forensic inpatient staffing through the peaks of the Omicron variant, but also reflecting elevated observations and sickness and vacancy cover;
- £0.5m of substantive staffing costs, including incentive payments introduced during the Omicron peak and required to support staffing levels in urgent care provision;
- £0.7m higher than planned trainee grade expenditure due to successful recruitment within the last medical rotation; and
- £5.1m net vacancies across the Trust which offset the above pressures and vacancy cover. Activities to progress recruitment and attract and retain staffing, including to bolster staff bank, are ongoing.

Non pay expenditure is £4.7m higher than planned, due to:

- £2.5m higher than planned purchased healthcare due to the need to provide additional bed capacity, including following the temporary closure

of an acute admissions ward in Scarborough due to staffing pressures. The Trust block contracted (and is fully utilising) five independent sector adult Mental Health assessment and treatment beds which have been contracted to the end of June 2022, however non-contracted capacity is also being used, with a focus currently on reviewing lengths of stay as a contributory driver of adult occupancy pressures;

- £0.6m higher than planned expenditure including to support ICS projects, reviews and investigations;
- £0.6m NHS Pensions 2021/22 final pay controls not known at plan;
- £0.3m unplanned drugs costs due to changed prescribing practice; and,
- £0.8m on computer hardware to support and improve smarter working.

3.4 Cash Releasing Efficiency Savings (CRES)

The Trust has offset its CRES requirements in full, using non-recurrent under spending linked to reduced non-pay costs and remote working arrangements supplemented by other non-recurrent savings. The offsets arising due to pandemic ways of working are reported as non-recurrent and have therefore not been subject to quality impact assessment. Recurrent related smart working schemes are being worked up for 2022/23.

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. Activities have been delayed because of operational pressures and will need to continue as a key focus into quarter one 2022/23.

3.5 Capital

Capital expenditure is £1.8m below plan. Two modest planned asset sales have also been delayed meaning the Trust is below its Capital Allocation by £0.8m at the end of month 11. The auction for one did not proceed as planned in February but is being rescheduled, tentatively for March 2022.

The Trust reported a forecast outturn of £14.5m; which would be £0.9m above its agreed ICS capital allocation of £13.6m. This reflected ongoing liaison throughout 2021/22 on VAT recovery via HMRC (and passported via the Trust's construction partner) that it had been assessed now seemed likely to continue beyond 31st March. The forecast assumed that IT infrastructure supplies are receipted as planned. On 22nd March, after Month 11 closedown, the Trust received confirmation that HMRC agreement has been secured, giving an estimated £650k favourable variance to plan. Regional colleagues have been alerted and an upside will be reported at month 12.

Indicative capital allocations have been used to develop draft 2022/23 Provider and ICS capital plans. Further work is in train to review the impacts of allocations on individual organisation requirements and respective risks. Final plans will be submitted in April, alongside revenue plans.

3.6 Workforce

Outside of Pandemic financial arrangements, tolerances for flexible staffing expenditure were set at 1% of pay budgets for overtime, 2.4% for agency (based on NHSI agency cost cap metric) and were 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 an equivalent cost cap of £7.0m for the year to date. Agency expenditure to date is £12.1m; which is £4.3m above the indicative cap for the period ending 28th February 2022. Expenditure spans 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. Levels have been volatile during the pandemic, but elevated use of inpatient 'headroom' has been observed since quarter 3.

Nursing and Medical expenditure headings account for 95% of total agency expenditure; cover is required to maintain essential services and to cover vacancies, sickness, increased test and trace and isolation levels and to support enhanced observations with complex clients.

The Workforce sub group of Senior Leadership Group is considering actions to target improved substantive recruitment and retention and wider options to target reduce agency staffing expenditure in 2022/23, e.g., a review of staffing bank and related pay. Medic-specific focus is also needed to understand options and will be led by the Medical Director. As pre-pandemic ways of working are re-established the Trust will also review arrangements to ensure optimal roster efficiency and planning. Reducing agency reliance and costs will need to be a key sustained area of oversight for the Board and Committees.

3.7 Statement of Financial Position

Cash balances are £93.5m as of 28th February 2022 which is £13.74m ahead of plan (£79.8m). This reflects the £0.8m higher than planned surplus (inclusive of disposals), receipt of £2.3m central capital funding, £0.9m lower than planned capital expenditure, and other movements in working capital including deferred income and increased accruals linked to capital and for IT equipment, where invoices from suppliers have not yet been received.

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

Conversations are ongoing with organisations to take collection of all debt over 90 days. 80% of aged debt relates to 9 organisations, all of which are public bodies. None of the amounts outstanding are currently disputed, the delay in payment is linked to process delays within organisations e.g., purchase orders not raised, invoices mislaid, staff sickness.

Aged debts that are not subject to repayment plans constitute £379k. Of this quantum, no further receipts have been collected at the time the report was circulated. Discussions continue as we support organisations to settle all debts.

3.8 Use of Resources Risk Rating (UoRR) and Indicators

3.8.1 The UoRR is impacted by Covid-19 with national monitoring suspended. However, the Trust continues to assess the UoRR based on planning submissions and actual performance. Detail can be found in table 2 below.

Table 2: Use of Resource Rating at 28 February 2022

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 28 February 2022	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	2.64x	1	2.56x	1	
Liquidity	41.1	1	38.5	1	
I&E margin	1.4%	1	1.2%	1	
I&E margin distance from plan	0.2%	1	0.0%	1	
Agency expenditure (£000)	£12,056k	4	£7,714k	1	
Overall Use of Resource Rating		**3**		**1**	

Operational planning guidance for 2022/23 indicated a return to more normal agency expenditure levels and controls would be required from April 2022. The Trust will need to re-visit and refresh related controls, including actions to closely monitor and address price and wage breaches and to develop sustainable bank alternatives and permanent staff recruitment as infection rates from the Omicron variant subside.

3.8.2 The **capital service capacity** metric assesses the level of operating surplus generated, to ensure Trusts can cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 2.64x (can cover debt payments due 2.64 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 41.1 days; this is ahead of 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 1.4%, this is ahead of 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 is 0.2% ahead of plan, which is rated as a 1.

3.8.6 The **agency expenditure** metric assesses agency expenditure against a capped target (pre-pandemic) for the Trust. Agency expenditure of £12.1m is £4.3m (56%) higher than planned and is rated as a 4. This will be a renewed area of focus for 2022/23. Recent regional reporting of sickness levels suggests peer mental health providers have experienced similar challenges. The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to the pattern of sickness absence.

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 £4.2m.
- Liquidity - to deteriorate to a 2 rating the Trust's working capital position would have to decrease by £46.6m.
- I&E Margin – to deteriorate to a 2 rating the Trust's financial position would have to decrease by £1.5m.
- Agency Costs – to improve to a 3 rating the Trust's agency expenditure would have to decrease by £0.5m.

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 The Trust, alongside NENC partners, is working to conclude organisation-level revenue and capital plans for 2022/23, with final plans due to be submitted at the end of April 2022. Key concerns include the real terms financial impacts of Pandemic recovery and the differential impact of Agenda for Change pay award costs for non-acute providers. The recurrent mechanism for funding the 6.3% increase in employers' NHS Pensions contributions (due to be funded through central arrangements during 2022/23) is of similar concern for non-acute providers from 2023/24.

5.3 The Board has discussed the challenge of 'post-pandemic' Mental Health recovery, including relating to ongoing staffing sickness levels, acuity, demand, and 'backlog'. Discussions have continued through local Partnership Boards, to agree joint immediate and future investment priorities.

5.4 CRES targets have been offset by non-recurrent underspending for the current financial year. Nationally, efficiency requirements have been more challenging

since October 2021; and equivalent to 1.1%, or £1.8m for TEWV in H2 and confirmed to continue via a 1.1% national tariff efficiency throughout 2022/23. At draft plan stage, NENC providers agreed the need to target a minimum 2% CRES for 2022/23. This is broadly consistent with informal intelligence about current national expectations. Nationally allocated Covid support funding reduced by 5% in H2 of 2021/22 and will reduce by 57% in 2022/23 (compared to 2021/22). As the Trust concludes financial planning activities it is possible that an efficiency exceeding 2% may be required based on draft plan assessments.

5.5 Monitoring of the UoRR nationally is currently suspended due to the Pandemic. Agency usage has been sustained in 2021/22 but increased since October, meaning that the Trust would score 4 against this individual metric. As a result, the Trust's overall UORR would be capped at 3. Excluding this cap, the Trust would be assessed as a rating of 1. Planning requirements for 2022/23 are targeted to support the NHS to navigate a planned phased national return, or 'glidepath', to more normal capitation-based allocations. This, alongside an explicit expectation of reduced agency expenditure, means our business plans and operational focus will target various actions to decrease agency utilisation and cost reductions.

6. CONCLUSIONS:

6.1 The Trust achieved a surplus of £4.9m for the period ending 28 February 2022, which is £0.3m ahead of our operational financial plan. This excludes £0.5m unplanned profit from the disposal of fixed assets, which are discounted when assessing NHS provider financial performance.

6.2 Work to finalise the Trust's financial plans and related CRES requirement for 2022/23 is linked to 'place' and ICS level planning activities, through which a composite break-even plan is required. Whilst significantly delayed contract offers and residual allocation uncertainty impacted Trust planning work, workstreams to develop schemes to deliver requirements on a recurrent basis, are now being progressed. Mitigations to offset efficiency requirements during 2021/22 have been identified, with scope to make some savings recurrent.

6.3 As a result of the Trust's agency risk rating the overall UORR would be capped as a 3 for the period ending 28 February 2022 and is behind plan. Excluding this cap, the Trust would be assessed as a rating of 1. Levels of expenditure on agency workers are higher than planned and are a key risk requiring mitigation moving into the new financial year.

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

Tees, Esk and Wear Valleys
NHS Foundation Trust

Appendix 1

Key Financial Indicators for the period ending 28 February 2022

Surplus variances are shown as negative	Year to date			RAG	Prior Month Variance	RAG
	Plan	Actual	Variance			
I&E (Surplus) / Deficit £m	-4.6	-5.4	-0.8	●	-0.9	●
Profit on sale of Asset (Inc in I&E performance shown above)	0.0	-0.5	-0.5	●	-0.5	●
Income £m	-377.9	-390.1	-12.2	●	-12.2	●
Pay Expenditure £m	301.0	308.0	7.0	◆	6.9	◆
Non Pay Expenditure £m	68.6	73.3	4.7	◆	4.7	◆
Non Operating Expenditure £m	3.7	3.9	0.2	◆	0.2	◆
Capital Expenditure (including disposals) £m	12.4	11.7	-0.8	●	-1.4	●
Capital Service Cover	2.56x	2.64x	-0.08x	●	-0.14x	●
Liquidity Days	38.6	41.1	-2.5	●	-0.9	●
I&E Margin	1.2%	1.4%	-0.2%	●	-0.3%	●
Variance from I&E Margin plan	0.0%	0.2%	-0.2%	●	-0.3%	●
Agency Expenditure £m	7.7	12.1	4.3	◆	3.8	◆
Cash Balances £m	79.8	93.5	-13.7	●	-6.5	●
Total debt over 90 days	5.0%	15.6%	10.6%	◆	4.0%	◆
BPPC NHS invoices paid < 30 days	95.0%	95.8%	-0.8%	●	-0.8%	●
BPPC Non NHS invoices paid < 30 days	95.0%	95.6%	-0.6%	●	-0.7%	●

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Board Performance Dashboard
As at 28th February 2022

journey to change

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

CONTENTS

Executive Oversight

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Out of our 21 key performance measures, there are 11 areas of concern identified within the February 2022 report that we are trying to improve.

Our key concerns remain within our Quality, Activity and Workforce domains and we continue to experience challenges in relation to staff sickness. Our waiting times are longer than we would like our patients to experience and the pressures on our inpatient services remain a significant concern. We are continuing to meet our financial targets; however it is important to note that this is not at the expense of our other standards.

Quality

Performance continues to be impacted by national pressures throughout the NHS and locally within Trust services in respect of high demand and staff capacity, and we remain concerned that we are not assessing or treating our patients in as timely a manner as we would like. Initiatives are continuing in relation to service models and waiting list management; however, whilst a number of our actions have been completed, we are not seeing the improvements that we anticipated and we are engaging with our services to identify whether there are any further concerns.

We are continuing to see an increase in the number of patients that we are placing in beds external to our Trust. Whilst this is a national issue due to current demand levels, it is something that we are concerned about and are monitoring closely.

Activity

Pressures on our inpatient services are continuing and our bed occupancy remains high; within our adult and older people wards we continue to have a high number of patients remaining in beds for over 90 days within Durham and Tees localities and this month we have started to see a potential concern in North Yorkshire & York. A key challenge continues to be the availability of beds within local funded care home placements.

Workforce

Whilst our vacancy levels have returned to a level that we would expect to see, intelligence from our services indicates this remains a concern from a clinical management perspective. Work is underway to assess whether our measure is appropriately reflecting the level of vacancies within the Trust. Our sickness levels continue to be higher than we aspire to across all Localities and whilst all sickness is managed in line with Trust Policy and is closely monitored within operational services, this is impacting the delivery of our some of our services. Whilst sickness levels throughout January were both covid and non-covid related, it is important to note that Omicron continued to impact staff absence. We are continuing to see small increases in the number of staff that have up to date appraisals and mandatory & statutory training, but these remain not as significant as we would like to see and work is still ongoing in some localities to establish trajectories for achieving our ambitions.

Finance

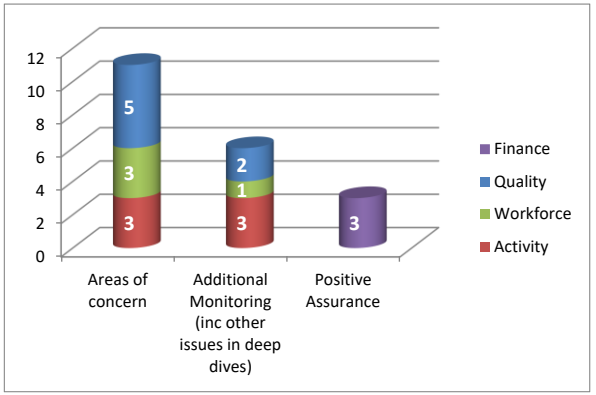
We are continuing to meet our financial targets; however it is important to note that this is not at the expense of our other standards. The key drivers impacting on delivery of the quality, activity and workforce standards are the levels of demand, acuity of patients and availability of staff. The Trust is committed to improving the quality of our services and the health and well being of our patients and staff and considerable work is being undertaken to improve our performance in those areas.

Summary Position

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 (5993 patients out of 6972 in February which is 85.94% compared to our standard of 90%).
- The number of **patients receiving treatment within 6 weeks** is not as high as we would like (911 patients out of 1544 in February which is 59.00% compared to our standard of 60%).
- We recognise the potential to improve our learning from **Serious Incidents.** Whilst in January, 25% (2 from a total of 8) compared to our standard of 32% serious incidents () were found to have a significant lapse or lapse in care (equivalent to a root cause or contributory finding), monitoring continues to ensure this improvement is sustained.
- Our Adult and Older Persons' teams are not demonstrating the **improvement we would like in patient outcomes (HONOS)** (34 out of 84 in February which is 40.48% compared to our standard of 60%).
- Our Adult and Older Persons' teams are not demonstrating the **improvement we would like in patient outcomes (SWEMWBS**) (48 out of 81 in February which is 59.26% compared to our standard of 65%).
- The number of **patients being referred and taken on for treatment** is fewer than we would expect (2043 patients out of 8524 referred in November which is 23.97%). 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 (9498 occupied bed days out of 9436 available bed days which is 100.66% in February compared to our standard of 90%).
- The number of Adult and Older People **staying in beds longer than 90 days** is higher than we would like (75 patients in February compared to our standard of no more than 61).
- The number of **staff with a current appraisal** is not as high as it was previously (4934 members of staff out of 6269 in February which is 78.70% 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 (92,830 training courses out of 107,654 in February which is 86.23% compared to our standard of 92%)
- **Sickness Absence rates** for staff are higher than we would like them to be (16,913 working days out of 215,779 in January which is 7.84% 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 or that the actions we have taken are having the desired impact:

- Whilst we are placing significantly fewer of our patients in a bed outside their local hospital, there were 18 patients placed in beds external to the Trust accounting for 589 **inappropriate OAP days** in the 3 months ending February.
- Whilst **patients report their overall experience** is showing an improvement it remains slightly lower than our ambition.
- Whilst the number of **patients referred** is at a level we would expect, concern is now visible within Forensics.
- The number of **patients with an assessment completed** is lower in Forensics than we would expect.
- The number of **patients discharged** is lower in Tees than it was previously.
- Whilst the number of **vacancies** is higher that we would like, a downward trend is now visible within the data and vacancies are at a level we would expect.

All three finance measures are providing assurance that we are delivering in line with our financial plan.

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 Feb - 2022	Assurance Ending Feb - 2022	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%	86.77%	90.00%
2) Percentage of patients starting treatment within 6 weeks of an external referral	L	?	60.00%	57.48%	60.00%
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	L	?	1,833	589	1,833
4) Percentage of patients surveyed reporting their recent experience as very good or good	H	?	94.00%	89.35%	94.00%
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding		?	32.00%	61.11%	32.00%
6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind	L	?	60.00%	47.29%	60.00%
7) % of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) - month behind	L	?	65.00%	64.40%	65.00%

Activity

Measure Name	Variation Ending Feb - 2022	Assurance Ending Feb - 2022	Standard (YTD)	Actual (YTD)	Annual Standard
8) Number of new unique patients referred				89,093	
9) The percentage of new unique patients referred with an assessment completed (2 months behind)	H			77.21%	
10) The percentage of new unique patients referred and taken on for treatment (3 months behind)	L			30.74%	
11) Number of unique patients discharged (treated only)				31,346	
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	H	?	90.00%	98.39%	90.00%
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot	H	P	61	75	61
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)		?	9.90%	8.17%	9.90%

Workforce

Measure Name	Variation Ending Feb - 2022	Assurance Ending Feb - 2022	Standard (YTD)	Actual (YTD)	Annual Standard
15) Finance Vacancy Rate				-8.34%	
16) Percentage of staff in post with a current appraisal	L	F	95.00%	78.70%	95.00%
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	L	?	92.00%	86.23%	92.00%
18) Percentage Sickness Absence Rate (month behind)	H	?	4.30%	6.45%	4.30%

Money

Measure Name	Plan (YTD)	Actual (YTD)
19) Delivery of our financial plan (I and E)	-4,610,000	-5,406,502
20) CRES delivery	1,994,330	1,994,330
21) Cash against plan	79,834,000	93,508,994

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.

6972 patients attended a first appointment during February; of those, **5992 (85.94%)** were within 4 weeks of referral

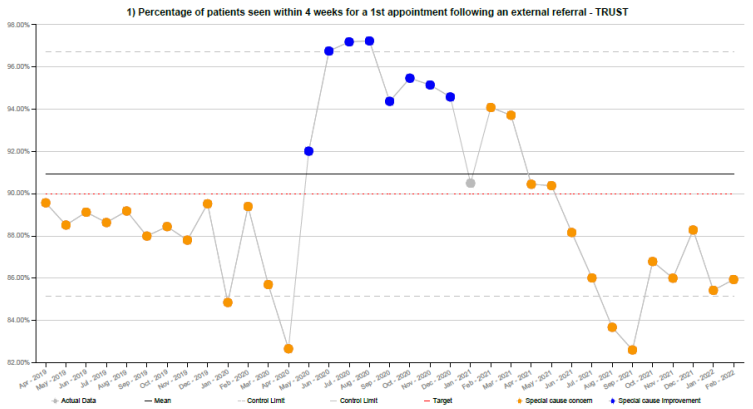
We're aiming to have high performance and we're moving in the wrong direction.

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		
DURHAM AND DARLINGTON		
FORENSIC SERVICES		
NORTH YORKSHIRE AND YORK		
TEESSIDE		

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.		Whilst a slightly increasing position has been visible since September, there has been no sustained improvement. 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
Tees Locality			
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 and the backlog is now cleared. Pending any further concern being identified, this issue will be removed from next month's report.	Performance is above standard now at a level we would expect.
High levels of sickness and an increase in referrals has impacted capacity within the 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 offered through February and March, with positive uptake. The Advanced Practitioner started in post mid-February to support the triage process and the care of complex patients. Only one member of staff is now on sick leave and a return date is agreed. One Band 6 member of staff is on maternity leave and steps are in place to cover their workload with a Band 5 joining the team. The Corporate Performance lead is to work with the service during March to confirm whether this remains an issue.	A decreasing position is visible; however, actions remain ongoing.
	Head of Service to lead a review to streamline the referral documentation for Access services, to reduce the time required to record assessments for patients who receive advice and support and are then signposted to other services	**Ongoing.** A working group has been established alongside corporate and CITO colleagues to assess the options available. An update will be provided next month.	
Whilst waiting times within 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.	**Complete**. Recruitment into MHSOP Community Teams is now complete; all staff are expected to be in post by April.	A decreasing position is visible; however, not all staff have commenced in post.

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
	The Corporate Performance lead is to work with the service during March to confirm whether this remains an area of concern.	**Not started.**	
Further analysis of 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.	**Complete**. Improvements have been noted in both teams and we can conclude there is no current area concern.	An increasing position is visible and whilst the standard is being achieved, performance remains at a lower level that we would expect. Actions remain ongoing.
There are a number of vacancies across the service that are impacting on our waiting times.	Recruitment is ongoing to appoint new staff to enable demand to be met.	**Ongoing**. The recruitment campaign is ongoing and is being reviewed weekly by a Trust-wide group, chaired by the Locality Managers from each locality, with Human Resources, Temporary Staffing and the Tees lead. There remain 29 vacant posts across Tees LD services; however, the service is performing above standard.	
North Yorkshire & York Locality			
Children and Young People's (CYP) Services are being impacted by staffing resources within the Single Point of Access Team.	Recruitment is underway, which would provide more staff to undertake assessments. Staff from the generic CYP team to provide interim overtime support to reduce the backlog of screening forms.	**Complete.** All current posts are recruited and this is supporting timely triage and the assessment of more patients. **Ongoing**. Overtime is continuing and has had a positive impact; however the York and Northallerton generic community teams have implemented business continuity and this has reduced the level of support available. The service is working with the Quality Improvement team to look at the flow of referrals and an update on this work will be provided in March.	An increasing position is visible but performance remains at a lower level that we would expect. 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
There are a number of vacancies within the Mental Health Services for Older People (MHSOP) Harrogate, Scarborough and Ryedale community teams and Harrogate Memory team.	Recruitment is underway, which would provide more staff to undertake assessments.	**Complete.** Harrogate, Ryedale and Whitby community teams are fully recruited to. Scarborough Community team have 3 clinical posts vacant; however all recruitment has been put on hold while they are reviewing their services (see below action).	No visible impact at this point; actions remain ongoing.
The teams are concerned they do not have sufficient nursing and medical staff to operate the current model and meet the demand of referrals.	The Scarborough, Whitby and Ryedale Locality Manager for MHSOP, with Quality Improvement and Finance, to review existing vacancies across all teams to better align posts to demand.	**Ongoing.** Initial data is being collated and a meeting is scheduled for the 1st March 2022 to develop an action plan; delivery dates will be included in future Board reports.	
The York Memory Service has been impacted by capacity issues due to an increase in referrals and under-establishment.	A pilot to be undertaken with GPs to support the referral process and minimise inappropriate referrals.	**On hold.** This work has been paused indefinitely to support business continuity. Funding was requested for additional resources for this to continue, but this reduces the availability of staff for assessments and redirected resources from the waiting time work. The service continues to work towards the target of all waiters to be eliminated by April 2022 but this has been impacted by an increase in referrals.	
	A 0.6 whole time equivalent clinical staff member to return from secondment to increase support.	**Complete.** The member of staff has now returned to work in the team.	

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 Adult Mental Health Services, there has been reduced staff capacity due to vacancies and sickness within the Hambleton & Richmondshire East community team, and the team do not have the capacity to meet current demand and acuity of referrals.	Recruitment is underway, which would provide more staff to undertake assessments.	**Ongoing.** The team continues to be impacted by reduced staffing capacity, with 2.6 clinical post vacancies; however, interviews are scheduled for March. A daily staff escalation meeting is in place to mitigate this, looking at patient flow, assessment capacity and any immediate actions that can be taken.	No visible impact at this point; however, actions remain ongoing.
The York North, York South, Scarborough and Whitby & Ryedale community teams have been impacted by vacancies. The Scarborough team has been unsuccessful in sourcing permanent or agency staff.	Recruitment is underway, which would provide more staff to undertake assessments.	**Ongoing**. York North CMHT and York South CMHT are now fully recruited and are achieving standard. The final posts within the Whitby and Ryedale teams are due to commence in March. The Scarborough community team still has 3 Band 6 senior practitioner posts vacant; to mitigate this a Band 4 nurse associate, occupational therapist and a zero contract clinician provide support. Interviews for a Band 7 psychologist post are scheduled for March. It should be noted the Scarborough team has been impacted by new episodes of short term sickness due to covid; interim capacity from the crisis team has been provided to support assessments.	
	Third sector support as part of winter pressure monies to be explored with commissioners to assist the Scarborough team.	**Complete.** Funding was not approved.	

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
The York & Selby Wellbeing Access service has received a significant increase in referrals, which has impacted staff capacity. The team has a number of vacancies and some staff sickness, which has reduced the number of assessments that can be completed and consequently, the number of patients taken on for treatment.	'Stop the line' process to be established to enable current processes to be reviewed.	**Complete.** Staff capacity has improved following the return of staff from short term sickness; therefore support is no longer required from the community teams and the team is no longer in 'Stop the line' process.	A decreasing position is continuing. We are considering any further actions that could be undertaken.
	All referrals for patients that have been previously discharged within the last year to be allocated directly to the community teams in York and Selby.	**Complete.** Processes are in place to enable patients to be assessed and allocated slots quickly following re-referral; staff have been supported to up-skill to improve the efficiency of assessments. Assessment processes are embedded and most patients are now being assessed within 4 weeks of referral.	
	The service to initiate a triage process to address the backlog of patients waiting for assessment from November 2021.	**Complete**. Triage process is in place and capacity has been created to screen referrals in line with service criteria. This has addressed the backlog; however, referrals continue to be above assessment capacity.	
	The Head of Service, Locality Manager, Team Manager and Advanced Nurse Practitioner to review staff capacity to enable the maximum number of assessments slots to be offered.	**Complete.** The review has been completed, staffing is now at full capacity and processes are in place to enable efficient management of assessment slots.	
	Recruitment is underway, which would provide more staff to undertake assessments.	**Complete**. The team is fully recruited to and staff are going though pre-employment checks. The service is working at maximum capacity in terms of staff and the number of assessments being offered; however this is not sufficient to meet the increase in demand.	

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
Capacity within the North Yorkshire & York Perinatal team has been impacted by staff sickness.	Sickness to be managed through the Trust sickness procedure.	**Complete.** All members of the team have now returned to work	No visible impact at this point; however, actions remain ongoing.
Capacity within the North Yorkshire and York Perinatal team has been impacted by reduced capacity due to vacancies.	Recruitment is underway which will increase staff's capacity to commence treatment.	**Ongoing.** The are 2.2 wte clinical posts vacant within the team and a consultant is expected to leave in June 2022.	
	Team Manager to work with the Quality Improvement team during March and April 2022 to support effective diary management and assessment capacity.	**Not started**. This work will commence in March.	
Durham & Darlington Locality			
Within Children & Young People's (CYP) Services potential concerns were identified within the Darlington, Easington, North Durham and South Durham Targeted Teams and the specialist Autism and Eating Disorder teams.	A review of waiting list management across all Locality CYP services to be undertaken, with support from the Head of Service, Information team, Performance Team, Quality Improvement and the Service Development Manager.	**Complete**. The standardised procedure for tracking patients waiting for assessment and treatment is in place, including daily huddles and the operation of the visual control board to ensure progress is maintained and any concerns identified immediately and actioned.	Although an increased position can now be seen within the data, concern remains visible.
	The Corporate Performance lead is to work with the service during March to confirm whether this remains an area of concern.	**Not started.**	
Within Mental Health Services for Older People, episodes of long term sickness and staff vacancies have impacted the Derwentside community team.	Retire-and-return support to be sourced.	**Ongoing.** 0.8 wte member of staff is due to start in June; 2 days a week.	A decreasing position remains visible; however, actions remain ongoing.
	Recruitment is underway, which would provide more staff to undertake assessments.	**Ongoing**. Three vacancies remain in the team.	
	Corporate Performance Lead to work with the Team Manager during March to identify the capacity issues that have not been addressed by recruitment.	**Ongoing**. An update will be provided next month.	

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
Durham & Darlington Locality			
The Darlington-Teesdale community team has been impacted by staff vacancies.	Recruitment is underway, which would provide more staff to undertake assessments.	**Ongoing.** Whilst the original vacancy issues identified have been resolved, the team has two additional vacancies for a locum consultant and a Band 5 nurse. The nursing post has been advertised unsuccessfully 3 times and over-recruitment for 2 Band 6 posts is now being pursued. The team is also being impacted by a vacancy within the Darlington-Teesdale Care Home Liaison team, which impacts assessment capacity as it requires backfilling with duty shifts by community team staff.	A decreasing position remains visible; however, actions remain ongoing.
Forensic Services			
We are concerned that waiting times for patients within our Health & Justice Service are being impacted by capacity within the Criminal Justice Liaison Service.	Corporate Performance Team with the Service Manager to undertake further analysis during March 2022 to ascertain any areas of concern.	**Ongoing.** Work has started and will be progressed in March.	A decreasing position is visible.

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.

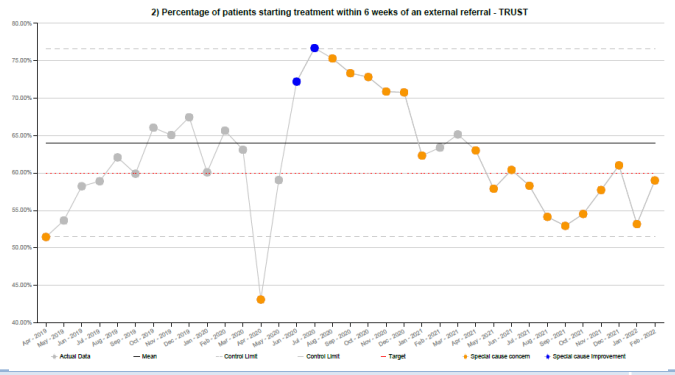
1544 patients started treatment during February; of those, **911 (59.00%)** started within 6 weeks of being referred

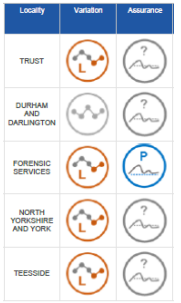
We're aiming to have high performance and we're moving in the wrong direction.

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%





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.
Durham & Darlington Locality			
In 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.** There are now 59 unrecruited to vacancies across the CYP service. Recruitment continues and the service are currently receiving support from the Trust recruitment team to market their vacancies. From March pre-employment checks will be managed by the NHS Business Services Authority, which will release some capacity in the Recruitment team to provide further support.	Whilst performance remains just below target, it is at a level we would expect. Actions remain ongoing.
Waits for 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 and Senior Leadership Group have agreed that it is not appropriate for these patients to be included within this measure as they are waiting for specialist assessment not treatment. Work is underway to action these changes. This action will remain on this paper pending the completion of this work.	

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
Some data quality issues were identified within the Darlington CYPS Team and Mental Health Services for Older People.	Work to be undertaken to understand and correct data quality issues.	**Ongoing.** All newly identified issues within MHSOP are resolved routinely. Resource has been provided to rectify data quality issues in the CYP dashboard and staff are amending the earliest treatment interventions to accurately reflect waiting times for all patients.	
Within Adult Mental Health Services performance is being impacted by data quality issues within the Access team.	Locality Manager to meet with the Access Team leadership in December to agree the actions required to improve data quality.	**Ongoing**. The rescheduled meeting took place in February and actions are being agreed; support is being provided by the Corporate Performance lead to review the patient data to identify specific data quality issues.	An increasing position is visible; actions remain ongoing.
Tees Locality			
There is a delay in the assessment process within the 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.	**Complete.** Review completed and process streamlined. **Complete.** The backlog has been cleared and triaged as appropriate. **Complete.** Patient flow through the SPOC teams has improved and both teams are now achieving the standard.	Whilst slightly below standard, performance is at a level we would expect. Actions remain ongoing.
High vacancy levels and sickness has impacted capacity within CYP.	Head of Service to review the current position and identify all required actions.	**Ongoing**. There are 5.1 wte vacancies within Psychology, 3 within the Getting Help Teams and 8 within the community teams. Posts have been advertised and interviews have taken place for a number of posts throughout February with varying success. A Band 5 nurse has been identified to work a 12-month rotation covering the two Neurodevelopmental teams, Learning Disabilities teams and the Intensive Positive Behaviour Support Team.	

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
High levels of sickness and vacancies have impacted capacity within the Mental Health Services for Older People (MHSOP).	Recruitment is underway, which would provide more staff to offer treatment.	**Complete.** Recruitment is now complete and the last members of staff will be in post by the end of April.	No visible impact in the data; however staff will not be in post until April.
North Yorkshire & York Locality			
Waits for 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 and Senior Leadership Group have agreed that it is not appropriate for these patients to be included within this measure as they are waiting for specialist assessment not treatment. Work is underway to action these changes. This action will remain on this paper pending the completion of this work.	An increasing position is visible but concern remains. Actions remains ongoing.
The Scarborough ADHD team, York & Selby and Harrogate community teams are being impacted by a number of vacancies and the capacity to manage the volume of referrals.	Recruitment is underway, which would provide more staff to commence treatment interventions	**Ongoing.** Vacancies remain in all teams.	
	The Head of Service to work with the Quality Improvement and Finance teams to review the vacancies across all teams to support better alignment of posts to demand, which will support improved waiting times. This work will be completed by the end of March 2022.	**Ongoing.** A meeting is scheduled for 1st March and an action plan with timescales will be produced.	
Staffing resources due to sickness and staff turnover is resulting in delays in the Northallerton community team.	Director of Operations to raise staff concerns at Gold command in February to establish whether the team implements business continuity.	**Complete.** The team implemented business continuity processes in February.	
	Recruitment is underway, which would provide more staff and/or release staff's capacity to commence treatment interventions	**Ongoing.** The team currently has 8 vacant clinical posts.	

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
Within Mental Health Services for Older People (MHSOP) the York Memory Service has been impacted by capacity issues due to an increase in referrals and under-establishment.	The service to establish a trajectory to eliminate waiters.	**Complete.** A trajectory has been established to eliminate all waits by the end of June 2022.	No visible impact; a decreasing position remains visible. Actions remain ongoing.
There are a number of vacancies within Scarborough and Harrogate Memory Service and the community teams within those areas.	Recruitment is underway to provide more staff to undertake assessments.	**On hold.** Recruitment has been placed on hold pending a capacity/demand exercise being led by the Head of Service. (Please see below action)	
	The Head of Service to work with the Quality Improvement and Finance teams to review the vacancies across all teams to support better alignment of posts to demand, which will support improved waiting times. This will be completed by the end of March 2022.	**Ongoing.** A meeting is scheduled for 1st March and an action plan with timescales will be produced.	
The Scarborough Memory Team is being impacted by a reduction in medical staff resources due to long term sickness.	A ring fenced clinical post to be created to take over medication monitoring patients, releasing staffing capacity to the memory service.	**On hold.** This is pending restructure discussions within the service; these will be held during March 2022.	
Scarborough, Whitby Ryedale Memory teams are concerned they do not have sufficient nursing and medical staff to operate the current model and meet the demand of referrals	Scarborough, Whitby & Ryedale MHSOP Locality Manager to lead a review of budgets and current staffing numbers with the Quality Improvement team, which will include consideration of increased medical input. This will be completed by March 2022.	**Ongoing**. Data has been collated and the Locality Manager will meet with the Quality Improvement team on the 1st March 2022 to review the data and develop an action plan.	
The Hambleton & Richmondshire Memory Team is impacted by reduced staffing capacity due to sickness and reduced medic input	A multi-disciplinary approach to be established within the service to formulate diagnosis without medic input for non-complex patients.	**Complete.** The approach is established but the service has confirmed this will only have a minimal impact as only non-complex patients can be diagnosed without consultant involvement. Corporate Performance Lead to work with the Team Manager during March to identify any further actions that are being undertaken.	

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.

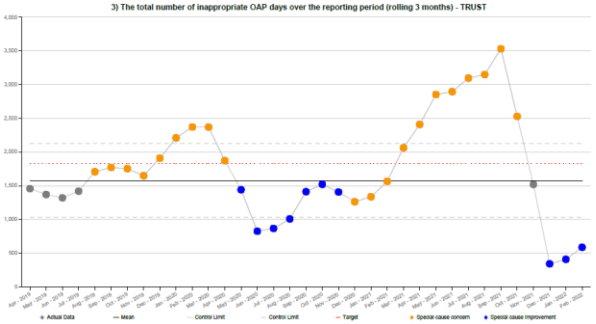
589 days spent by patients in beds away from their closest hospital during December 21, January 22 and February 22.

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

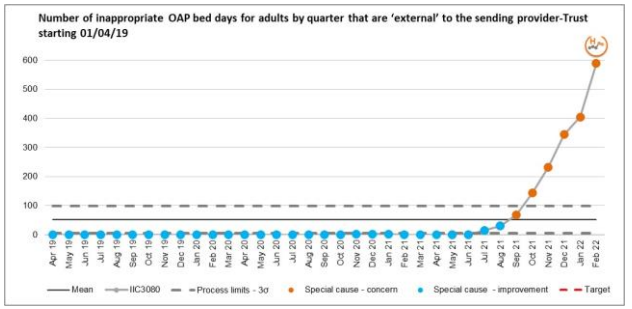
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

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

DQ 90%



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



Note: the improvement in the measure (first chart) is driven by the earlier months, which include internal placements. The second chart shows the increasing position in respect of placements out of the Trust.

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.	**Complete.** Following initial analysis, data is monitored monthly. Bed managers continue to work together to support repatriation as soon as a local bed becomes available and it is clinically appropriate to do so	Whist an improvement is now visible within the data, reflecting the reduction in internal OAPs and compliance to the Continuity of Care Principles, external OAPs are visibly increasing and are a concern.
	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.	**Complete.** A paper was presented to the Executive Oversight Team on the 5th October 2021. All recommendations were supported and work is now underway to include the principles within the Modern Matrons Audit from January 2022.	
	The Out of Area Protocol to be reviewed to ensure is up to date and fit for purpose.	**Complete.** The protocol was circulated on the 11th November 2021 with immediate effect.	

TD03) The total number of inappropriate OAP days over the reporting period - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Four beds were purchased initially in the independent sector until the 30th September 2021 for AMH and MHSOP patients. This has subsequently been increased to 5 beds and has been extended to the 30th June 2022. Eight patients occupied these beds during February (133 bed days).	External support to help us to understand if there is anything further we can do to manage inpatient pressures and out of area placements to be commissioned.	**Ongoing.** The three suppliers approached did not submit quotes and there is now no prospect of this work commencing in 2021/22. The lead for the Clinical Strategic Journey is to review the requirement to determine whether all work elements are still required, and the next steps will be agreed. An update will be provided in April 2022.	
	Bed census to be undertaken to help us understand our current patient base.	**Complete.** The bed census has been undertaken and shared with Senior Leadership Group and Service Development Groups. A number of actions and proposals are being considered and will be included in March's report.	
	Increased monitoring of external placements to be undertaken.	**Complete**. External OAPs are now included within this report for oversight.	
	Acting Head of Corporate Performance to contact NHS England to renegotiate the Trust's trajectory for out of area placements.	**Ongoing.** Discussions are underway with commissioners to agree the 2022/23 trajectories.	

TD04) Percentage of Patients surveyed reporting their recent experience as very good 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.

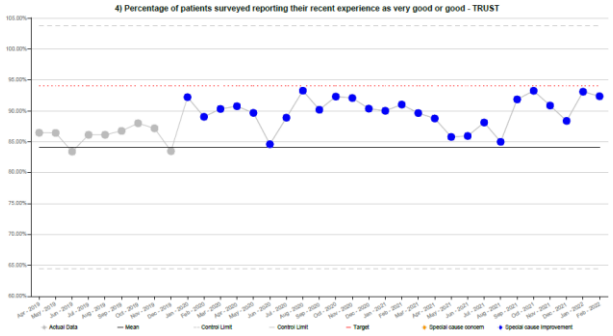
732 patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **676 (92.35%)** scored "very good" or "good"

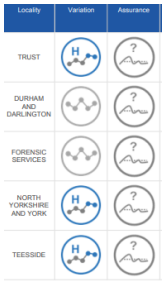
We're aiming to have low performance and we're moving in the right direction.

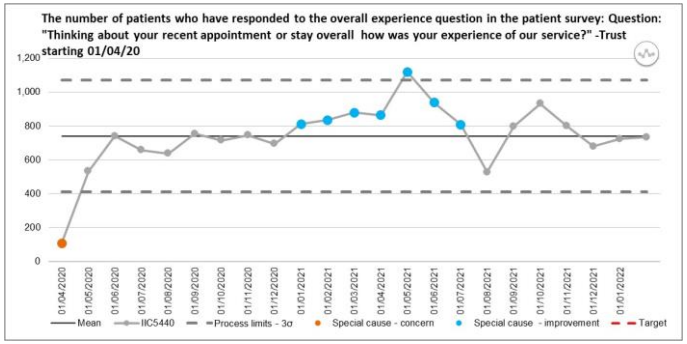
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

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

95%







KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Whilst our patients have continuously rated our care as very good or good, we are concerned that the number of responses we receive to our surveys are not as high as we would like. This has been impacted by operational pressures and a reduction in face to face contact, as remote clinical contacts have increased in response to pandemic pressures.	Monthly monitoring of response rates and progress against the Patient Experience Improvement Plans to be established.	**Ongoing**. 18 out of 27 actions completed 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 patient experience projects in Durham and Darlington, introduction of a standard process to reallocate cases following staff absence in Teesside and recruitment of patient experience leads in North Yorkshire and York, as well as providing training on accessing Meridian, the Integrated Information Centre and implementing Quality Assurance Group reporting templates. However, a number of actions across localities have not been completed and are still ongoing.	Whilst performance remains below standard, continuous improvement is visible.
	A comparison exercise to be undertaken with Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust on the 'Feeling Safe' theme. This is due to be completed December 2021.	**Ongoing.** A joint meeting was held between TEWV and CNTW on the 10th November. We undertook a comparison of themes identified by patients on inpatient wards and found similarities in feedback in relation to feeling safe, witnessing violence and aggression and the number of activities available. To explore further we agreed to hold focus groups initially within secure services during February 2022, which due to capacity issues within the service this have been delayed to complete in March 2022 with support from the service manager. The focus group will aim to better understand what safety means to patients and what a safe day on the ward would look like.	

TD04) Percentage of Patients surveyed reporting their recent experience as very good or good continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
A data quality issue has been identified as a number of survey responses have not been aligned to Trust cost centres and are, therefore, incorrectly excluded from the measure.	The IIC team Manager and Corporate Systems Manager to work with Meridian, the survey provider to investigate and identify appropriate actions to correct the measure. Actions will be developed and shared in April 2022.	**Ongoing**. Work has started and will continue throughout March 2022.	

TD05) Percentage of Serious Incidents which are found to have a root cause (significant lapse) or contributory finding (lapse) (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.

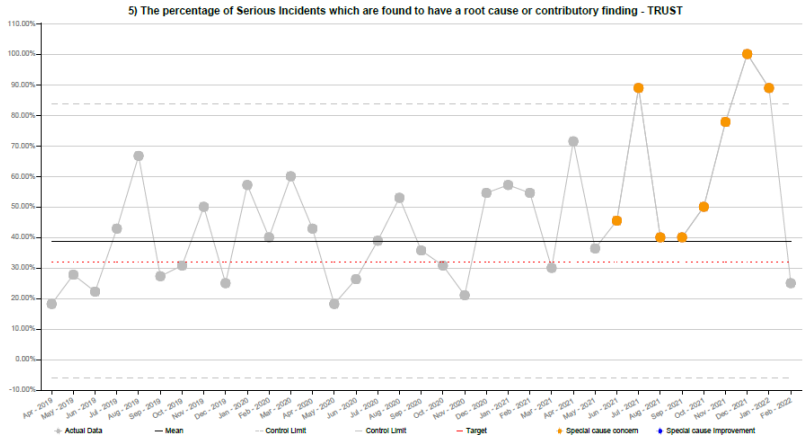
8 serious incidents were reported to the Trust Director Panel during January; of those, **2 (25.00%)** were found to have a root cause or contributory finding

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		
NORTH YORKSHIRE AND YORK		
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 (please see following page). 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.	A decreasing position is visible this month but that is not sufficient to denote an improvement.

TD05) Percentage of Serious Incidents which are found to have a root cause (significant lapse) or contributory finding (lapse) (month behind) - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
	External subject matter expert to be identified to enable objective scrutiny of perinatal services, enabling opportunities for sharing mutual learning through external networks.	**Ongoing.** Work is underway with a Consultant Perinatal Psychiatrist from Neuro & Specialist services in Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust. The initial focus is working with the TEWV senior leadership team to review incidents across all 3 localities, including a review of similar incidents within CNTW to share learning. Detailed findings will be shared by 31st March 2022, once the review has completed the assurance cycle. Established links between the Trust's three localities and the external reviewer will continue to maintain oversight of perinatal patient safety incidents for the purpose of sharing learning between Trusts. Learning will also be shared in the Trust-wide perinatal forum as well as the Clinical Advisory Group within the Perinatal Mental Health Network. A further update will be provided by June 2022 once findings are shared.	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.
	Participation in a national collaborative focusing on sexual safety to assist in testing tools and interventions to reduce sexual safety incidents. The methodology will shared Trust-wide.	**Ongoing.** A proposal is being developed to pilot a single sex psychiatric intensive care unit in Tees; risk and risk management assessments are currently being undertaken before the proposal can be finalised. The sexual safety review remains ongoing; findings from two cases have received external oversight and a further two cases are under internal investigation. Findings from the oversight of these four cases will be shared by June 2022 once the review has completed the assurance cycle.	
	A range of safeguarding initiatives to be established.	**Ongoing.** Best practice guidance has been issued on the completion of the PAMIC tool, a safeguarding tool to support clinicians in considering the likelihood and severity of the impact of an adult's parental mental ill health on a child. Development work on PARIS is planned to move the tool to one central place within the safety summary to support easy access and improve the flow of documentation. This work will take 3-4 weeks for completion and once complete guidance will be shared with all staff. An update will be provided in April 2022.	

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

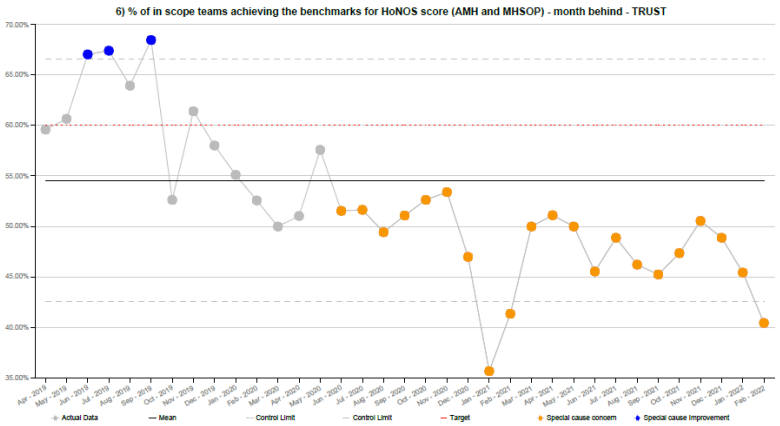
84 in scope teams have discharged patients from Trust services in the last three months; of those, **34 (40.48%)** achieved the agreed improvements in their Health of the Nation Outcome Score (clinician rated outcome measure)

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		
DURHAM AND DARLINGTON		
NORTH YORKSHIRE AND YORK		
TEESSIDE		

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.	Adult Service Development Managers to complete detailed analysis to understand what is impacting on our patients' improvement and why our patients feel that they have experienced an improvement (see TD07 SWEMWBS) but clinically have not shown that. This work will be completed March 2022.	**Ongoing.** Analysis work is ongoing and will be completed by the end of March 2022 and findings shared. The work will be used to inform baselines for CQUIN and new dashboard measures.	A decreasing position is visible.
	Mental Health Services for Older People Service Development Manager to establish training sessions for all staff by March 2022.	**Complete.** Initial and refresher training has been completed. Clinical outcomes now forms part of huddle updates, supervisions sessions and pathway meetings.	
	Adult Mental Health Services Service Development Manager to establish training sessions for all staff by June 2022.	**Ongoing.** Training is currently being developed. Clinical outcomes now forms part of huddle updates, supervisions sessions and pathway meetings.	
	The Chief Clinical Strategy Officer to incorporate outcomes work as part of the Clinical Journey to Change.	**Ongoing.** Outcomes are now established on the agendas for the Workforce Senior Leadership Group and Programme Board.	

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

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
	MHSOP Service Development Group to consider an appropriate approach for monitoring outcomes for patients with degenerative illness. This is to be completed by the end of April 2022.	**Ongoing.** The MHSOP Service Development Manager has completed training with team managers and the consultant group, and demonstrated how to use the Trust tools to monitor outcome data. Each clinical pathway in MHSOP has a task and finish group to ensure the clinical standards expected for the pathway are achieved; results are reported into the Service Development Group on a quarterly basis, including progress against action plans. Community matrons have shadowed processes and issues identified have included delays in completing the reviews, administrative delays in recording on the system and delays in completing the paperwork.	
	The SDM to review the clinical pathways within MHSOP to ensure they remain in line with Trust policy, sit within the clinical risk management process and the MHSOP specific harm minimisation modules. This is to be completed by the end of April 22.	**Ongoing.** The Delirium Pathway, Dementia Pathway and Behaviours that Challenge Pathway have now all been relaunched incorporating updates around outcomes monitoring and harm minimisation modules. The review of the functional pathway with Adult Mental Health remains outstanding and delivery dates are being requested.	

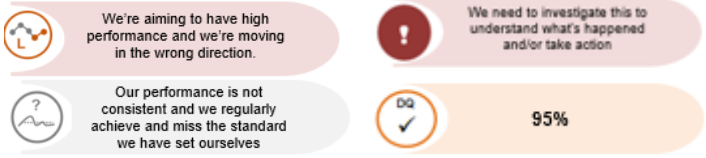
KEY CHANGE
Whilst there are a number of improvement actions as outlined above, we are currently developing a number of key outcome measures that are more clinically meaningful as part of the new Trust Integrated Approach to performance. These new measures will be implemented in 2022/23 as part of the new Integrated Performance Dashboard.

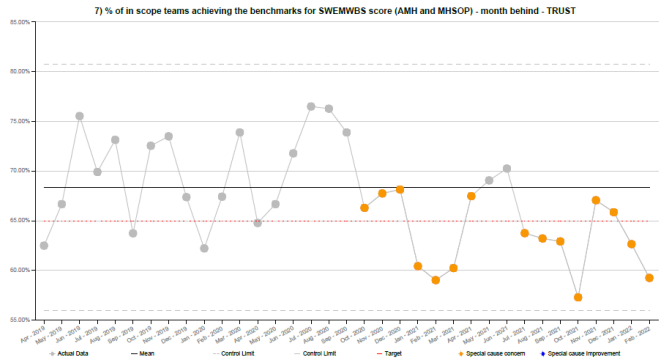
TD07) Percentage of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) (month behind) – *Trust Standard 65%*

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

81 in scope teams have discharged patients from Trust services in the last three months; of those, **48 (59.26%)** achieved the agreed improvements in the short version of the Warwick–Edinburgh Mental Wellbeing Scale (patient rated outcome measure)





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).	A decreasing position is continuing.
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.	**On hold.** At the October Locality Quality Assurance & Improvement meeting, due to capacity issues within the Locality, the Director of Operations was asked to identify two key issues to focus on within the coming weeks. The focus on SWEMWBS has currently been put on hold, whilst they focus on reducing the length of stay of adult patients and completion of basic life support training.	

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.

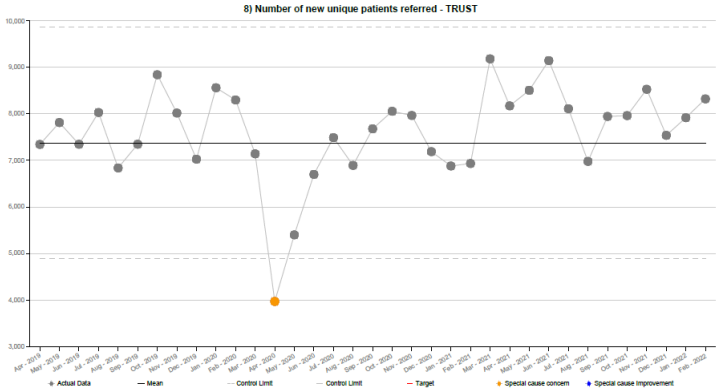
8393 patients referred in February that are not currently open to an existing Trust service

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 previously identified a high number of referrals of within our **Forensics** services, linked to an increase in referrals to the Cleveland and Durham Liaison & Diversion teams. One action remains ongoing	Referrals to be reviewed over the next 6 months to understand demand and to inform the discussion and business case with commissioners.	**Ongoing.** It has been agreed with commissioners that data will continue to be collected until April and reviewed in May 2022, to allow more data to be collected to better understand the demand.	A decreasing position is visible; however actions are ongoing.
However, referrals are reducing within the teams and we are now seeing fewer patients in our Health & Justice Liaison & Diversion teams than we would like due to vacancies for Navigators within the Cleveland and North Yorkshire teams.	Recruitment is ongoing to appoint new staff to enable demand to be met.	**Ongoing.** A business case has been submitted to commissioners. Six posts are vacant across the teams (3 in Cleveland and 3 in North Yorkshire. Once the remaining Navigators are appointed the service anticipates an increase in referrals.	

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

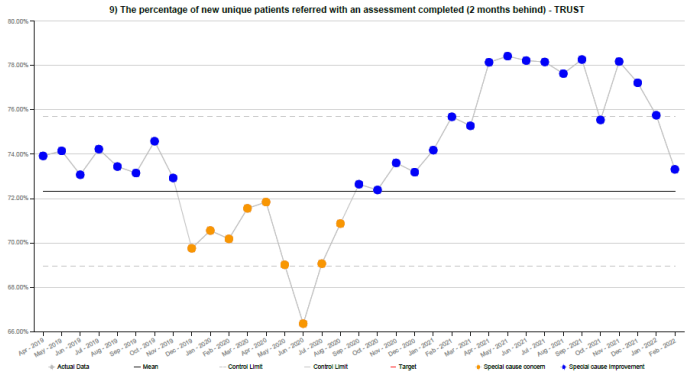
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment 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.

7537 patients referred in December; of those **5526 (73.32%)** patients have now had an assessment

H — We're aiming to have low 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	H

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 the following pages.	Improvement has been visible since September 2020.

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
Tees Locality			
We are not assessing as many children & young people (CYP) within our 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.	**Complete.** The Assistant Psychologist has started with the team. A Psychological Therapist and Band 6 Nurse have been recruited.	Improvement has been visible since September 2020; however a decreasing position can be seen. If improvement remains in March, it is proposed to remove this issue from the report.
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.	**Complete.** The process enabled 80 patients from the waiting list to be progressed to the teams. **Complete**. The Triage Coordinator, Highly Applied Psychologist and 0.5 whole time equivalent Applied Psychologist are now in post; the remaining 0.5 post will start in May 2022.	
North Yorkshire & York Locality			
Within Adult Mental Health (AMH) the York & Selby Mental Wellbeing Access service has been impacted by a significant increase in referrals.	'Stop the line' process to be initiated.	**Complete.** Staff capacity has improved in the team as staff have returned from short term sickness. Support is no longer required from the community teams and the team is no longer is 'Stop the line' process.	A decreasing position is continuing. We are considering any further actions that could be undertaken.
	The service to initiate a triage process to address the backlog of patients waiting for assessment from November 2021.	**Complete**. Triage process is in place and capacity has been created to screen referrals in line with service criteria. This has addressed the backlog; however, referrals continue to be above assessment capacity.	
	The Head of Service, Locality Manager, Team Manager and Advanced Nurse Practitioner to review staff capacity to enable the maximum number of assessments slots to be offered.	**Complete**. The review has been completed, staffing is now at full capacity and processes are in place to enable efficient management of the assessment slots.	

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
Within Mental Health Services for Older People the Hambleton and Richmondshire Memory service has been impacted by reduced consultant capacity.	The Locality Manager to develop a process enabling simpler diagnostic decisions to be made in a multi disciplinary meeting to facilitate quick assessment completion.	**Complete.** The team has developed a process to enable a diagnosis to be made where clinically appropriate, without a consultant. This will enable quicker assessment completions reducing waiting time for patients and will increase consultant availability for complex assessments.	The decreasing position is continuing; however actions remain ongoing.
There are a number of vacancies in Scarborough and Harrogate Memory Services. In addition, there has been a reduction in the number of venues in Ripon and Wetherby at which the Harrogate team can provide assessments.	Recruitment is underway to provide more staff to undertake assessments.	**Complete.** Harrogate, Ryedale and Whitby community teams are fully recruited to. Scarborough Community team have 3 clinical post vacant however all recruitment has been put on hold while they are reviewing their services.	
	The Harrogate team manager to modify the assessment pathway for less complex referrals using the DIADEM tool, tool used to assess memory patients which are less complex, to increase the number of assessments completed each week	**Ongoing.** Approximately 30 care home patients had been identified as potentially suitable to complete DIADEM rather than the routine assessment process; of these, only 5 were appropriate, 2 have been completed and 3 are booked in within next 4 weeks. For this to have a sustained positive impact on waiting times, we need to work with GPs to facilitate initial screening by them.	
	The Harrogate service to agree with primary care services the use of Ripon community building in and a Wetherby GP surgery.	**Complete** . Both locations are now being utilised.	
The teams are concerned they do not have sufficient nursing and medical staff to operate the current model and meet the demand of referrals.	The Scarborough, Whitby and Ryedale Locality Manager for MHSOP, with Quality Improvement and Finance, to review existing vacancies across all teams to better align posts to demand.	**Ongoing.** Initial data is being collated and a meeting is scheduled for the 1st March 2022 to develop an action plan; delivery dates will be included in future Board reports.	
Scarborough Memory Team are being impacted by delays in the delivery of computerised tomography scans.	Discussions to be held with the acute Trust.	**Complete**. Whilst discussions have been held it has not been possible to increase the number of scans available.	

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
Scarborough Memory Team is also being impacted by a reduction in medical staff resources due to long term sickness.	A ring fenced clinical post to be created to take over medication monitoring patients, releasing staffing capacity to the memory service.	**Ongoing.** Discussions are continuing with Recruitment.	

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.

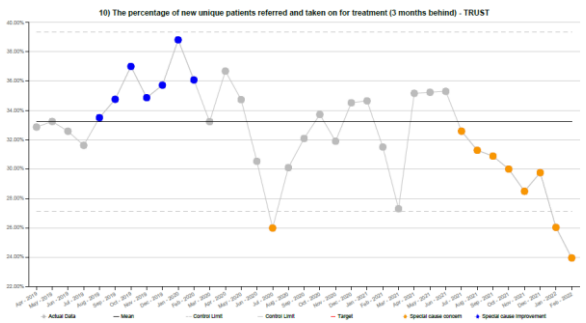
8524 patients were referred in November; of those, **2043 (23.97%)** patients have now been taken on for treatment

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.	The decreasing position is continuing; however actions remain ongoing.
Forensic Services			
We are treating fewer patients within our 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. **Completed**. Senior Leadership Group approved the removal of the L&D teams from the scope of this measure on the 24th November 2021. Work will be completed by March 2022 to implement the change within this measure. Providing no further concerns are identified, these issues will be removed from the March report.	Activity is at a level we would expect..

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
Tees Locality			
We are treating fewer patients within 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 to support pressures experienced during the pandemic.	**Complete.** The changes made during the pandemic enabled us to offer a memory service to patients without interruption.	A decreasing position is visible; however actions remain ongoing.
	The Consultant Psychiatrist to lead a wider review of the dementia pathway to strengthen pathway leadership.	**Ongoing.** The Dementia Pathway Group is now meeting monthly. Training has been delivered to all memory clinic staff and a series of actions have been identified for the coming months including working with GPs to facilitate blood tests and other investigations required as part of the referral process, reviewing referrals and diagnostic processes to achieve consistency, and working with user/carer groups on the delivery of memory services.	
Some treatment codes are not recorded correctly.	Service Development Manager (SDM) to review all data quality issues.	**Complete**. The SDM has developed training, which was rolled out to all staff on the 1st October 2021, and all treatment codes are being recorded correctly.	
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.	**Complete.** All episodes of long term sickness have ended and staff have returned to work.	
	Recruitment to be undertaken to fill all vacancies.	**Complete.** Recruitment is now complete and staff are going through induction processes.	
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	

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
Children & Young People's Services have a new service model, triaging referrals in a Single Point of Contact (SPOC) 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 and processes have been streamlined. Patient flow through the SPOC teams has improved and both teams are now achieving the standard.	A decreasing position is visible.
North Yorkshire & York Locality			
We are concerned that within our 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.** There is now only one vacant post within the team; however following the impact of short term sickness within the team, they are currently undertaking 16-18 assessments a week as opposed to the ambition of 20.	A decreasing position is continuing. 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.	**Complete**. The deep dive identified that assessment and treatment intervention codes are not recorded consistently on PARIS as this is not the team's primary patient based system.	
	The team manager to work with the team to resolve the current data quality issues and agree a data recording process. This work will be completed in November.	**Ongoing**. As Paris is not the main system for the capture of activity, a standardised process has been established to ensure treatment interventions are recorded and reviewed to resolve any data quality issues. However most patients seen by the team do not usually commence treatment, but are referred to the memory service or partner organisations to prevent mental health crisis. Further investigations will be undertaken in March with the service to consider whether it is appropriate this service be included within the measure.	

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
North Yorkshire & York Locality			
Within Children & Young People Services (CYP) the Northallerton, Selby, Harrogate and York East community teams have reduced staffing capacity due to a number of vacancies. This has been further affected by support they have been providing to the York CYP Crisis service.	Recruitment is underway, which would provide more staff to be able to provide treatment appointments.	**Ongoing.** Recruitment is continuing in York East, 1 post has been recruited to and is undergoing pre-employment checks; 3 Clinical Nurse posts are being advertised. In Selby, 2 administrative staff have been recruited and are undergoing pre-employment checks; 7 posts (a mix of roles) are currently out to advert. In Harrogate 3 posts are currently being advertised and the Crisis team are recruiting 3 clinicians. The Child & Adolescent Mental Health Services community teams continue to provide support to the Crisis team on an adhoc basis.	A decreasing position is continuing. Actions remain ongoing.
	'Stop the line' process to be established to enable current processes to be reviewed.	**Complete.** The service has held a number of locality-wide events to look at pressures across all of the teams and are working with Organisational Development to understand the impact for staff and to formulate an action plan.	
Staffing resources due to sickness and staff turnover is resulting in delays in the Northallerton community team.	Director of Operations to raise staff concerns at Gold command in February to establish whether the team implements business continuity.	**Complete**. Business continuity has been implemented for the team.	
Potential recording issues have been identified within the Scarborough Community team.	The team manager to review the use of treatment codes within the team during November. An update will be provided in December.	**Complete.** The caseload refresh and safety summary work is now complete and identified recording issues have been resolved.	
Within Adult Mental Health (AMH) the Harrogate Community service has a number of vacancies that they are struggling to appoint to.	Recruitment is underway, which would provide more staff to be able to provide treatment appointments.	**Ongoing**. Five vacancies remain; 3 have been recruited to. In the interim, support has been provided by recruiting agency staff; they are expected to commence in post in March.	A decreasing position is continuing; however, actions remain ongoing.

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
The York & Selby Wellbeing Access service has received a significant increase in referrals, which has impacted staff capacity as the team has a number of vacancies and some staff sickness. This has reduced the number of assessments that can be completed and consequently, the number of patients taken on for treatment.	'Stop the line' process to be established to enable current processes to be reviewed.	**Complete.** Staff capacity has improved following the return of staff from short term sickness; therefore support is no longer required from the community teams and the team is no longer in 'Stop the line' process.	A decreasing position is continuing. We are considering any further actions that could be undertaken.
	All referrals for patients that have been discharged within the last year to be allocated directly to the community teams in York and Selby.	**Complete.** Processes are in place to enable patients to be assessed and allocated slots quickly following re-referral; staff have been supported to up-skill to provide more efficient assessments. Assessment processes are embedded and most patients are now being assessed within 4 weeks of referral.	
	The service to initiate a triage process to address the backlog of patients waiting for assessment from November 2021.	**Complete**. Triage process is in place and capacity has been created to screen referrals in line with service criteria. This has addressed the backlog; however, referrals continue to be above assessment capacity.	
	Recruitment is underway, which would provide more staff to undertake assessments.	**Complete**. The team are fully recruited and staff are progressing through pre-employment checks.	
Durham & Darlington Locality			
In 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.** All actions identified as part of TD02 Percentage of patients starting treatment within 6 weeks of an external referral, are relevant to this measure.	A decreasing position is continuing; however, actions remain ongoing
Within Adult Mental Health Services performance is being impacted by data quality issues within the Access team.	Locality Manager to meet with the Access Team leadership in December to agree the actions required to improve data quality.	**Ongoing.** All actions identified as part of TD02 Percentage of patients starting treatment within 6 weeks of an external referral, are relevant to this measure.	A decreasing position is continuing; however, actions remain ongoing

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

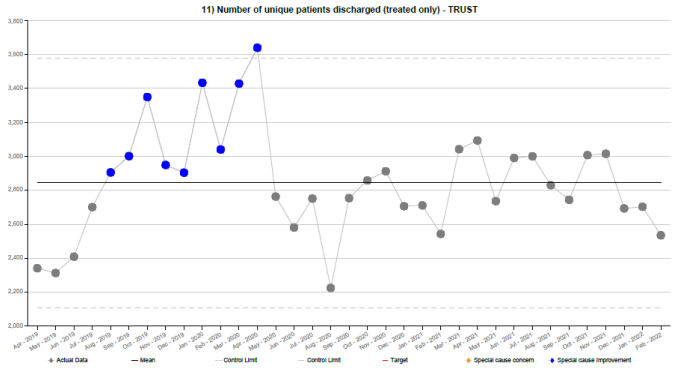
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are discharged from our services is important as it demonstrates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

2535 have been discharged in February 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 was fully investigated and attributed to:

- a restructure within the Children & Young Peoples Services generic community from a 4-team model to a 7-team model, sharing caseloads across the 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 we concluded this was not an area of actual concern.

However, the decrease within that Locality is continuing and to assure ourselves that there are no other underlying issues, the Corporate Performance Team will engage with the Service Managers to undertake further analysis during March 2022.

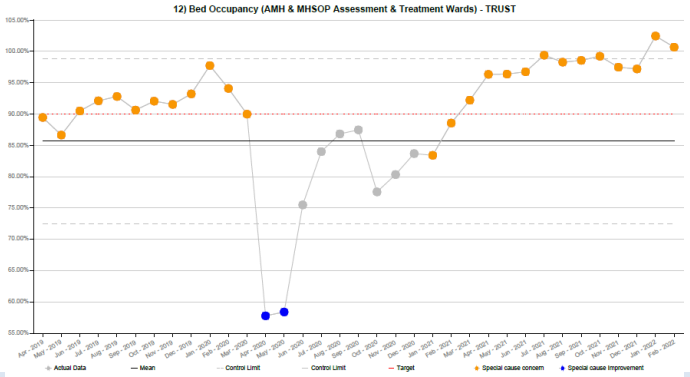
TD12) Bed Occupancy (AMH & MHSOP A & T Wards) – *Trust Standard 90%*

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 February **9436** daily beds were available for patients; of those, **9498 (100.66%)** were occupied.

- 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). 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.	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. Demand forecasting analysis to be undertaken to understand future pressures. Four beds to be purchased in the independent sector for AMH and MHSOP patients. Increased focus to be given to inpatient pressures at Locality Quality Assurance & Improvement Groups.	**Completed.** Following initial analysis, data is monitored monthly. Services have established groups to review patients with longer lengths of stay and Bed Managers are in post to monitor inpatient pressures more closely. **Completed.** Analysis shared with Chief Operating Officer, directors and key representatives of inpatient management. Routine monitoring agreed. **Completed:** Contract commenced 13th August 2021 and has now been extended to the 30th June 2022. An additional fifth bed has been purchased and all 5 beds are occupied. **Ongoing.** Discussions continue within the monthly meetings; however these were stood down during January and February due to service pressures. The next meeting is to take place on 11th March and an update will be provided in April 2022.	The increasing position remains visible and we have reported over-occupancy for two months. Actions are still ongoing.

TD12) Bed Occupancy (AMH & MHSOP A & T Wards) - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Throughout January 2022, significant pressures have continued in inpatient services and acuity is high. One 13 bed female AMH ward has been closed to admissions, and 2 further AMH wards (one male and one female) and 2 MHSOP wards have been closed to admissions due to Covid outbreaks.	External support to help us to understand if there is anything further we can do to manage inpatient pressures and out of area placements to be commissioned.	**Ongoing.** The three suppliers approached did not submit quotes and there is now no prospect of this work commencing in 2021/22. The lead for the Clinical Strategic Journey is to review the requirement to determine whether all work elements are still required, and the next steps will be agreed. An update will be provided in April 2022.	
	Bed census to be undertaken to help us understand our current patient base.	**Complete.** The bed census has been undertaken and shared with Senior Leadership Group and Service Development Groups. A number of actions and proposals are being considered and will be included in March's report.	

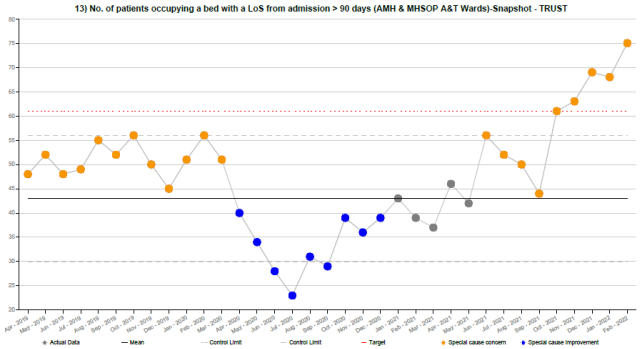
TD13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards – T*rust Standard no more than 61 patients*

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 28th February 2022, **75** inpatients had a length of stay longer than 90 days

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
P – Our system is expected to consistently hit the target/expectation	DQ ★ – **100%**



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

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Durham & Darlington Locality			
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 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. Demand forecasting analysis to be undertaken to understand future pressures. AMH service to form a Quality Assurance Group (QuAG) sub group to discuss and agree further actions.	**Complete.** Following initial analysis, data is monitored monthly. Findings continue to show the majority of instances involve patients with complex needs. No further themes were identified. **Complete.** Analysis shared with the Chief Operating Officer, directors and key representatives of inpatient management. Routine monitoring agreed. **Complete.** QuAG met on the 19th November and additional actions have been identified; these are detailed below.	An increasing position remains visible. Actions remain ongoing.

TD13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
	The Locality Manager to start weekly locality meetings to review 60+ and 90+ day admissions. The meeting will discuss any concerns and escalate issues from ward level up to locality managers. It will enable the locality to understand any common themes or concerns they need to take to further locality or Trust-wide discussions	**Complete**. Established at the end of November the meeting includes leadership representation from the clinical inpatient, crisis and community teams.	
	Service Manager to develop a flowchart detailing funding streams and escalation routes, to make it easier for clinical teams to find suitable placements for patients ready for discharge and address delays. An update will be provided in February 2022.	**Ongoing.** This is progressing to plan and the flowchart will be developed in March.	An increasing position remains visible. Actions remain ongoing.
	Consultant Psychologist to develop a template for completion of Independent Funding Requests by the end of December to increase the efficiency of this process. An update will be provided in February 2022.	**Complete.** The template has been developed and embedded into processes.	
	Work is underway within MHSOP with Local Authorities to facilitate discharges into local care following the issue of new legislative guidance.	**Complete.** We have developed partnerships with Local Authority legal teams to seek advice and work through processes where suitable places are available for patients but outside the area their families prefer. This ensures patients and their families are supported by the local authority and ourselves. However, our concern remains that whilst we are working to find patients appropriate care facilities, we are placing more patients in care homes outside of their preferred area.	
	The service to meet each week to discuss all patients with a length of stay over 50 days to discuss any issues or concerns and actions in place where possible.	**Ongoing.** The meetings are continuing and the challenge remains to find care home placements within the locality area and patient/family care home choice. These are issues outside of Trust control.	

TD13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Tees Locality			
In October 2021 we identified a potential area of concern in Mental Health Services for Older People (MHSOP). This is attributable to the needs and level of support required for the patients in our care.	Locality Manager, ward managers and community team leads to meet weekly to review patients with a length of stay over 50 days, to discuss any issues or concerns and establish any actions.	**Ongoing.** The meetings are continuing and the challenge remains to find funded care home placements within the locality area and patient/family care home choice. These are issues outside of Trust control.	An increasing position remains visible. Actions remain 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.

204 patients were discharged during February; of those, **17 (8.33%)** were readmitted within 30 days

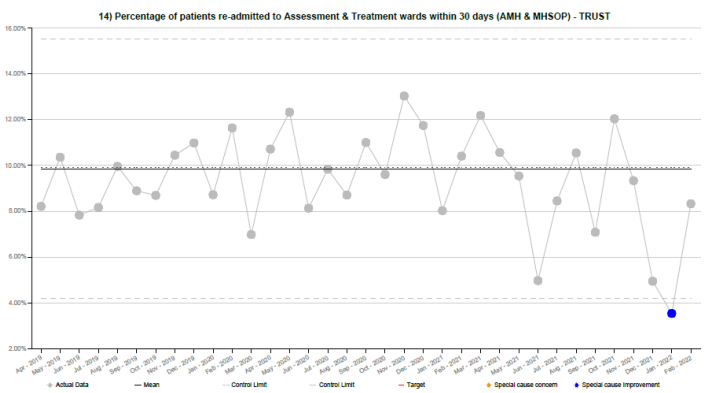
Nothing to note. Our activity is within the expected levels of performance

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

We have achieved the standard we have set ourselves and whilst, we remain concerned about the pressures on inpatient services within Adult Mental Health and Mental Health Services for Older People, our performance against this measure indicates that we are not readmitting a significant number of patients within 30 days of their previous admission and are, in fact, seeing a visible improvement.

Therefore, at this stage this measure is not a cause for concern.

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

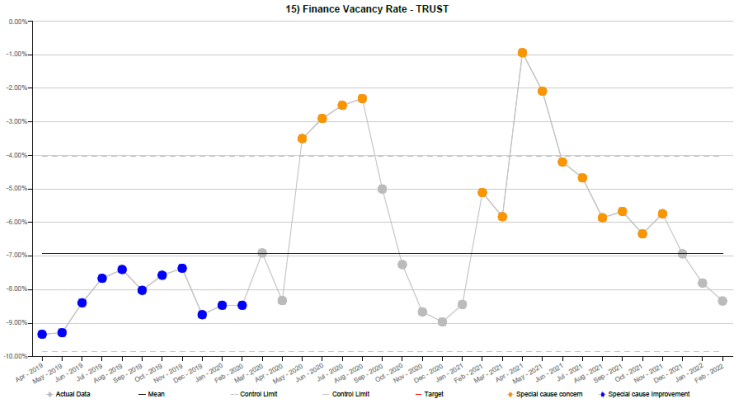
We are all committed to co creating a great experience for patients, and carers and families by ensuring we have staff available in the right place and with the right skills, supporting continuity of care for our patients. As a Trust having a full establishment ensure we can manage our resources and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

During February we budgeted for **7760.38** full time posts; however **647.07 (8.34%)** of these were vacant

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 ✓ **80%**



KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that we have a high number of vacancies across the Trust. First identified in August 2021, the highest levels were identified within Tees and North Yorkshire & York.	Analysis to be undertaken to understand whether there were any areas of concern.	**Complete.** Analysis has been undertaken and a number of issues have been identified. These are detailed on this and the following page.	A decreasing position is visible and performance is at a level we would expect. Actions remain ongoing.
Tees Locality			
The current position within Children and Young People's (CYP) services is impacted by significant investment into the Child Eating Disorder service earlier in the year. Whilst a number of people are in post, the service model is in the process of being developed and the remaining posts will not be recruited to until the end of this financial year.	Head of CYP and team managers to agree the service model and complete recruitment by the 31st March 2022. An update will be provided in December 2021.	**Complete**. The service model has been agreed and an intensive home treatment team has been established to provide intensive packages of care for families within the home, or support when in acute care. All posts are fully recruited to.	No visible impact.

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
There is a high number of vacancies within Adult Learning Disability (ALD) Services.	To undertake a recruitment campaign with the external company Indeed, to support the recruitment of up to 18 Health Care Assistants (HCA). This work is being led by the Head of ALD and is part of the work around changing the workforce model for Inpatient services.	**Ongoing.** Vacancies remain for 14 healthcare assistants.	A decreasing position is continuing and performance is at a level we would expect. Actions remain ongoing.
	Head of ALD to develop a 12 month recruitment strategy for LD services. The aim is to market the service and nursing roles and includes linking with local schools and colleges to promote the role of ALD nurses. An update will be provided in January 2022.	**Ongoing**. This work is now being undertaken as part of a Trust-wide workforce package within the Adult Learning Disabilities Inpatient Redesign Programme Board. A Trust-wide recruitment working group has been created to manage immediate pressures and longer term strategy. Work includes standardising processes and implementing efficiencies, including the establishment of service leads to liaise with recruitment candidates. A dedicated recruitment event is being planned and connections are being established with local education providers. We are also exploring work experience placements to ensure we have a robust succession planning strategy.	
North Yorkshire & York Locality			
All specialities within the locality are struggling to recruit, with nursing posts, in general, and the Scarborough, Whitby & Ryedale area, in particular, being impacted the most.	Employment of a Project Manager for Recruitment & Retention to support intensive improvement work.	**Complete.**	A decreasing position is continuing and performance is at a level we would expect. Actions remain ongoing.
	Vacancy advertisements to be improved, including communication methods (eg using social media) and international recruitment. An update will be provided in February 2022 once these have been embedded.	**Ongoing**. Recruitment is continuing and 8 international nurses are being recruited for the Scarborough, Whitby & Ryedale area. However, international constraints placed upon some candidates are causing delays.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
	A 1-year pilot to be undertaken for Scarborough Inpatient services, to enable a premier to be paid to staff recruited to these posts.	**Ongoing**. The service have commenced recruiting to posts in Scarborough Whitby & Ryedale using premier payment. The exact numbers of staff that can be recruited will be confirmed by the Corporate Recruitment team in March 2022.	
	A community bank service to be created within the Trust to reduce the use of agency staff. An update will be provided in January 2022.	**On hold**. A proposed community bank model was discussed at the Workforce Senior Leadership Group in January and the concept approved. This work is being led by the Senior Programme Manager for Safe Staffing and further analysis is required to understand demand within community services. This will be completed early Quarter 1 2022/23; until then this is on hold.	A decreasing position is continuing and performance is at a level we would expect. Actions remain ongoing.
	An exercise to be undertaken by the Senior Project Officer Recruitment & Retention to identify the reasons for staff leaving and actions we can take to improve retention. An update will be provided in January 2022.	**Complete.** The exercise has been completed by the Senior Project Officer Recruitment & Retention and findings are being shared with the Locality (please see below action).	
	The Project Manager for Recruitment and Retention to undertake conversations with Locality and Team Managers to discuss any actions to support the work/life balance of staff, including ways jobs could be more flexible.	**Ongoing**. An update on these discussions will be provided in March 2022. In the interim a 'Don't go' leaflet has been distributed to encourage staff to stay within the Trust.	

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 **6269** eligible staff in post at the end of February; **4934 (78.70%)** had an up to date appraisal

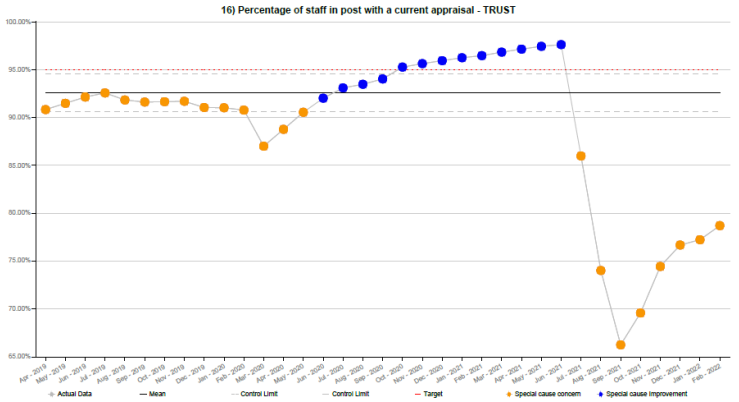
We're aiming to have high performance and we're moving in the wrong direction.

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.** Tees Locality and Forensics Services have a trajectory for achieving standard by the 30th April 2022. Durham & Darlington developed some initial trajectories but there is concern that these need to be revisited and a further discussion is being tabled at the March Locality meeting. North Yorkshire & York do not have any trajectories is place.	An increasing position continuing; however this does not yet denote an improvement. Actions remain ongoing.

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.

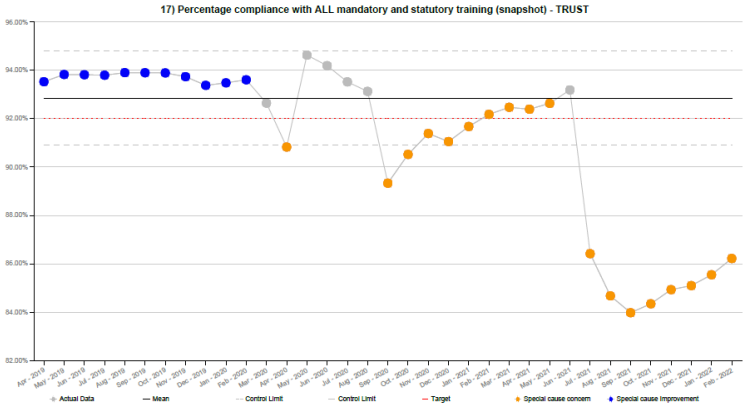
107,654 training courses were due to be completed for all staff in post by the end of February. Of those, **92,830 (86.23%)** courses were actually completed

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

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

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.** Health & Justice Services are achieving standard and secure Inpatient Services have a trajectory in place to achieve standard by July 2022; compliance is being impacted by the availability of face to face courses. Durham & Darlington developed some initial trajectories but there is concern that these need to be revisited and a further discussion is being tabled at the March Locality meeting. North Yorkshire & York and Tees do not have any trajectories is place; compliance is being impacted by staffing pressures, vacancies, use of bank and agency and patient acuity.	A slightly increasing position is now visible; however this does not yet denote an improvement. Actions remain ongoing.

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.

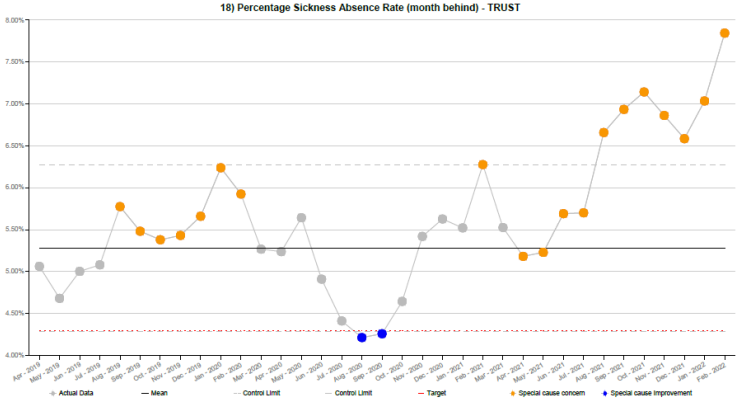
There were **215,778.94** working days available for all staff during January; of those, **16,913.65 (7.84%)** days were lost due to sickness.

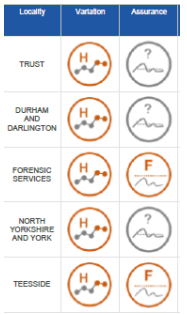
We're aiming to have low performance and we're moving in the wrong direction.

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

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

DQ ✓ **85%**





Note: the Omicron variant was prevalent during January 2022

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.	**Ongoing.** Whilst a number of actions are ongoing within the localities, improvement has been impacted by the Omicron wave that started in December.	An increasing position is visible; however actions remain ongoing
Durham & Darlington Locality			
Sickness within the Crisis team in Adult Mental Health Services is being impacted by current low staffing levels.	Team Manager to ensure all long term sickness Is managed in line with Trust policy.	**Ongoing.** Regular reviews are in place and a number of members of staff have returned to work; 3 long-term sickness absences are ongoing. The team is currently operating at 50.7% staffing.	An increasing position is visible; however actions remain ongoing.
	Recruitment is underway to increase capacity within the team.	**Ongoing.** Further staff have left and there are now 18.06 wte vacancies. Currently 9 posts have been recruited to but are pending a start date. Further options are being considered to try to attract more applicants.	

TD18) Sickness Absence - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Forensic Services This was first identified as a concern in May 2020 and issues identified included a number of long term sickness episodes and the impact of Covid-19.	An action plan is in place for Secure Inpatient Services (SIS).	**Ongoing.** The Forensics Sickness action plan has been refreshed to reflect the current situation in the service and focus on Secure Inpatient Services, which has been driving the Directorate position. Sickness absence rates increased in January 2022 to 17.3%. Of the 360 episodes of sickness across all Forensic Services, 143 were due to Covid 19; 130 were within SIS. The new action plan was implemented in January and has 17 actions, of which 9 have been completed. Remaining actions include: • Summarising the findings and themes from audits of SIS staff cases with high episodes of absence. • Training sessions & supporting documentation for managers on management of sickness to be offered • A review of the support packs / leaflets to send to staff absent due to sickness • The provision of sickness administrative resource to support trend analysis of ward sickness • Training to be provided to managers on effective 'return to work interviews' • Human Resources lead to discuss the use of Return to work interview soft intelligence with teams, and how it can be used to understand absences and any additional support that may be required. • The uptake of Trust employee support services to be explored to understand why this may be lower in Secure Inpatient Services than other areas of Trust • Quarterly review of cases over 90 days with Head of Service and General Manager.	An increasing position is visible; however actions remain ongoing.

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
	During March 2022, Human Resources Lead to resend communications out to all Health & Justice (H&J) teams to promote the weekly HR drop I clinics.	**Not started**	
	By April 2022, Human Resources Lead to review the uptake of Trust employee support services by H&J staff, with a view to identifying whether the services are used and if any lessons can be learned and improvements implemented.	**Not started**	
We have a high number of staff absent from work due to sickness within the Oakwood Locked Rehabilitation centre.	By March 2022, Human Resources Lead to meet with the team managers to obtain a background and intelligence on any staff concerns.	**Ongoing.** The Human Resources lead has met with the current team manager but further discussions are required with the previous manager, to understand any historic issues. This will be completed in March.	
Tees Locality			
Within AMH, long and short term sickness absence is monitored weekly by the Head of Service and Locality Manager. All episodes of sickness are managed according to Trust Policy. Caseloads of those staff on long term sickness are being reallocated to ensure that patients are not waiting; however, this is impacting on the stress levels of remaining staff.	A review of locality sickness pressure to be undertaken to identify any actions required to mitigate risk.	**Complete.** Caseloads of those staff on long term sickness are being reallocated to ensure that patients are not waiting; however, this is impacting on the wellbeing of the remaining staff.	An increasing position is visible; however actions remain ongoing.
	The Locality Manager to proactively encourage good wellbeing practice within the Middlesbrough Affective Team.	**Ongoing.** A number of meetings have taken place with the Consultant Clinical Psychologist and action plans have been developed. Supervision is being prioritised along with caseload management to enable to staff to maintain workable caseloads.	
	Recruitment to be undertaken within the Hartlepool teams.	**Ongoing.** Two vacancies have now been appointed to. Interviews for the remaining 1 vacancy are scheduled for March; therefore it is proposed that this action will be closed from next month.	
	Regular contact to be maintained with all staff absent from work. This will be supported by the Workforce team.	**Complete.** Regular contact is maintained and this is supported by the Workforce team.	

TD18) Sickness Absence - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
	During March 2022, Human Resources Lead to resend communications out to all Health & Justice (H&J) teams to promote the weekly HR drop I clinics.	**Not started**	
Ongoing staff sickness and vacancies are impacting the ADHD team.	Paper to be submitted to the February Quality Assurance Group with a proposal to outsource assessments to a private provider.	**Completed:** The paper was submitted and plans are underway progress the proposed actions relating to the current Waiting List Initiative. A further meeting is scheduled for the 24th March.	
North Yorkshire & York Locality			
We are concerned that a number of members of staff within North Yorkshire & York are absent from work due to sickness.	The Corporate Performance Team to undertake further analysis with the Service Managers during March 2022 to identify if this is an area of concern.	**Not Started.**	

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 delivered a **(£5,406k)** surplus to 28th February against a planned year to date surplus of **(£4,609k),** including £509k unplanned profit on asset disposal.

(£797k) Favourable variance from plan

No further action is needed at this point in time

DQ ✓ **95%**

TD 21) Cash against Plan

We have an actual cash balance of **(£93,509k)** against a planned year to date cash balance of **(£79,834k)**.

(£13,675k) Favourable variance from plan

No further action is needed at this point in time

DQ ✓ **95%**

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

SUMMARY

The Trust targeted a (£4,720k) surplus for the first 6 months of the financial year (H1), and delivered a £5,021k actual surplus. A second half (H2) surplus of (£47k) was planned, providing a full year planned surplus of (£5,068k). The surplus to 28th February is (£5,406k), or (£797k) ahead of the (£4,609k) year to date plan. This includes (£509k) of unplanned profit from a fixed asset disposal (land); which is excluded when assessing financial performance, leaving (£288k) favourable operational plan variance.

Work is now in train Integrated Care System (ICS) levels to understand the implications, for individual organisations and 'sub ICS' places, of 2022/23 ICS-level draft revenue and capital envelopes. Planning requirements for 2022/23 to 2024/25 are understood to be targeted to support the NHS to navigate a planned phased national return, or 'glidepath', to more normal capitation-based revenue allocations. Business Planning activities to assess, coordinate and prioritise resource requirements for the new financial year have commenced. This includes assessing options for delivering recurrent cash releasing efficiency savings and the scoping of opportunities identified before the Pandemic. Key programmes of work include:

- Reconciling of our anticipated income including shares of Place level income and Service Development Funding compared to forecast expenditures
- Agreeing key planning assumptions, including for workforce recruitment, turnover, vacancy profiles and their management
- Assessing key plan risks including i) from tariff-based funding mechanisms for nationally negotiated Agenda for Change and employers national insurance increases, and ii) forward risks from increased employer NHS Pensions contributions (funded nationally again in 2022/23, but with recurrent arrangements unknown).

Cash balances are £13,675k higher than plan. This reflects the £797k higher than planned surplus, receipt of £2,250k central capital funding, £889k lower than planned capital expenditure, and other movements in working capital including deferred income and increased accruals linked to capital and for IT equipment, where invoices from suppliers have not yet been received.

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

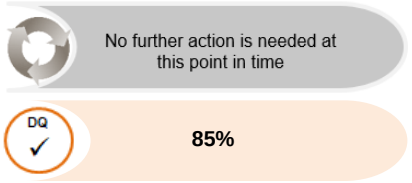
TD20) CRES Delivery

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 planned to deliver **£1,994k** Cash-Releasing Efficiency Savings (CRES) for the year to date and have identified **£1,994k non-recurrent** CRES mitigations.

£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 to within overall income, including to deliver national efficiency expectations (set out in national tariff assumptions) and to managed any additional cost pressures arising from organisational and / or system operational plan requirements. Tariff adjustments are usually applied to provider contracts annually and comprise:

- a national % uplift for estimated pay and price inflation, offset by
- a national % 'deflator' for the required annual efficiency requirement

Providers receive the 'net' cash increase of an inflationary % uplift less the efficiency % deflator. This means that CRES are needed to maintain real terms funding levels (to finance inflation). CRES requirements will exceed the national tariff efficiency requirement where other local unfunded cost pressures need to be managed. The NHS seeks to find more cost efficient ways to deliver services and utilise resources. E.g. CRES might include reviewing processes, staffing skills mix, premises utilisation, procurement or digital solutions.

As a result of national financial arrangements operating during the pandemic, the focus on CRES was initially suspended. More recently, the NHS was asked to recommence CRES delivery in 2021/22 with a view to returning to more normal 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).

High level 2022/23 national planning guidance was issued on 24th December, with supporting allocation tools and technical guidance following during January. Guidance included a national tariff efficiency requirement of 1.1% for 2022/23. Regional financial pressures suggest that organisations will need to target a minimum of 2% recurrent efficiency an/or waste reduction schemes for 2022/23. The Trust Board will consider the draft financial plan when it meets in March 2022.

System Oversight Framework

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

SUMMARY

From a **Trust** perspective, 4 standards have not been met during February:

- IAPT: Percentage of people who have waited more than 90 days between first and second appointments
- The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment
- The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment
- Number of inappropriate OAP bed days for adults by quarter that are 'external' to the sending provider

These are detailed below, with key **CCG** levels of concern.

1. **IAPT: Number of people accessing the service** – We did not achieve the ambitions within all CCG areas during February. Actions are in place to increase the number of appointments available to our patients as well as to ensure staff are in place to deliver the number of assessment appointments required.

2. **IAPT: Percentage of people who have waited more than 90 days between first and second appointments** – As a Trust we are exceeding the 10% standard at 13.50% as we have not delivered the standard in all four CCG areas County Durham (14.09%), Tees Valley (Darlington Service) (14.66%), North Yorkshire (12.08%) and Vale of York (12.95%). This is the first month of concern for North Yorkshire and analysis is underway to understand the position and any actions required. Within County Durham and Tees Valley, actions are in place to increase staffing levels and waiting list management is ongoing. Within Vale of York staffing levels have been a concern but these have now increased and vacant posts are being advertised. Work is also underway to review the waiting lists to increase flow and ensure efficiency, which has enabled the service to reduce waiting times from 17 to 10 weeks.

3. **Inappropriate out of area placements for adult mental health services** - *This measure is contained within the Board Performance Dashboard (TD03) please see page 21 for further details.*

4. **Proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment** - The children and young people within our Eating Disorders service are waiting longer than the 95% national standard for routine referrals at Trust level (54.79%) and within all CCG areas; County Durham 33.33%, Tees Valley 80.61%, North Yorkshire, 40.74% and Vale of York 51.47%.
5. **Proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment** - The children and young people within our Eating Disorders service are waiting longer than the 95% national standard for urgent referrals at Trust level (46.96%) and within all CCG areas; County Durham 50.91%, Tees Valley 58.33%, North Yorkshire, 35.71% and Vale of York 30%.

   Within County Durham and Tees Valley work continues to fill vacancies and to ensure that appointments are available at times and venues suitable for patients. Within North Yorkshire and Vale of York recruitment is also continuing, in addition to focused improvement work on the referral forms used by referrers. A Kaizan improvement event took place in February and the assessment process has been streamlined

Tees, Esk and Wear Valleys NHS
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Item 12

Quality Assurance Committee: Key Issues Report

Report Date to Board: 31st March 2022

Date of last meeting: 3rd March 2022. **Membership:** Quoracy was met. Apologies received – Bev Reilly, Chair of Committee

1 **Agenda items considered:**

- Board Assurance Framework and Corporate Risk Register – risks to Quality and Safety
- Trust Level Quality Assurance & Learning Report
- CQC Inspections and updates from NHSE/I and TEWV Quality Improvement Board
- Locality updates (North Yorkshire & York, Teesside, Durham & Darlington, and Forensics)
- Safe Staffing
- Draft Quality Assurance Programme 2022/23
- Annual Clinical Audit of Emergency Response Bags

2a **Alert (by exception)**

The Committee alerts the Board to the following:

CQC Update and NHSEI Quality Board:

The Committee were advised that preparations were being made for Engagement with the CQC on 9th March 2022, and that the purpose of the meeting was to review the Trust's position in relation to a whistleblowing incident concerning safeguarding in secure inpatient services (SIS) and action plans in response to the S29A letter, linked to children's services (CAMHS) and Forensic Services.

The Committee was given assurance that immediate actions had been taken, following the whistleblowing concerns in SIS, to ensure that patients were safe and safeguarded.

Three out of the four actions in the CQC Action plan (Core service/Well led) that were due to be completed by the end of February 2022 remained at amber status. This was due to resource issues linked with staff sickness over the last couple of months (Omicrom), together with the need to embed some of the changes that would then demonstrate the actions should turn green.

Committee members voiced their concerns over whether the Trust was able to provide positive assurances to the CQC at the Engagement meeting, based on the many challenges for the organisation, particularly managing sickness, recruitment and retention issues as well as high levels of acuity and demand on services.

In response to the challenge, members were advised that the Trust's approach to updating the CQC would be with absolute transparency and honesty, recognising that assurance could only be provided where there is evidence of the mitigations making a real difference.

Trust Level Quality and Learning Report:

The Committee noted an update with assurance on the key areas of quality and safety of patient care at a trust level. Statistical process Control (SPC) is used where appropriate to identify where situations may be improving or deteriorating.

The Committee noted that unapproved incidents for January had improved with 485 incidents. 99% of these related to no or low harm. A process of prioritisation for all moderate harm and above is in place which equated to 1% of the unapproved incidents,

At Trust level there were four measures of quality and safety in January 2022, that are reporting statistically as a cause for concern,

- Self-Harm (506 incidents were recorded in January).

- Number of patients occupying a bed with a Length of Stay from admission >90 days
- Mandatory Training (trust and locality level (92,617 training courses out of 108,268 in January which is 85.54% compared to our standard of 92%). The two key areas of concern relate to Basic Life Support and Positive Approaches Team training, both delivered face to face therefore impacted by Covid. (The Trust is currently implementing a recovery plan focusing on the high-risk areas)
- Appraisal Training - Trust and locality level (4,836 members of staff out of 6,262 in January which is 77.23% compared to our standard of 95%)
- The number of Adult and Older People staying in beds longer than 90 days (68 patients in January compared to a standard of no more than 61).

The Committee requested a report detailing the Trust programme of work underway in relation to suicide and self-harm.

Locality Updates:
The messages from all four localities remained consistent. Staffing issues, vacancies and recruitment and retention. Staff health, wellbeing and morale. High bed occupancy accompanied by a continued high acuity of patients. The impact of the closure of some care homes. A continued challenge to meet mandatory training requirements, appraisals, and basic life support training. Each locality provided mitigations in relation to the efforts being made to address concerns.

Committee members challenged the variation in reporting from the dashboard in relation to the use of tear proof clothing. (Dashboard reported seven uses in January, whereas the locality report from Forensic services confirmed there were eight uses relating to four different patients from Sandpiper Ward). This was placed on the action log for resolution of the discrepancy to be reported back to Committee.

Clinical representatives from the localities asked for weekly updates to LMGB on the developments and transitionary progress of the new governance structures, including the Care Group Boards, from 1st April 2022 and this was actioned accordingly.

A short report was requested by the Committee with further information on progress by the Environmental Risk Group on the work underway to manage risks.

Monthly Safe Staffing Exception Report
The Committee noted the safe staffing report for January 2022.

Gold Command continued to monitor the areas remaining in business continuity.
A ward on SIS was collapsed to support staffing requirements within the service.
There were 90 shifts worked that exceeded 13 hours across the shift, 60 of which were under 14 hours. Some of these shifts related to staff helping to support patient care when there was a fire on Danby Ward with patients' safety decanted to Esk Ward. Other areas were Swift and Cedar PICU.

Staff continue to be encouraged to raise safe staffing incidents via the SafeCare red flag system and this remains a service priority, with an ongoing review of the staffing escalation process. During January 9.6% of available shifts had a red flag raised, 70% of which were reported on a day shift and 86% of the red flags were within SIS.

The use of agency had decreased by 0.7% from December to 12.1%.
The use of bank staff increased by 4.7% in December to 27.2% in January, primarily due to absence, observations, vacancies, business contingency planning and high acuity.
A deep dive was underway by Worforce Senior Leaders Group as workforce remains a high risk.

Enhancing Board Oversight: A New Approach to NED Champion Roles

The committee's attention was drawn to a new report from NHS England, which has implications for the role of the Quality and Strategy and Resources Committees. It is proposed that some of the previous champion roles transition to be discharged by the relevant Committee. The committees with their Executive Director leads will need to reflect on how to integrate those changes into Trust level reports.

2b	**Assurance: The Committee assures members of the Board on the following matters:** **Board Assurance Framework (BAF) (risks relating to QuAC)** The BAF presented to Committee was the version that went to the Board of Directors at the end of February and was currently awaiting updates from Executive Directors, ensuring that all risk profiles reflected the CQC inspection. Assurance was given to members of the Committee in relation to how any risks scoring above 25 are placed on the Corporate Risk Register, with monitoring and ownership at Executive Director level. **Corporate Risk Register – Risks to Quality and Safety** The Committee were advised that as part of the Internal Audit Programme, some work will be undertaken to look at the governance flow of risks from localities up to Sub-Committee level. The risk scoring matrix will also be changed to reflect the Trust Board Assurance Framework. Members challenged the downgrading of risk 1000: in relation to the quality and safety of care for young people who are placed in adult mental health beds, due to a lack of capacity in CYP as they felt this was still a significant risk. They were reassured that any young people placed in adult beds, will be given extra support to lessen any potential impact. It was also felt that ownership of this risk covers multiagency stakeholders, as it does not uniquely belong with the Trust. On the day of Committee, it was reported that delayed discharges had increased to 29. **Draft Quality Assurance Programme 2022/23** The Committee approved the draft Quality Assurance Programme for 2022/23. Members were provided assurance on the governance arrangements for the programme of audits, which the Audit and Risk Committee will also have oversight of. Concerns about ensuring that quality data is transfferred from Paris to CiTO will be raised at the Digital Programme Board. **Annual Clinical Audit of Emergency Response Bags** The Board is to note that this annual review of emergency response bags Trust wide demonstrates although there is generally high compliance with the practice standards, there are still challenges with achieving 100% compliance. This is despite good clinical engagement and the introduction of new response bags that are sealed to prevent items being removed. Four outstanding actions from the clinical audit will be completed. Assurance can be provided to the Board that any non-compliant areas in the audit were mitigated with immediate follow up with relevant assurance sent to the Clinical Audit and Effectiveness team. **Positive Practice Examples:** Thornaby Road CQC inspection was rated overall good. New Inpatient peer workers have been recruited and will start on AMH wards in April 2022, with a Community Peer Lead who will start in March 2022. A new SIS model of care was launched in secure services in February 2022. A development programme for ward managers and clinical leads commenced in January, which will look at how to lead a successful service.
2c	**Advise:** The Committee members agreed that the key issues to draw to the Boards attention from the meeting held on 3rd March 2022 are: 1. Staffing – recruitment and retention. 2. Bed availability. 3. Delayed transfers of care noting joint ownership of risk with multiagency involvement. 4. The request for a report on suicide and self-harm. 5. The request for a short report from the Environmental Risk Group on progress with the work to manage risks in relation to ligatures and self-harm. 6. Ongoing concerns about the health, safety and wellbeing of staff.
Recommendation: **The Board is asked to note** the contents of the report.	
3	**Risks to be considered by the Board:** There were no risks that were considered should be escalated to the Board.

	Report compiled by, Shirley Richardson, Acting Chair of Quality Assurance Committee, Elizabeth Moody, Director of Nursing & Governance/ Donna Keeping, Deputy Trust Secretary

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People, Culture and Diversity Committee: Key Issues Report		
Report Date: 31st March 2022	**Report of: People, Culture and Diversity Committee**	
Date of last meeting: 15 March 2022	The meeting was quorate, there were no apologies for absence	
1	**Agenda: The following agenda items were considered during the meeting:** • Colleague Story • Voluntary Services Annual Report • Board Assurance Framework and Corporate Risk Register • Equality & Diversity Scoring (EDS2) • Freedom to Speak Up Guardian • People & Culture Structure • Performance Workforce Dashboard and Staff Networks • Programme Board Plan on a Page • Staff Survey Results 2021	
2a	**Alert** **The Committee alerts members of the Board that:** **Staff Retention and learning from Exit Interviews** Members of the Committee discussed the importance of learning lessons from those staff members that are choosing to leave the Trust. It was acknowledged that there is some work to do to improve the processes that support this. **Cost of Living and Expenses** Concerns have been expressed recently at a Joint Consultative Committee and through other forums, that staff are increasingly worried about the cost-of-living rise, particularly the impact on mileage, especially those working out in the community. Members were advised that this matter has been raised at Senior Leaders Group and Executive Directors are considering the potential impacts, in line with national guidance.	
2b	**Assurance** **The Committee assures members of the Board that:** **Board Assurance Framework & Corporate Risk Register** The Board Assurance Framework (BAF) has been reviewed. Although there are no significant changes this month, it is anticipated that there will be some adjustments to risks, reflecting progress on mitigating actions. The Corporate Risk Register was circulated on the day of Committee. Directors of Operations are flagging up those areas that are difficult to recruit to and consideration will be given to how this is reflected on the Corporate Risk Register and potentially the BAF. **Freedom to Speak Up Guardian Report** The Committee received the first update on developments within the Freedom to Speak up role over the last six months, together with local, regional, and national developments. Members requested that the report come back to the Committee on a six-monthly basis. (Alternating with the formal board report)	

	The Board is to note that a member of staff has reached out to NHSEI to report a patient/staff safety concern. The concerns are related to patient dignity, the environment and the adequacy of staff training to be able to provide the level of care necessary. Given the multiple strands of the concerns a coordinator has been appointed to oversee developments. Assurance can be provided to the Board that immediate action was taken, with a visit to the site by an independent manager, which will be followed up with ongoing oversight of the service, both at a local level and with external support.
2c	**Advise** **The Committee advises the Board that:** **Colleague Story/Experience** The Committee heard about the experiences of a Trust volunteer and how the role had given him a sense of belonging, at a difficult time in his own life facing mental health challenges. He told members how he felt honored and privileged, to be part of the volunteering team and the Trust, which helps and supports people who are vulnerable. **Voluntary Services Annual Report** The Committee welcomed the significant growth in the variety of opportunities that are available for volunteers, which has happened largely in response to the pandemic, together with an increase in the number of volunteers to help support service users, carers, and families. Members asked for this good news, with regular updates going forward, to be published. **Performance/Workforce Report and Staff Networks** The Committee received an update on the key issues, actions being taken and progress on all workforce related matters, including staff networks. Despite an 80% increase in activity for the recruitment team over the last year there have been some significant improvements. Through the Quality Improvement (QI) work improvements have been made with the introduction of a single point of contact, starter forms simplified, 31% improvement in trac messages waiting and a 41% improvement in candidates waiting in the pre-employment stage. Due to the pre-employment stage being the most complex and time consuming, this has been managed by the Business Services Authority, since the beginning of March 2022, where there have been dramatic results. There has been a 96% reduction in candidates waiting for pre-employment checks and a reduction of 31% of people waiting for a conditional offer letter. **Evidence and Scoring (EDS2)** The EDS2 is a self-assessment tool to measure whether Trusts can demonstrate evidence of protected characteristics, with a range of scores including “undeveloped” – with little evidence of protected characteristics to “excelling” with all 9 protected characteristics. The Trust took the view that it would look for direct evidence linked to outcomes and experiences. It is, however, difficult to make any comparison with other Trusts as the approach taken and method of scoring varies. It is easier therefore for the Trust to focus on improvements. One of six components included in the criteria is: - being a ‘representative and supportive workforce’ and it is recognised that there is bias in the Trust recruitment process, with less people being shortlisted and appointed who have protected characteristics. A piece of work is currently underway with the University of Surrey to identify ways of reducing bias in the recruitment and interview process. **People & Culture Structure Update** Progress overall is going very well for the re-structure, with slotting staff into

	roles, interviews planned and staff side involvement. To ensure sufficient time for robust staff engagement, a one-week extension has been added to the timeline. **Staff Survey Results** Committee members were advised that efforts are being made to try and publish the survey results in a timelier way, as almost a year has elapsed by the time of publication. Ethical approval is being sought for some research which will pull out three questions from the staff survey and track them on a regular basis. Some of the positive results show that: ➢ Incidents of physical violence are more likely to be reported ➢ Staff feel less pressure from manager to attend work if not feeling well ➢ Less incidents of harassment, bullying or abuse experienced by staff from their colleagues or manager ➢ Staff feel trusted to do their job ➢ Staff feel secure when raising concerns on unsafe clinical practice Some of the negative results show that staff: ➢ Feel there are not enough staff to do jobs properly ➢ Wouldn't recommend TEWV as a place to work ➢ Wouldn't recommend TEWV to family or friends if they needed care or treatment ➢ Don't feel valued ➢ Are coming to work when unwell **Programme Board Plan on a Page** Members of the Committee welcomed the one-page infographic - 'Plan on a Page', which clearly sets out the top three challenges for People & Culture -recruitment and retention, staff wellbeing and culture. The plan also details the Great Place to Work Programme and the work that is being scoped to meet Our Journey to Change goal 2: *"to co-create a great experience for our colleagues. Improved staff experience will also improve the experience of patients, families and partners".* Assurance was provided that prioritising work for 2022/23 will take a clear steer from the Big Conversation considering what resources will allow.	
2d	**Risks**	Consideration was given if there are any new risks raised during the meeting for consideration of including on the BAF or CRR. There were no new risks identified.
Recommendation: The Board is asked to note the contents of this report.		
3	**Any Items to be Escalated to another Board Sub-Committee/Board of Directors**	There were no items agreed to be escalated to another Board Sub-Committee. There were two items that were agreed to be escalated to the Board: 1. The progress on recruitment. 2. The work that was underway in relation to retention, particularly trying to learn and understand from those people leaving the Trust.
4	**Report compiled by:** *Donna Keeping**, Deputy Trust Secretary (Corporate)*** Shirley Richardson, ***Non-executive Director/Interim Deputy Chair (Committee Chairman)*** Sarah Dexter-Smith, **Director of People and Culture** Minutes are available from: *Donna Keeping*	

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 14

For General Release

Meeting of:	**The Board of Directors**
Date:	**31st March 2022**
Title:	**Annual Staffing Establishment Review**
Executive Sponsor(s):	**Elizabeth Moody**
Author(s):	**Joe Bergin** **Andrea Reid**

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

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

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

Contribution to the delivery of the Strategic Goal(s):
The report aims to achieve the Trust's goal to ensure that its highly skilled workforce and staffing resource are made available at the right place and time to deliver the best possible experience for patients that is safe and of high quality***.***

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
1	**Recruitment and Retention**	**The staffing establishment review is a mitigating action against BAF risk 1**

Executive Summary:	
Purpose:	The purpose of this report is for information and to provide assurance of the Trust's approach to reviewing and addressing results from the clinical team staffing establishments over the period June 2021 – November 2021. The Trust needs to consider and ensure the correct baseline establishments to provide high quality patient care.
Proposal:	This report sets out a summary table of key findings and themes arising from the review, key actions and assurance flows. This report identifies a potential resource implication which will require presentation to the Resource Committee for further discussion following completion of the key actions identified.
Overview:	This report details the Trust approach to the mandated systematic review of staffing resources to ensure safe staffing levels are met according to national workforce guidelines and standards as described in the NHS Improvement 'Developing Workforce

	Safeguards' (NHSE/I, 2018) and the National Quality Board (NQB) guidelines (NHS, 2018). The report delivers against expectation 1 ('Right Staff', evidence based workforce planning and professional judgement) and 2 ('Right Skills', mandatory training, multi-professional working, recruitment and retention) of the NQB requirements and discusses expectation 3 ('Right place and time', effective deployment, reducing waste, minimising agency) as well as outlining a set of mitigating actions to address the issues highlighted from service feedback and data analysis. Engagement with clinical and operational services regarding professional judgement reports have been supported by an evidence base. This builds upon the approach and processes agreed from a QI event in 2019. The Senior Leadership Group has reviewed the approach and process and are assured of its robustness. Further review will take place within the People, Diversity and Culture Committee (PDCC) for independent assurance. Following the identified actions being undertaken with oversight from the People, Diversity and Culture Group further assurance will flow to the Quality assurance and Improvement committee and PDCC Where any gaps in assurance have been identified, requiring further information, analysis or actions, a plan has been set out.
Prior Consideration and Feedback	The Senior Leadership Group has reviewed the process and are assured of its robustness. The financial detail has been presented to the Finance Sustainability Board for information and discussion. It was agreed that further work as detailed will need to be undertaken before any proposal regarding staffing investment can go to the Resources Committee. People, Diversity and Culture Group (Workforce-SLG) have been informed of the highlighted key messages within the report. Elements of the report, e.g. The RCN Workforce Standards gap analysis have also been presented to the Trust Board and the Quality Committee.
Implications:	Adhering to NHSI requirements will provide compliance with CQC standards of which the professional judgment discussions within the team reports are based on. Insufficient staffing and skill mix can negatively impact on safety and quality of care and as a result our ratings for the CQC 'safe' and 'well led' domains. This report highlights areas where staffing shortfalls may need to be addressed or mitigated and how these areas will be taken forward to mitigate the risks. The financial/value for money areas discussed in the report states that the ability to demonstrate effective investment to commissioners and to free up resources for better more effective

	use will be supported by being able to better manage unavailability of staffing and reducing the premium cost of workforce cover. There are no issues highlighted regarding the areas of Legal and Constitutional (including the NHS Constitution), and Equality and Diversity.
Recommendations:	• For the Board to consider the report and agree the actions required to be undertaken in relation to staffing resources and mitigation of key issues raised. • For the Board to confirm its level of assurance from the report, advising if any further actions are needed to achieve the required assurance.

1. PURPOSE:

1.1. The purpose of this report is for information and assurance of the Trust's clinical team staffing establishments reviewed over the period June 2021 – November 2021. It outlines the Trust approach to the mandated systematic review of staffing resources to ensure safe staffing levels are met according to national workforce guidelines and standards as described in the NHS Improvement 'Developing Workforce Safeguards' (NHSE/I, 2018) and the National Quality Board (NQB) guidelines (NHS, 2018). This report delivers against expectation 1 and 2 of the NQB requirements and discusses expectation 3.

1.2. The aims of the annual evidence-based staffing establishment review process are to:

- Strengthen assurance and accountability for safe, sustainable, and productive staffing
- Promote a consistent, systematic, and proactive approach to staffing decisions which supports CQC fundamental standards
- Improve governance processes from ward to board regarding workforce and staffing
- Increase staff awareness, engagement, and participation in workforce solutions
- Support stronger Board engagement with workforce challenges and issues
- Ensure compliance with NHSE/I requirements
- Improve staff welfare, morale and well being
- Support a reduction in temporary staffing usage, particularly agency staff

1.3. The review utilises the following approaches in its methodology:

- Professional Judgement
- The Mental Health Optimal Staffing Tool (MHOST) for Acuity/Dependency.
- Care Hours Per Patient Day (CHPPD)
- Peer group validation
- Benchmarking and review of national guidance including Model Hospital data
- Review of e-Rostering data
- Review of ward-based metrics
- Review of patient related data

1.4. Further background and context can be found in appendices (circulated under separate cover).

2. KEY FINDINGS:

2.1. **Service's Professional Judgement Reports.** Discussion with operational services identified 203 clinical teams for inclusion in the 2022 establishment review process, 120 community teams (59%), 26 specialist service teams (13%) and 57 inpatient teams (28%).

2.2. Following the same process as in 2019, team managers completed a professional judgement report in conjunction team specific workforce and patient related data, provided a RAG rating of their team based upon the criteria shown in Table 1.

RED	RED / AMBER	AMBER	AMBER / GREEN	GREEN
Not Safe	**Partially Safe**	**Safe**	**Safe**	**Safe**
Major adjustment required	Significant adjustment required	Although moderate adjustments required	Although minor adjustments required	No changes required
Not Safe and poor quality	Partially Safe and concerns about quality	Safe and Satisfactory quality	Safe and good quality	Safe and High quality

Table 1: Professional Judgement RAG rating criteria

2.3. Following review of individual team reports Heads of Service compile a service summary report and RAG rating then discussed at governance frameworks. The summary of the final team RAG ratings from the establishment reviews are shown in Table 2; teams in the Red and Red/Amber category are summarised in appendix 2.

November 2021	RAG Rating					Grand Total
Service Setting	Red	Amber Red	Amber	Amber Green	Green	
COMMUNITY	8	17	39	46	10	120
INPATIENT	8	22	19	5	3	57
SPECIALIST TEAMS	2	1	7	12	4	26
Grand Total	**18**	**40**	**65**	**63**	**17**	**203**

Table 2: RAG ratings for Clinical Teams from Head of Service / QuAG / LMGB

2.4. Table 3 highlights a worsening picture from the RAG ratings of 2021 to that from the previous exercise done in 2019. In comparison to the reported position in 2019 it is seen:

- a shift towards red and red/amber ratings for inpatient teams, going from a combined total of 5 teams in 2019 to 30 teams in this 2021 review, equating to a rise from 12% to 53% of inpatient teams reporting significant issues.
- the number of inpatient teams reporting as amber has also increased which means only 14% of inpatient teams are either amber/green or green.
- community teams have an also seen an increase of 7 teams reporting red/amber.

RAG Rating - Comparison November 2021 and September 2019 (** Community and Urgent Care teams)										
Service Setting	Red		Red Amber		Amber		Amber Green		Green	
Year	2021	2019	2021	2019	2021	2019	2021	2019	2021	2019
COMMUNITY**	10	10	18	11	46	48	58	45	14	87
INPATIENT	8	1	22	4	19	13	5	27	3	15
Grand Total	**18**	**11**	**40**	**15**	**65**	**61**	**63**	**72**	**17**	**102**

Table 3: RAG ratings comparison for Clinical Teams - November 2021 vs September 2019

2.5. Table 4 shows the 10 teams of the 26 teams reporting Red and Red / Amber categories for 2019 remain in this category, most notably

- 3 NYY CYPS remain in at Red status, 3 other CYPS teams remain at Red / Amber
- Rowan Lea has moved from Red / Amber to Red.

Area	Loc	Spec	New Team Name	2019 RAG	2021 RAG
CMHT	NYY	AMH	AMH SCARBOROUGH COMMUNITY	Red	Red Amber
CMHT	NYY	CYPS	CHILD AND YP YORK COMMUNITY	Red	Red
CMHT	NYY	CYPS	CHILD AND YP SCARBOROUGH ADHD ASSESSMENT AND INTERVENTION	Red	Red
CMHT	NYY	CYPS	CHILD AND YP SELBY COMMUNTIY	Red	Red
CMHT	D&D	CYPS	CYPS SOUTH DURHAM TARGETED TEAM	Red Amber	Red Amber
CMHT	D&D	CYPS	CYPS SOUTH DURHAM TARGETED TEAM	Red Amber	Red Amber
CMHT	NYY	CYPS	CHILD AND YP EATING DISORDERS	Red Amber	Red Amber
CMHT	Tees	MHSOP	MHSOP TEES INTENSIVE COM LIAISON	Red Amber	Red Amber
IP	NYY	MHSOP	MHSOP IP SCARBOROUGH ROWAN LEA	Red Amber	Red
IP	Tees	MHSOP	MHSOP RP WESTERDALE SOUTH	Red Amber	Red Amber

Table 4: Red & Red/Amber teams in 2019 remaining in this category for 2021

2.6. A summary of themes from services are shown below and detailed in appendix 3.

- Recruitment, retention, and turnover
- Staff well-being
- Safety, clinically effectiveness, and acuity related

- Other- impact of change, infrastructure

2.7. It is recommended that the Head of Service and team reports should be reviewed at Care Group Board level (appendix 4), which highlight the service specific issues with current work and mitigating actions that are in place for each service area. The themes identified from the service reports have defined key actions, responsibilities and governance routes which are outlined in appendix 5. Further discussion is required to agree planned timelines.

2.8. The Q4 21/22 establishment setting review resulted in investment of £5.48m (130.71 WTE) of which £3.62m (79.67 WTE) was for AMH admission and PICU and £1.86m (51.04 WTE) for Secure Inpatient Services (SIS) for staffing requirements with the aim to support clinical leadership, improve skill mix and to increase availability for nursing care time.

2.9. Appendix 6 details the outcomes for the further planned work to consider the immediate priorities for MHSOP, Learning Disabilities and Eating Disorder services. Table 5, shown below for care group/commissioners, summarises these investment requests. Further investigation is required of specific service issues impacting these areas and to better understand the clinical models prior to discussion with the Resources Committee.

Service	DTV	NYY	Specialist	Totals
	£m	£m	£m	£m
AMH skill mix	-	0.172	-	0.172
MHSOP	1.078	0.617	-	1.695
Learning disabilities	2.386	0.035	-	2.421
Eating disorders			0.337	0.337
Totals	**3.464**	**0.824**	**0.337**	**4.625**

Table 5: Summary of prioritised investment requests for further discussion at Resources Committee

2.10. **Assessment using the MHOST and LDOST (see appendix 7).** MHOST assessments from inpatient wards during November 2021 excluded day units, wards undergoing closure, respite units, and single patient wards. Benchmarked average patient acuity profiles for each ward are shown in appendix 8. Of the 52 wards reviewed, 23% met the benchmark for budgeted Registered Practitioner (RP) staffing, mainly in AMH where the recent investment had supported an improvement in this metric. Ward Acuity is seen to be generally higher than that of the benchmark values, which correlates with ward reports. Appendix 9 gives details and narrative of the MHOST outcomes and financial discussion.

2.11. A summary of pay expenditure below shows the level of overspend for the inpatient care setting and the underspend for community settings for clinical services for the year to date. The inpatient widening gap (appendix 10) for pay budget and expenditure due to unavailability and increases in patient need and high cost agency staffing and premia.

Setting	Pay budget YTD £m	Pay exp YTD £m	Pay exp. Variance YTD £m
Clinical support	33.794	34.314	0.520
Community	143.661	135.911	-7.749
Inpatient	62.193	74.068	11.875
Management	14.983	14.484	-0.500
Prisons	4.478	3.917	-0.561
Totals	**259.108**	**262.694**	**3.585**

Table 6: Pay budget, expenditure, and variance summary by setting YTD April 2021-Feb 2022

2.12. **Care Hours Per Patient Day (CHPPD).** Appendix 11 sees unregistered CHPPD exceed that of registered CHPPD values. This correlates with the increased use of additional temporary staffing which is predominantly an HCA resource. This data also supports the shortfall of registered nurses discussions highlighted within the review in line with identified Board risks. The latest available Model Hospital inpatient data (appendix 12) shows AMH (Admissions, Eating Disorders, and Rehab) as the only service area below the CHPPD median value; (please note the benchmark data ranges vary from April 2021 to November 2021. Further review will benefit deeper analysis and triangulation by ward at care group level.

2.13. **Fill Rates.** Table 7 shows that the increased fill rate of HCAs across the shifts patterns are compensating for the reduced availability of RNs. This presents risks in terms of CQC compliance and limits the quality and safety of interventions that can be offered from a registered nursing perspective as well as clinical leadership and oversight on the ward. Appendix 13 provides additional narrative and detail.

Averages across Jun 21 - Nov 21	RN Days	RN Nights	HCA Days	HCA Nights
Number of Wards < 90% Fill Rate	31 (52%)	16 (27%)	11 (18%)	7 (12%)
Number of Wards >120% Fill Rate	3 (5%)	4 (7%)	32 (53%)	38 (63%)
Number of Wards Meeting Trust Fill Rate Target	26 (43%)	40 (67%)	17 (28%)	15 (25%)

Table 7: Fill rate Summary

2.14. **Headroom review summary.** The review is detailed in appendix 14 and summarised below for existing and proposed headroom requirement and cost for inpatient services:

Headroom	Current	Revised RN	Revised	Weighted	Change
Headroom	27.7%	28.7%	27.5%	28.0%	+0.3%
Costs p.a. £m	£11.358m	£6,075m	£5.458m	£11.533m	£0.174m

Table 8: Current and Proposed Headroom Requirement

2.15. **Headroom requirements and roster performance.** For the 60 rostered wards reviewed, the number of teams exceeding the headroom limit of 27.7% weekly over a 6 month period, ranged from more than half to nearly all the teams, clearly showing that teams struggle to effectively meet their headroom requirements and/or effectively manage their ward unavailability such as Annual Leave, Study Leave, Working Day, Parenting, Sickness.

2.16. COVID-19 continues to impact on the levels and management of headroom (appendix 15) and challenges workload, sickness, and availability of skilled staff, with ward leaders and the MDT required to be part of the staffing numbers to maintain safe staffing levels, which in turn can lead to a reduction in activities such as appraisals, training, and supervision.

2.17. Inpatient unavailability (registered and unregistered staff) shows higher levels against planned levels for sickness, impacting level loading of annual leave and training with subsequent additional costs as well as unplanned/unfunded unavailability.

Inpatient RN and HCSW unavailability April 2021-Dec 2021				
	Planned	Actual	Variance	prorated annual value
	£m	£m	£m	£m
Sickness	1.669	3.413	1.744	2.325
Annual leave*	5.702	4.048	1.654	2.205
Training*	1.279	0.905	0.374	0.499
Parenting (Net costs)	0	0.286	0.286	0.381
Working day	0	1.077	1.077	1.436
Other	0	0.547	0.547	0.729
Totals	**8.650**	**10.276**		**7.575**
*assumes additional cost for annual leave and training not level loaded				

Table 9: Unavailability costs

2.18. Annual leave level loading remains an issue; consistently less than half the teams achieve the headroom target and is sometimes as low as one in twelve. “Working Day” unavailability, where staff are coded as supernumerary to carry out non patient facing or indirect care duties, requires better understanding at service level regarding this usage. Both of these areas contribute to increased temporary staffing usage if poorly managed. Further detailed analysis regarding unavailability is found in appendix 16.

2.19. **Vacancies.** The vacancy rate for the clinical teams across the Trust is 399 FTE, 6.3% of the budgeted establishment 6,310 FTE for November 2021. The summary breakdown across team setting is shown as appendix 17. The total reported nursing vacancies (registered and unregistered) across the inpatient areas at the time of the staffing review (November 2021) were running at 72 FTE (4.7%) with registered nurse vacancies at 99 (15.1%) and unregistered over establishment at 27 FTE (3.1%).

2.20. **Bed Occupancy.** For the 55 wards considered, the overall average for bed occupancy was 87%; 36 wards (65%) had an occupancy of 85% or more, with 24 of these wards having an occupancy exceeding 95% (appendix 18). AMH services (Admissions, PICU, Rehab, Eating Disorders) and MHSOP Functional wards consistently have significantly high bed occupancies. High occupancy and increasing acuity are a constant strain upon clinical services to consistently meet the service and patient requirements of this increasing demand where budgeted establishments are positioned to provide for an 85% occupancy level.

2.21. **Flexible/Temporary staffing expenditure.** A breakdown of flexible staffing pay expenditure (at November 2021) shows agency (4%), bank (3.3%), overtime (1.7%), additional standard duty hours (0.5%) and basic pay costs 90.6%. Appendix 19 also shows total flexible staffing costs (Apr 21 to Jan 22) were £27m, with agency staffing costs contributing £10.86m of this total. Agency workforce costs have increased over the period April 2021 to January 2022 (appendix 20) in response to numbers of agency workforce required to meet additional patient needs requiring agency staff to be sourced at costs above the NHSE ‘price cap’.

2.22. **Nursing Temporary Staffing Shift Requests** Temporary staffing (nurse bank and agency) requests continue to rise across the Trust supporting staffing shortfalls, such as increased patient acuity, patient leaves/escorts, vacancy backfill and unavailability’s. Appendix 21 shows the bank staff capability appears to be at saturation point with additional staffing requests being either filled by agency staff or remain unfilled. The fill rate for temporary staffing for April to November 2021 is 75% indicating a potential shortfall on the staffing requirements of the ward. Further narrative and detail are found in appendix 22.

2.23. Actions need to be identified that will support targeting agency cost reductions to mitigate existing overspending and ensure ‘best value’, i.e. reduce non framework/“above cap”

agencies. A further review of the bank staff payrates and available grades to work on the bank will support reduce agency expenditure.

2.24. **SafeCare, Red Flags and Datix Reporting.** When red flags are raised the matron and/or duty nurse coordinator will support teams with local actions to mitigate the issue(s). Red flags currently show an 80% staff-related and 20% patient-related split. Distribution of red flags shows a peak incidence of Monday (21%) Friday (18%) which correlates to days with highest number of unfilled temporary staffing shift requests. Staff still see staffing levels as a concern. A reduction in the number of Datix reports following a peak in August 2021 is noted potentially due to the introduction of SafeCare red flags in September 2021 Ward-based level 3 self-harm Datix reported incidents show PICUs, female AMH admissions and SIS wards have the highest incidence. Further narrative and detail are provided in appendix 23.

2.25. **Observation Levels.** Inpatient trend analysis over 2 years shows an overall average of 46 special engagement and observations per day from an average daily patient population of 633, with +/- 2% variance. Appendix 24 shows a small decrease in the number of 1:1 observation levels, however an increase in acuity and complexity resulting in an increase in 2:1 and 3:1 levels which necessitates an increase in staffing levels. Further analysis is required to understand how the dynamics of observation and engagement levels are managed and built into establishments to development a planned and strategic approach rather than a reliance upon a temporary staffing solution.

2.26. **Patient Experience** Patient feedback regarding “feeling safe” consistently fails to achieve the Trust target of 88%, with reasons that include availability of staff as well as the impact of other patients and related incidents. Negative comments relating to staffing in community and inpatient settings include staff availability and consistency of staff. Additional comments from patient experience surveys indicated improved staffing was required within our inpatient wards due to patients suggesting that staff had excessive workloads and are not able to support further activities and leave, and continuity of care if regular staff are not available. Positive patient experience was reported about nursing staff. Patient experience regarding feeling safe is a priority within the Trust’s Quality Account with a range of work being undertaken to address these concerns working the Regional Patient Experience network.

2.27. Further narrative and discussion relating to the themes derived from service reports and data analysis, the current mitigating work in progress and the planned mitigations represented by the key actions discussed in paragraph 2.7 can be found in appendix 25.

3. IMPLICATIONS

3.1. Adhering to NHSI requirements will provide compliance with CQC standards of which the professional judgment discussions within the team reports are based upon. Insufficient staffing and skill mix can negatively impact on ratings for the CQC ‘safe’ and ‘well led’ domains. This report aims to highlight areas where staffing shortfalls may need to be addressed or mitigated.

3.2. A summary of the financial/value for money areas discussed prior in the report is brought together in appendix 26, which reiterates that the ability to demonstrate effective investment

to commissioners and to free up resources for better more effective use will be supported by being able to better manage unavailability and premium cost of workforce cover.

3.3. There are no issues highlighted regarding the areas of Legal and Constitutional (including the NHS Constitution), and Equality and Diversity.

3.4. **Risks**

- The Board Assurance Framework recognises that 'Inability to recruit and retain sufficient qualified and skilled staff might jeopardise our ability to provide high quality/safe services'.
- A significant number of teams are RAG rated as Red and Red/Amber which indicates a presenting risk to patient safety, patient outcomes and patient experience in addition to a risk to staff wellbeing due to increasing work related pressures. Many teams are also currently RAG rated Amber, if the issues currently expressed by these teams are not sufficiently addressed or supported this situation may worsen.
- The sustained impact of COVID on staff and patient well-being and sickness absence.
- National and local shortages of RN's and AHP's impact on recruitment and subsequent long lead times to recruit to any required registered practitioner posts.
- Reduced levels of experienced staff may increase risk to staff and patient wellbeing.
- The ability to be clinical effective without service capacity and investment required to meet the ambitions of the long-term plan.
- The challenges around the chronic shortage of suitable and available doctors
- Reliance on temporary staffing measures to fill vacant posts and unavailability leading to increased costs from using agency as cover.
- Insufficient substantive staffing numbers provide a reliance upon temporary staffing
- Poor RP to SW skill mix ratios will impact upon the quality of clinical care delivered, effective clinical leadership, culture of the Trust and ultimately patient safety.

3.5. The Trust needs to consider and ensure the correct baseline establishments are to provide high quality patient care. This will also prevent a reliance on temporary bank and agency staff, reduced compliance with statutory and mandated training, staff burnout. Recruitment and retention difficulties further compound issues regarding the lack of availability of staff from the registered MDT pool, and is also influenced by the reduced levels of experience of new staff entering the Trust. These areas will challenge quality of care and patient safety and experience. As such the overall expectation of the Trust is to provide a positive impact upon the following areas:

- Time to care – releasing nursing staff time to care
- Leadership and culture
- Enhance quality focus and skill mix
- Enhance patient experience and reduce incidents
- Support workforce development and retention
- Reduce the use of bank staff and reliance on overtime

4. RECOMMENDATIONS: -

- For the Board to consider the report and agree the actions required to be undertaken in relation to staffing resources and mitigation of key issues raised.
- The Trust to confirm its level of assurance from the report, advising if any further actions are needed to achieve the required assurance

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**31st March 2022**
TITLE:	**Constitutional Change – Staff Classes**
REPORT OF:	**Phil Bellas, Company Secretary**
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:

1 Introduction:

1.1 The purpose of this report is to seek the approval of the Board of Directors to amend the Constitution in regard to the Staff Classes (sub-divisions of the Staff Constituency) and the composition of the Council of Governors.

2 Background:

2.1 Under the NHS Act 2006, as amended, changes to the Constitution must be approved by both the Board of Directors and the Council of Governors.

2.2 The model Constitution, published by NHS E/I and adopted by the Trust, includes provisions on the membership constituencies/classes (including the minimum number of Members required to hold elections and the number of Governors representing them) and the composition of the Council of Governors.

2.3 The present Staff Classes are based on the Trust's Localities and a separate Class for Corporate Services with each being represented by 1 Governor (5 Staff Governors in total).

2.4 Changes to the provisions on the Staff Classes and the Composition of the Council of Governors (Annexes 2 and 4 to the Constitution) are now required to reflect the new organisational structure and the establishment of the Care Groups.

2.5 There is some urgency in making these changes as they are required to enable the annual elections to the Council of Governors, which will commence in early April 2022, to proceed.

3 Key Issues

3.1 At its meeting held on 8th March 2022 the Council of Governors approved amendments to Annexes 2 ("The Staff Classes") and 4 ("The Composition of the Council of Governors") to the Constitution as attached to this report.

3.2 In summary, these changes, which are based on the present Governor/Member ratio, are as follows:

New Staff Class	Predecessor Class(es)	No of Governors	Implications
Corporate Directorates	▪ Corporate	1	None
North Yorkshire, York and Selby Care Group	▪ North Yorkshire and York	1	None except to the description of the Staff Class which is aligned to the new Care Group
Durham Tees, Valley and Forensics (DTVF) Care Group	▪ County Durham and Darlington ▪ Teesside ▪ Forensic Services	3	All Staff Members in the Class will elect the three Governors.

3.3 The main area of focus in developing the Staff Classes has been the arrangements for the DTVF Care Group. Consultation was undertaken with the Staff Governors on three options: (a) one Class for the whole Care Group; (b) Staff Classes based on speciality; (c) Staff Classes based on geography. Whilst no consensus emerged, there was some support for option (b); however, it was also recognised that this was the most challenging to implement given the risks that work to reconfigure Trust systems, which feed the membership system, might not be completed in time for the elections.

3.4 The Board is asked to note that the Council of Governors approved the proposed changes to the Constitution as a temporary measure and has requested that engagement should be undertaken with Staff Members in the DTVF Care Group over the next 12 months on future arrangements for the Staff Classes in the area.

Recommendations:

The Board of Directors is recommended:

(1) To approve the revised Annexes 2 and 4 to the Constitution, as attached to this report, to come into effect on 1st April 2022.

(2) To support the Council of Governors' decision that engagement should be undertaken with the staff members in the Durham, Tees Valley and Forensics Care Group on the future arrangements for the Staff Classes in that area.

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ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraphs 8.3 and 8.4)

1. **The Staff Constituency**

The Staff Constituency is divided into 3 (three) classes. These are:

Class	Minimum number of members	Number of Elected Governors
Corporate Directorates	150	1
Durham, Tees Valley and Forensics Care Group	400	3
North Yorkshire York and Selby Care Group	200	1

2. Should an individual class within the Staff Constituency fail to achieve the above minimum numbers, no election shall take place in that class, until such time as the minimum number is reached. An election within that class will then take place within a time period determined by the Chairman of the Trust.

3. Staff will only be able to become a member and vote in one class within the Staff Constituency.

ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 11.2 and 11.3)

COMPOSITION OF THE COUNCIL OF GOVERNORS		
Constituency		**Number of Governors from 1/4/20**
Public	Stockton-on-Tees	3
	Hartlepool	2
	Darlington	2
	Durham	8
	Middlesbrough	2
	Redcar & Cleveland	2
	Scarborough and Ryedale	3
	Hambleton and Richmondshire	2
	Harrogate and Wetherby	3
	City of York	3
	Selby	2
	Rest of England	1
Staff	Corporate Directorates	1
	Durham, Tees Valley and Forensics Care Group	3
	North Yorkshire, York and Selby Care Group	1
Appointed Governors	Durham County Council	1
	Darlington Borough Council	1
	Hartlepool Borough Council	1
	Stockton-on-Tees Borough Council	1
	Middlesbrough Borough Council	1
	Redcar & Cleveland Borough Council	1
	North Yorkshire County Council	1
	City of York Council	1
	University of Teesside	1*
	University of Sunderland	1*
	University of York	1*
	University of Newcastle	1*
	NHS County Durham CCG	1*
	NHS Tees Valley CCG	1*
	NHS North Yorkshire CCG	1*
	NHS Vale of York CCG	1*
TOTAL		**54**

Notes:

1 The terms of Governors holding office on 1st April 2022 are unaffected by the amendments to the Constitution which come into force on that day.

2 The appointing organisations marked (*) in the above schedule are specified for the purposes of sub-paragraph 9(7) of Schedule 7 for the 2006 Act (as amended).

ITEM 16

BOARD OF DIRECTORS

DATE:	**31st March 2022**
TITLE:	**Update to Standing Financial Instructions (SFIs)**
REPORT OF:	**Liz Romaniak, Director of Finance, Information and Estates**
REPORT FOR:	**Decision, Assurance and Approval**

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 Trust's Standing Financial Instructions (SFIs) require periodic review to ensure they reflect current practice and remain relevant to both the changing environment and working practices.

All changes proposed are itemised in this report, and a full copy of the Trust's revised draft SFIs are attached as appendix 1.

The proposed amendments will ensure that the Trust's Constitution and Standard Financial Instructions remain compliant with the Health and Social Care Act 2012 (as amended); and remain appropriate for the changing needs of the organisation, including impacts arising from the recent operational restructure.

The Audit and Risk Committee supported the amendments set out in this paper at their meeting 17th March 2022, taking into account feedback from the Senior Leadership Group, and agreed a recommendation that the Board of Directors adopt the revised SFIs.

Recommendations:

The Board of Directors is requested to agree the amendments as set out in this paper, as recommended by Audit and Risk Committee on 17th March 2022.

1. INTRODUCTION & PURPOSE

1.1 The Board of Directors is asked to agree to the updates to the Standing Financial Instructions (SFIs).

2. BACKGROUND INFORMATION

2.1 The proposed amendments are to ensure the SFIs reflect current requirements, and remain fit for purpose.

2.2 The SFIs have been discussed at SLG 16th March 2022, and ARC 17th March 2022. Any updates requested are included in the version attached.

2.3 When updating the SFIs, the Trust Secretary was involved to ensure all constitution and governance requirements were met, other FT SFIs were used as a benchmark when considering scheme of delegation, and the new operational structure was incorporated.

3. KEY ISSUES:

3.1 The Standard Financial Instructions detail the financial responsibilities, policies and procedures to be adopted by the Trust and apply to everyone working for the Trust and its constituent organisations.

3.2 A complete copy of the SFIs is included as an annex to this paper. The document includes tracked changes so the reader can view all amendments, however for ease of use the following key is applicable:

- Factual updates are not highlighted (they can be seen in tracked changes)
  - These are organisation name changes etc.
- Yellow highlighted items are new / updated sections.
- Green highlighted items will be updated following adoption

3.3 The key amendments are as follows:

1. Section 10 – “Tendering and contract procedure” has had a complete rewrite to reflect the updated working practices and legislative guidance.

2. Appendix 1 – “Scheme of delegation” has been updated to reflect the new structure and review delegated expenditure limits. This has been benchmarked against similar organisations to ensure it is appropriate.

3. Appendix 2 – “Investment Approval” has been updated to confirm the accepted approval process within the new structure and review delegated approval limits.

4. Appendix 3 – "Tendering thresholds" has been updated to reflect Public contract regulations (PCRs) post Brexit.

    a. We have also added in a separate procurement threshold table for construction contracts. This is in line with PCRs, and supports the capital / EFM team to respond to urgent requests (e.g. safety requirements, damage rectification etc.).

    b. There has been an NHS wide reduction in the value of procurement exercises that require a full tender, to £122k over a 4 year period.

5. Throughout the document there have been a number of minor factual changes to ensure the document reflects current working practice (structure, organisation names etc.).

6. Addition of narrative confirming how SFIs support the Trusts Journey to Change.

4. IMPLICATIONS / RISKS

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

5. CONCLUSIONS

5.1 The proposed amendments will ensure that the Trust's Constitution and Standard Financial Instructions remain compliant with the Health and Social Care Act 2012 (as amended); and remain appropriate for the changing needs of the organisation.

5.2 The Audit and Risk Committee supported the proposed changes at their meeting 17th March 2022.

6. RECOMMENDATIONS

6.1 The Board of Directors is requested to agree the amendments as set out in this paper, as recommended by Audit and Risk Committee on 17th March 2022.

Liz Romaniak
Director of Finance, Information and Estates

Tees, Esk and Wear Valleys
NHS Foundation Trust

TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS

APRIL 2022

(Approved by the Board of Directors - TBC)

DOCUMENT CONTROL – Standing Financial Instructions

Application	These SFIs pertain to all areas, departments, and services of Tees, Esk and Wear Valleys NHS Foundation Trust
Associated policy reference and title	
Date of Ratification	March 2022 - TBC
Date of Review	March 2022 - TBC
Replacing	Standing Financial Instructions (December 2017)
Lead	Liz Romaniak
Members of working party	Consultation with the Audit and Risk Committee on 17 March 2022

This policy has been agreed and accepted by: (Director)

Name	Designation	Signature	Date
Liz Romaniak	Director of Finance, Information and Estates		16th March 2022

This policy has been ratified by:

Board of Directors or Board of Directors Sub Committee (specify)	Date of Board of Directors or Sub Committee
Board of Directors	31st March 2022 - TBC
This policy has gone through an equality impact assessment (EqIA)	Date of EqIA 16th March 2022

STANDING FINANCIAL INSTRUCTIONS

EXECUTIVE SUMMARY

1. Under Standing Order 3 the Board must adopt Standing Financial Instructions as an Integral Part of Standing Orders setting out the responsibilities of individuals.

2. The Board operates within a Constitutional framework which includes its Standing Orders. In addition to the Standing Orders and SFIs, there will be a Scheme of Delegation, Financial Procedural Notes and locally generated rules and instructions. Collectively these must comprehensively cover all aspects of financial management and control. In effect, they set the business rules which Directors and employees (including employees of third parties contracted to the Trust) must follow when acting on behalf of the Board.

3. The SFIs support the delivery of Trust's Journey to Change, and our ambition to co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism.

   It helps us deliver all our strategic goals as follows:

   It supports the Trust to co-create a great experience for all patients, carers, and families; by adding to the governance framework that underpins patient centred care.

   It supports the Trust to co-create a great experience for our colleagues, by providing staff with clear instructions to ensure that they feel protected in the decisions they make.

   It supports the Trust to be a great partner by providing assurance to our community that we operate under a strong structure of governance designed to support our services; and protect every pound spent on healthcare.

   This policy also reflects Our Journey to Change by supporting its values. Living our values is intrinsic to delivering our Journey to Change. This policy helps support staff by providing clear guidance to ensure they can complete the requirements of their roles. It also treats staff with respect and makes stopping all types of corruption the responsibility of everyone. It is a culture that we live to be the best professionals we can be.

CONTENTS

1. INTRODUCTION

1.1 GENERAL

1.1.1 These Standing Financial Instructions (SFIs) are issued under Standing Order 3 of the Board of Directors. They shall have effect as if incorporated in the Standing Orders of the Trust.

1.1.2 These SFIs detail the financial responsibilities, policies, and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy to achieve probity, accuracy, economy, efficiency and effectiveness.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance, Information and Estates.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance, Information and Estates or Deputy Director of Finance must be sought **before you act.**

1.1.5 **FAILURE TO COMPLY WITH SFIs IS A DISCIPLINARY MATTER WHICH IN EXTREME CASES COULD RESULT IN DISMISSAL.**

1.1.6 Where these SFIs refer to NHS England, this includes organisations working as representatives on their behalf.

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

(a) "Trust" means the Tees, Esk and Wear Valleys NHS Foundation Trust;

(b) "Board" means the Board of Directors of the Foundation Trust;

(c) "Budget" means a resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

(d) "Chief Executive" means the Accounting Officer of the Trust;

(e) "Director of Finance, Information and Estates" means the chief financial officer of the Trust;

(f) "Budget Holder" means the Director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation; and

(g) "Legal Adviser" means the properly qualified person appointed by the Trust to provide legal advice.

1.2.2 Wherever the title Chief Executive, Director of Finance, Information and Estates, or other nominated officer is used in these instructions, it shall be deemed to include such other Director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term "employee" is used it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on Directors and employees as indicated in the Scheme of Delegation (Annex 2 to the Standing Orders of the Board of Directors).

1.3.2 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation Document adopted by the Trust. (The extent of delegation should be kept under review by the Board.)

1.3.3 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board for ensuring that its financial obligations and targets are met.

1.3.4 The Chief Executive and Director of Finance, Information and Estates will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.5 It is a duty of the Chief Executive to ensure that existing Directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.

1.3.6 <u>The Director of Finance, Information and Estates is responsible for:</u>

(a) implementing the Trust financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of Directors and employees to the Trust, the duties of the Director of Finance, Information and Estates include:

(d) the provision of financial advice to the Trust and its Directors and employees;

(e) the design, implementation and supervision of systems of financial control; and

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.7 All Directors and employees, individually and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss, including those consequential to cyber threats;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.8 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.9 For any and all Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which Directors and employees discharge their duties must be to the satisfaction of the Director of Finance, Information and Estates.

2. AUDIT

2.1 AUDIT AND RISK COMMITTEE

2.1.1 In accordance with Standing Orders the Board shall establish an Audit and Risk Committee which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

(b) reviewing financial and key control systems;

(c) ensuring compliance with Standing Orders and Standing Financial Instructions;

(d) reviewing schedules of losses and compensations and making recommendations to the Board.

2.1.2 Where the Audit and Risk Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the chair of the Audit and Risk Committee should raise the matter at a full meeting of the board. Exceptionally, the matter may need to be referred to the Council of Governors.

2.1.3 It is the responsibility of the Director of Finance, Information and Estates to ensure an adequate internal audit service is provided and the Audit and Risk Committee shall be involved in the selection process when an internal audit service provider is changed and in determining the sufficiency and focus of the annual internal audit plan.

2.2 FRAUD AND CORRUPTION

2.2.1 In line with the Foundation Trust terms of authorisation, the Chief Executive and Director of Finance, Information and Estates shall monitor and ensure compliance with Service Condition 24 of the NHS Standard Contract.

2.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS fraud and corruption manual and guidance.

2.2.3 The Local Counter Fraud Specialist shall report to the Director of Finance, Information and Estates and regularly liaise on all matters of fraud and corruption.

2.2.4 The Local Counter Fraud Specialist shall investigate all cases of suspected fraud and corruption.

2.2.5 The Local Counter Fraud Specialist shall work with the Director of Finance, Information and Estates to ensure compliance with the Bribery Act 2010 is embedded into Trust policies and procedures.

2.2.6 The Local Counter Fraud Specialist shall work with the Director of Finance, Information and Estates to ensure compliance with the Managing Conflicts of Interest in the NHS (NHS England 2017) is embedded into Trust policies and procedures.

2.3 DIRECTOR OF FINANCE, INFORMATION AND ESTATES

2.3.1 The Director of Finance, Information and Estates is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation, and other irregularities;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit and Risk Committee and the Board. The report must cover:
(i) a clear statement on the effectiveness of internal control,
(ii) major internal financial control weaknesses discovered,
(iii) progress on the implementation of internal audit recommendations,
(iv) progress against plan over the previous year,
(v) strategic audit plan covering three to five years,
(vi) a detailed plan for the coming year.

2.3.2 The Director of Finance, Information and Estates or designated auditors are entitled, without necessarily giving prior notice, to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under an employee's control; and

(d) explanations concerning any matter under investigation.

2.4 ROLE OF INTERNAL AUDIT

2.4.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences,
(ii) waste, extravagance, inefficient administration,
(iii) poor value for money or other causes.

2.4.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected

irregularity in the exercise of any function of a pecuniary nature, the Director of Finance, Information and Estates must be notified immediately.

2.4.3 The Head of Internal Audit shall report directly to the Director of Finance, Information and Estates and shall independently refer audit reports to the appropriate officer designated by the Chief Executive. Failure to take any necessary remedial action within a reasonable period shall be reported to the Chief Executive and the Audit and Risk Committee. Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation of the objectivity of the audit, the Head of Internal Audit shall have access to report direct to the Chairman of the Trust or the Senior Independent Director, as appropriate.

2.4.4 A representative of Internal Audit will normally attend Audit and Risk Committee meetings and has a right of access to all Audit and Risk Committee Members (initially through the Chair of the Committee), the Chairman and Chief Executive of the Trust.

2.5 EXTERNAL AUDIT

2.5.1 The external auditor is appointed by the Council of Governors and paid for by the Trust. It is the role of the Audit and Risk Committee to ensure a cost-efficient and independent external audit service is provided to the Trust throughout each audit engagement. Should there appear to be a problem, then this should be raised with the external auditor and referred on to the Council of Governors if the issue cannot be resolved.

2.5.2 The firm providing External Audit Services shall not be commissioned to undertake non-audit activities except in accordance with the "Policy on the Engagement of the External Auditor for Non-Audit Services", as approved by the Audit and Risk Committee.

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 PREPARATION AND APPROVAL OF BUSINESS PLANS AND BUDGETS

3.1.1 The Chief Executive will compile and submit to the Board a Business Plan which takes into account financial targets and forecast limits of available resources. The annual business plan will meet the requirements of NHS England and contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in activities, delivery of services or resources required to achieve the plan.

3.1.2 Prior to the start of the financial year the Director of Finance, Information and Estates will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Business Plan;

(b) accord with delivery of services and workforce plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds; and

(e) identify potential risks.

3.1.3 The Director of Finance, Information and Estates shall monitor financial performance against budget and business plans, periodically review them, and report to the Board.

3.1.4 All budget holders must provide information as required by the Director of Finance, Information and Estates to enable budgets to be compiled.

3.1.5 The Director of Finance, Information and Estates has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2 BUDGETARY DELEGATION

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service; and
(f) the provision of regular reports upon the discharge of those delegated functions.

The budgetary delegation for revenue and capital expenditure limits together with investment approval are detailed in Appendix 1.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.3 BUDGETARY CONTROL AND REPORTING

3.3.1 The Director of Finance, Information and Estates will devise and maintain systems of budgetary control. These will include:

(a) financial reports to the Board or designated Board Committee, in a form and frequency approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;
(ii) movements in working capital;

(iii) capital project spend and projected outturn against plan;

(iv) explanations of any material variances from plan;

(v) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance, Information and Estates' view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial and workforce budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

3.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement or otherwise mitigated across their overall budgets is not incurred without the prior consent of the Board;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement; and

(c) no permanent employees are appointed unless they are provided for in the budgeted establishment as approved by the Board, unless supported by the approval of the Chief Executive.

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Business Plan and a balanced budget.

3.4 CAPITAL EXPENDITURE

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in Chapter 12.)

3.5 MONITORING RETURNS

3.5.1 The Chief Executive is responsible for ensuring that the appropriate external monitoring forms are submitted to the requisite monitoring organisation.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 The Director of Finance, Information and Estates, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the guidance given by NHS England and the Treasury, the Trust's accounting policies, and international financial reporting standards;

(b) prepare, certify and submit annual financial reports to NHS England in accordance with current guidelines; and

(c) submit financial returns to NHS England for each financial year in accordance with its prescribed timetable.

4.2 The Trust's Audited Annual Accounts must be presented to a public meeting of the Council of Governors.

4.3 The Trust will publish an Annual Report, in accordance with requirements set out by NHS England, and present it at the Annual General Meeting of the Council of Governors and the Annual Members Meeting. The document will comply with the requirements detailed in the FT Annual Reporting Manual and the Group Accounting Manual.

5. BANK AND GBS ACCOUNTS

5.1 GENERAL

5.1.1 The Director of Finance, Information and Estates is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/Directions issued from time to time by HM Treasury and NHS England.

5.1.2 The Board or designated Committee shall approve the banking arrangements.

5.2 BANK AND GBS ACCOUNTS

5.2.1 The Director of Finance, Information and Estates is responsible for:

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from bank or Government Banking Service (GBS) accounts do not exceed the amount credited to the account except where arrangements have been made; and

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

5.2.2 No member of staff, other than the Director of Finance, Information and Estates, shall open a bank account in the Trust's name.

5.3 BANKING PROCEDURES

5.3.1 The Director of Finance, Information and Estates will prepare detailed instructions on the operation of bank and Government Banking Service (GBS) accounts which must include:

(a) the conditions under which each bank and Government Banking Service (GBS) account is to be operated;

(b) the limit to be applied to any overdraft; and

(c) those authorised to sign cheques or other orders drawn on the Trust's accounts.

5.3.2 The Director of Finance, Information and Estates must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 TENDERING AND REVIEW

5.4.1 The Director of Finance, Information and Estates will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

5.4.2 Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 INCOME SYSTEMS

6.1.1 The Director of Finance, Information and Estates is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Director of Finance, Information and Estates is also responsible for the prompt banking of all monies received.

6.2 FEES AND CHARGES

6.2.1 The Trust shall follow the advice in the "NHSE Approved Costing Guidance " in setting prices for services delivered, where applicable.

6.2.2 The Director of Finance, Information and Estates is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

6.2.3 All employees must inform the Director of Finance, Information and Estates promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 DEBT RECOVERY

6.3.1 The Director of Finance, Information and Estates is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures.

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.4.1 The Director of Finance, Information and Estates is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance, Information and Estates.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7. CONTRACTING FOR PROVISION OF SERVICES

7.1 The Chief Executive, or an officer designated by him/her, is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan, and for establishing the arrangements for providing extra-contractual services. In carrying out these functions, the Chief Executive should take into account the advice of the Director of Finance, Information and Estates regarding:

(a) costing and pricing of services;

(b) payment terms and conditions; and

(c) amendments to contracts and extra-contractual arrangements.

7.2 Contracts should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Contract prices should comply with "NHSE Approved Costing Guidance".

7.3 The Director of Finance, Information and Estates shall produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income.

7.4 Any pricing of contracts at marginal cost must be undertaken by the Director of Finance, Information and Estates and reported to the Board.

8. TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND EMPLOYEES

8.1 REMUNERATION

8.1.1 The Board should formally agree the precise terms of reference of the Remuneration Committee, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (The Terms of Reference of this Committee are set out in the Integrated Governance Framework).

8.1.2 The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive and other executive directors (and other senior employees), including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(iv) approving local clinical excellence awards for consultant medical staff;

(b) make such recommendations to the Board on the remuneration and terms of service of executive directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate;

(c) monitor and evaluate the performance of individual executive directors (and other senior employees as may be determined by the Board); and

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

8.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of executive directors. Minutes of the Board's meetings should record such decisions.

8.1.4 The Board will approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

8.1.5 The Trust will remunerate the Chairman and Non-executive Directors in accordance with the instructions of the Council of Governors.

8.2 FUNDED ESTABLISHMENT

8.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

8.2.2 The funded establishment can only be varied within the delegated limits.

8.3 STAFF APPOINTMENTS

8.3.1 No director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive or through delegated powers; and

(b) within the limit of his/her approved budget and funded establishment.

8.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

8.4 PROCESSING OF PAYROLL

8.4.1 The Director of Finance, Information and Estates is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay;

(c) making payment on agreed dates; and

(d) agreeing method of payment.

8.4.2 The Director of Finance, Information and Estates will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee;

(h) procedures for payment by cheque, bank credit, or cash to employees;

(i) procedures for the recall of cheques and bank credits

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash; and

(m) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

8.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting staff variation details and other notifications in accordance with agreed timetables;

(b) completing staff variation details and other notifications in accordance with the Director of Finance, Information and Estates instructions and in the form prescribed by the Director of Finance, Information and Estates; and

(c) terminating employee contracts (using Manager Self Service) immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Director of Finance, Information and Estates must be informed verbally immediately and subsequently in writing.

8.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance, Information and Estates shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and those suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.4.5 The Director of Finance, Information and Estates shall verify that the rate of pay and relevant conditions of service are in accordance with current agreements and that proper compilation of the payroll and payments have been made. Disputes arising in the interpretation of conditions of service shall be referred to the Director of People and Culture for resolution.

8.4.6 All employees shall be paid monthly by bank credit, unless otherwise agreed by the Director of Finance, Information and Estates.

8.5 CONTRACT OF EMPLOYMENT

8.5.1 The Board shall delegate responsibility to the Director of People and Culture for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

9. NON-PAY EXPENDITURE

9.1 DELEGATION OF AUTHORITY

9.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

9.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) the maximum level of each requisition and the system for authorisation above that level.

9.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

9.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the appropriate Director or Head of Service shall be consulted.

9.2.2 All goods and services will be procured through the Trust's electronic purchasing system, Cardea (unless a permitted exclusion). Where this is not possible agreement with the Director of Finance, Information and Estates should be sought.

9.2.3 The Director of Finance, Information and Estates shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

9.2.4 The Director of Finance, Information and Estates will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained in line with procurement systems (electronic or written); and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; Tendering and Contract procedures are detailed further within section 10.

(b) prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of directors/employees (including specimens of their signatures) authorised to certify invoices, orders and requisitions.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment.

(iii) A timetable and system for submission to the Director of Finance, Information and Estates of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

9.2.5 Where an officer certifying accounts relies upon other officers to do preliminary checking he/she shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed the order and negotiated the prices and terms.

9.2.6 In the case of contracts for building and engineering works which require payment to be made on account during progress of the works the Director of Finance, Information and Estates shall make payment on receipt of a certificate form the appropriate Technical Consultant or Officer. Without prejudice to the responsibility of any Consultant or Estates Officer appointed to a particular building or engineering contract, a contractor's account shall be subjected to such financial examination by the Director of Finance, Information and Estates and any general examination by the Estates Officer as may be considered necessary, before the person responsible to the Trust for the contract issues the final certificate. All contracts will be added to the Trust's contracts register.

9.2.7 PFI unitary payments should be approved as per the agreed contract and in line with the scheme of delegation.

Separate contract variations for PFI additional works should utilise the PFI contract variation procedure within the PFI contract. PFI variations should be approved and monitored via the capital projects steering group within the overall scheme of delegation (for both capital costs and unitary payment consequences).

9.2.8 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) the appropriate Director/Head of Service must provide documentation demonstrating the business need and financial benefits versus risk;

(b) the Director of Finance, Information and Estates will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

(c) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director/Head of Service or Chief Executive if problems are encountered.

9.2.9 Official orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance, Information and Estates;

(c) state the Trust's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

(e) only be issued on receipt of a duly authorised, correctly coded requisition.

9.2.10 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance, Information and Estates and that:

(a) all contracts, leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance, Information and Estates in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with national rules on public procurement and comply with Public Contract Regulations 2015 (as amended);

(c) where consultancy advice is being obtained, the procurement of such skills must be in accordance with guidance issued by HM Treasury and the Department of Health;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance, Information and Estates on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except purchases from petty cash (unless a permitted exclusion);

(g) Verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order (to be raised immediately following the verbal / written order) and clearly marked "Confirmation Order". Examples of expenditure where a verbal order is permitted are clinical equipment that is required urgently, training courses and room hire; however verbal orders are only to be used as a last resort;

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of directors/employees authorised to certify invoices are notified to the Director of Finance, Information and Estates;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance, Information and Estates; and

(l) petty cash records are maintained in a form as determined by the Director of Finance, Information and Estates.

9.2.11 The Chief Executive must ensure that the Trust's Standing Orders are compatible with the requirements of the Trust and consistent with the terms of its authorisation. In addition, Standing Orders must also be compatible with the requirements of Royal Institute of British Architects (RIBA), Design and Build Contracts (D&B Contracts) and land and property transactions (Health Building Note 00-08 parts A & B). The technical audit of these contracts shall be the responsibility of the relevant Director. The Director of Finance, Information and Estates shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within these codes.

9.3 GRANTS TO OTHER BODIES

9.3.1 Grants to other bodies for the provision of patient services shall be consistent with the Trust's terms of its authorisation and within the terms of relevant patient service contracts.

For grants of up to £1,001 the Director responsible for the service may grant approval, for grants up to £5,001 the Chief Executive may grant approval. Above these sums the Board only may grant approval.

10 TENDERING AND CONTRACTING PROCEDURE

10.1 Duty to comply with Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Financial Instructions.

At present, the expert Procurement Function is outsourced to Synchronicity Care Limited (SCL), with SCL's Procurement Team being responsible for the Trust's tendering and contracting, alongside advising the Trust on procurement practice and the operation of contracts. In giving such advice the Procurement Team will have regard to any guidance on the matter as detailed in the Public Contracts Regulations 2015 (as amended) and as published by the Department of Health and Social Care.

10.2 Proof of Concept (Trials and Pilots)

The Director of Finance, Information and Estates (for goods and services) and the Chief Pharmacist (for medicines) are responsible for the approval of all 'proof of concept' trials or pilot projects that may lead to a contractual relationship within the Trust. Such approval must be sought prior to the engagement of any supplier.

10.3 Directives Governing Public Procurement

The Public Contracts Regulations 2015 (as amended) dictates the procedures for awarding all forms of contracts which shall have effect as if incorporated in these Standing Financial Instructions.

10.4 Department of Health and Social Care and NHS England Guidance

The Trust shall comply as far as is practicable with the requirements of any guidance issued by Department of Health and Social Care and NHS England. This includes guidance for NHS providers looking to commission consultancy services and guidance on delegated limits and business case approval process for capital investment and property transactions.

10.5 Formal Competitive Tendering

Prior to the commencement of tendering for any contract with a total value in excess of £50,000 (excluding VAT) the Procurement Department shall be consulted. The tendering of such contracts must be undertaken jointly by the nominated officer and the Procurement Department. This requirement is to enable compliance with Public Contracts Regulations 2015 (as amended).

All tender activity relating to expenditure above £50,000 (excluding VAT) for the Trust must be carried out by the Procurement Department. Officers may incur personal liability for contracts made in contravention of these rules.

Tendering procedures must be followed in all cases where a proposed tender has a value in excess of one of the Public Procurement thresholds (Appendix 3).

For proposed tenders below those thresholds, competitive tendering procedures may be waived by the Director of Finance, Information and Estates.

10.5.1 General Applicability

The Trust shall ensure that competitive tenders are invited for:

(a) the supply of goods and services;

(b) the provision of works;

(c) the provision of a concession;

(d) disposals

10.5.2 Health Care Services

Where the Trust is acting as a commissioner of healthcare services these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

10.5.3 Aggregation

The Public Contracts Regulations 2015 (as amended) state that the value of a contract must be estimated by reference to the contractually committed spend over the life of the contract. This is the annual value of the contract multiplied by the number of years in the contract, including all extensions, options and variations.

Where the duration of the contract is not determined, its value must be calculated as the estimated annual value of the contract multiplied by four.

The Trust must package a contract with regard to similar contracts which may be required in order to aggregate requirements.

A proposed contract may not be divided into smaller contracts in order to avoid the provisions of these SFIs or of the Public Contracts Regulations 2015 (as amended).

10.5.4 Exceptions and instances where formal tendering need not be applied

Formal tendering procedures need not be applied where:

(a) the estimated expenditure or disposal income does not, or is not reasonably expected to, exceed £50,000 (excluding VAT) over the life of the contract or where the contract period exceeds four years, the total value over a four year period whether reclaimable or not (see Competitive Quotations 10.7.2);

(b) the supply is proposed under special arrangements negotiated, or agreed by the Department of Health and Social Care, in which event the said special arrangements must be complied with;

(c) the requirement is covered by an existing contract;

(e) contracts are in place where the Trust has been named or covered in the scope of the contract participants when tendered;

(f) a consortium arrangement or national arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(g) Where national arrangements referred to in (f) above (e.g. Crown Commercial Services (CCS), NHS Supply Chain, and North of England Commercial Procurement Collaborative (NOECPC)) apply, then the relevant framework rules; whether this involves running a mini-competition or allowing a direct award, will apply.

(i) the supply is listed on the 'permitted list' as agreed with the Executive Director of Finance, Information and Estates. These are items of expenditure that the Associate Director of Procurement has deemed to be non-addressable expenditure such as contracts with exclusive rights (e.g. the supply of water utilities, North East Ambulance Service) or rental of buildings. A list of identified spend is maintained and held within the Procurement Department.

Formal tendering procedures may be waived with approval from the Director of Finance, Information and Estates in the following circumstances:

(a) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be appropriate or practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(b) where the timescale genuinely precludes competitive tendering but where failure to plan the work properly would not be regarded as a justification for a single tender;

(c) where specialist expertise is required and is available from only one source;

(d) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(e) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

The Director of Finance, Information and Estates will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit and Risk Committee.

10.5.5 Voluntary Ex-Ante Transparency (VEAT) Notice and Contract Award Notice (CAN)

The Public Contracts Regulations 2015 (as amended) must be followed at all times. Nothing in these SFIs can override the Regulation. In cases where there could be legitimate doubt as to the legal requirement to advertise the contract opportunity (for example, Schedule 3 services which fall below the higher threshold for the Light Touch Regime, below-

threshold contracts, service concessions and the award of contract under a national framework without a mini-competition) the Trust should seek to remove the risk of an application for ineffectiveness under the first ground (i.e. awarding a contract without a prior contract notice) by publishing a VEAT notice (where applicable) and can reduce the time limits for a finding of ineffectiveness by issuing a CAN.

If the total contract value exceeds the relevant Public Procurement threshold and the opportunity is not advertised it may be challenged under the Remedies Regulation. Remedies the court may order include rendering the contract ineffective, shortening the contract, imposing a fine on the Trust and/or awarding damages to the challenger for its losses.

The VEAT notice must contain details as to why the Trust considered that no prior contract was required, the nature of the intended contract and the identity of the successful tenderer. Furthermore, the Trust must not enter into the contract until the end of a ten day standstill period, commencing on the day after publication of the VEAT notice.

The CAN must be published within 30 days of the date of the contract award decision and, again, can be used where there is a change to the scope of a contract which might give rise to an allegation that the 'changed' contract amounts to an entirely new contract, one that has not been the subject of a prior contract notice. The CAN must explain why no prior contract notice was considered necessary. The effect of the CAN is that it reduces the time limit for a finding of ineffectiveness from 6 months from when the contract is signed to 30 days from the day after the CAN is issued.

VEAT notices and CAN should be used in the above cases. A CAN must also be used to award contracts under normal circumstance in line with the Public Contracts Regulations 2015 (as amended). Both provide the Trust a safety mechanism against ineffectiveness, but do not negate the risk of financial penalties under the Remedies Regulation.

10.5.6 Fair and Adequate Competition

Unless the exceptions set out in SFI No 10.5.4 apply, the Trust shall ensure that with all expenditure above £50,000 (excluding VAT), the Procurement Department will follow the appropriate tender procedure in-line with the Public Contracts Regulations 2015 (as amended).

10.5.7 Items which subsequently breach thresholds after original approval

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

10.6 Contracting / Tendering Procedure

All contracting / tendering procedures will be carried out in line with the Public Contracts Regulations 2015 (as amended), the Trust's SFIs and national guidance received from the Department of Health and other

appropriate organisations, such as, the Chartered Institute of Procurement and Supply (CIPS).

10.6.1 Electronic Tendering

In complying with contracting and tendering procedures an electronic tendering approach, utilising a proprietary system designed for such purposes, may be used. Any system selected to manage the administration of electronic tenders shall provide such functionality as to mirror the processes and incorporate the principles of conventional tendering, adhere with the requirements of public procurement legislation and provide a full audit trail.

10.6.2 Invitation to tender

(i) All invitations to tender shall be issued simultaneously and will state the date and time as being the latest time for the receipt of tenders.

(ii) Bidders wishing to submit tenders shall be provided with clear instruction and access to a portal to which tenders can be submitted.

(iii) Every tender for goods, services or disposals shall embody NHS Standard Contract Terms and Conditions as are applicable.

(iv) Every tender for building and engineering works shall embody or be in the terms of the current edition of the appropriate approved contract methods. The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects. Tendering based on other forms of contract may be used only after prior consultation with the Department of Health and Social Care.

10.6.3 Receipt and safe custody of tenders

(i) The electronic tendering system employed shall ensure that all tenders submitted are held in anonymity and are inaccessible until after the closing date and time for receipt of tenders.

(ii) The date and time of receipt of each tender shall be recorded by the system and a permanent record maintained.

10.6.4 Opening electronic tenders and Register of tenders

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, the electronic tendering system shall release the tenders received, maintaining a permanent record of the opening date and time of each tender.

(ii) The electronic tendering system shall maintain a permanent record of each tender submitted including the name of the bidder, the name of the person completing the tender on behalf of the bidder and all pricing information submitted.

(iii) The released tenders shall then be made available by the electronic tendering system to the originating department.

10.6.5 Admissibility

(i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(ii) Where only one tender is sought and / or received, the Chief Executive and Director of Finance, Information and Estates shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

10.6.6 Late, incomplete and amended tenders

(i) Bidders wishing to submit tenders after the due time and date may be considered only if the Chief Executive or nominated officer decides that there are exceptional circumstances such as IT system failure. The Chief Executive or nominated officer shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering must not be limited to only late submissions and must include all bidders.

(ii) Evidence of technically late tenders (i.e. those despatched in good time but delayed through no fault of the tenderer e.g. failures of the electronic tendering system) must have supporting evidence stored safely in the relevant tender folder if the justification and evidence is not clearly apparent on the electronic tendering portal.

(iii) Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer on their own initiative either orally or in writing after the due time for receipt) will be rejected.

(iv) Necessary discussions with a tenderer of the contents of their tender, in order to clarify technical points etc., before the award of a contract can only be carried out by the Procurement Department as part of the clarification stage and all communications must be through the electronic tendering portal and shared with all other bidders where applicable.

(v) The Trust is not bound to accept the lowest or any tender. The Trust also reserve the right to accept the whole or any part of any Tender submitted.

10.6.7 Acceptance of formal tenders

(i) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive or Director of Finance, Information and Estates.

(ii) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

(iii) All tenders should be treated as confidential and should be retained for inspection. The successful tender, including all associated documentation must be retained for six years plus the current financial year following the end of the contract period. Unsuccessful tenders must be retained for one year plus the current financial year following the date of contract award.

10.6.8 Reports to the Trust Board

Reports on single tender waivers will be made to the Audit and Risk Committee.

10.6.9 Contracted Suppliers - Financial Standing, Financial Suitability and Technical Competence of Contractors

During the period of the contract the Director of Finance, Information and Estates may make or institute any enquiries they deem appropriate concerning the financial standing, financial suitability and technical competence of contracted suppliers. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

10.7 Quotations

10.7.1 General position on quotations

Quotations are required electronically where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £10,000 (excluding VAT) but not exceed £50,000 (excluding VAT), whether reclaimable or not.

10.7.2 Competitive Quotations

(i) Quotations must be sought in conjunction with the Procurement department and should be obtained from at least three firms / individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(ii) Quotations should be in writing using the Trust's standard 'Request for Quote (RFQ)' documentation set and submitted via the electronic tendering system employed unless the Chief Executive or their nominated officer determines that it is impractical to do so.

(iii) All quotations should be treated as confidential and will be electronically stored as per the Department of Health and Social Care Retention of Records guidelines.

(iv) Clear evaluation methodology will be detailed to all bidders in the Request for Quote documents.

10.7.3 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions, except with the authorisation of either the Chief Executive or Director of Finance, Information and Estates.

10.7.4 Exceptions and instances where formal quotations are not required

Quotation procedures need not be applied where:

(a) the estimated expenditure or disposal income does not, or is not reasonably expected to, exceed £10,000 (excluding VAT) over the life of the contract or where the contract period exceeds four years, the total value over a four year period whether reclaimable or not;

(b) the supply is proposed under special arrangements negotiated, or agreed by the Department of Health and Social Care, in which event the said special arrangements must be complied with;

(c) the requirement is covered by an existing contract;

(d) contracts are in place where the Trust has been named or covered in the scope of the contract participants when tendered;

(e) a consortium arrangement or national arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

Quotation procedures may be waived with approval from the Director of Finance, Information and Estates in the following circumstances:

(a) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be appropriate or practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(b) where the timescale genuinely precludes competitive tendering but where failure to plan the work properly would not be regarded as a justification for a single tender;

(c) where specialist expertise is required and is available from only one source;

(d) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(e) where there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits

of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

The Director of Finance, Information and Estates will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

The waiving of competitive quotations should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive quotations are not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit and Risk Committee.

10.8 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation of a contract may only be decided by staff in conjunction with the Trust Board's Scheme of Delegation (appendix 1 of these SFIs).

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes. No contract shall be signed on behalf of the Trust unless it has been authorised by the Chief Executive or an Executive Director.

10.9 Procurement below the Quotation and Tendering Thresholds

The purchase of goods or services under an estimated value of £10,000 (excluding VAT) does not require formal competition. However, the purchase must still represent value for money and offer fair and equitable treatment to suppliers. It may therefore be necessary from time to time to obtain three quotations, although this must be considered against the associated procurement administration costs.

10.10 Compliance requirements for all contracts

The Trust Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Constitution and Standing Financial Instructions;

(b) The Public Contracts Regulations 2015 (as amended) and other statutory provisions;

(c) any relevant directions including the NHS England guidance such as the Capital regime, investment and property business case approval guidance, and guidance on the Procurement and Management of Consultants and the Department of Health and Social Care Health Building Note 00-08;

(d) the NHS Standard Contract Terms and Conditions as are applicable.

Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

In all contracts made by the Trust, the Trust Board shall endeavour to obtain best value for money by use of all systems in place. The Director of Finance, Information and Estates shall oversee and manage each contract on behalf of the Trust.

10.11 Substantive Employee Contracts and Agency or Temporary Worker Engagement Contracts

The Chief Executive shall delegate authority to nominated officers to enter into contracts of employment, regarding employees, and temporary worker arrangements for agency staff or bank workers on behalf of the Trust. This will be subject to adherence to relevant guidance from NHS England on use of agency workers.

10.12 Healthcare Contracts

Service agreements with NHS Commissioners for the supply of healthcare services shall be drawn up in accordance with the NHS Act 2006 (as amended by the Health and Social Care Act 2012) and administered by the Trust. An NHS Service Contract with a Foundation Trust is a legal document and is enforceable in law.

10.13 Disposals

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with Trust Policy;

(c) items to be disposed of with an estimated sale value of less than £10,000, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings classified as relating to commissioner requested services. Disposals of these properties shall be subject to compliance with the Trust's Provider Licence and NHS Improvement's (adopted by NHS England) guidance for Foundation Trusts 'Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts'.

10.14 In-house Services

The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

In all cases where the Trust Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer(s) and specialist(s).

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a Procurement officer and representative of the Director of Finance, Information and Estates. For services having a likely annual expenditure exceeding £100,000, a non-officer member should be a member of the evaluation team.

All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

The evaluation team shall make recommendations to the Trust Board.

The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

10.15 Applicability of SFIs on Tendering and Contracting to funds held in trust

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's charitable fund and private resources.

10.16 Declared Interests

Trust staff, including Trust Board members, must declare any interests of a nature personally beneficial, either directly or indirectly to them, which may affect or be affected by, a contract other than their own employment contract, which the Trust has let, or is considering letting.

Trust staff may not use their own employment with the Trust to influence the awarding of any contract in which they have any interest, either direct or indirect.

Where an interest creates a potential conflict of interest, this should be reported to the Director of Finance, Information and Estates.

The Director of Finance, Information and Estates will then review the conflict of interest and where the member of staff has a direct influence over the Trust's purchasing decisions or is privy to information that would provide an unfair advantage to the organisation or company, advise the individual on a recommended course of action:

(i) the employee cannot participate in a particular procurement decision, or

(ii) the employee may participate but will be cautioned to act in the best interests of the trust, or

(iii) the Trust Board will be advised that the Trust will not contract with that organisation or company whilst the conflict of interest exists

11. EXTERNAL BORROWING AND INVESTMENTS

11.1 EXTERNAL BORROWING

11.1.1 The Director of Finance, Information and Estates will advise the Board of Directors concerning the Trust's ability to pay dividend on, and repay, both the Public Dividend Capital and any proposed new borrowing. The Director of Finance, Information and Estates is also responsible for reporting periodically to the Board concerning loans and overdrafts where relevant.

11.1.2 Any application for a loan or overdraft will only be made by the Director of Finance, Information and Estates or by an employee so delegated by him.

11.1.3 The Director of Finance, Information and Estates must prepare detailed procedural instructions concerning applications for loans and overdrafts.

11.1.4 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Director of Finance, Information and Estates.

11.1.5 All long term borrowing must be consistent with the plans outlined in the current Business Plan.

11.2 INVESTMENTS

11.2.1 Temporary cash surpluses must be held only in such public or private sector investments as approved within the Trust's Investment Policy.

11.2.2 The Director of Finance, Information and Estates is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

11.2.3 The Director of Finance, Information and Estates will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 CAPITAL INVESTMENT

12.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without confirmation of relevant commissioner(s) support and the availability of resources to finance all revenue consequences, including capital charges; and

(d) shall ensure that all business cases meet the requirements of the NHS capital regime, as advised by NHS England.

12.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the *Capital Investment Manual*) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

(ii) appropriate project management and control arrangements; and

(b) that the Director of Finance, Information and Estates has certified professionally to the costs and revenue consequences detailed in the business case;

(c) that the requirements of the NHS capital regime, as advised by NHS England, have been met.

12.1.3 For capital schemes where the contracts stipulate staged payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "Health Building Note 00-08 parts A&B".

The Director of Finance, Information and Estates shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.1.4 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Health Building Note 00-08 parts A&B" guidance and the Trust's Standing Orders.

12.1.5 The Director of Finance, Information and Estates shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

12.2 PRIVATE FINANCE

12.2.1 When the Trust proposes to use finance which is to be provided other than through its own internally generated resources, the following procedures shall apply:

(a) The Director of Finance, Information and Estates shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) The proposal must be specifically agreed by the Board, NHS England (using the parameters of the Guidance on Transactions for NHS Foundation Trusts) and, if the size of the scheme warrants it, it may be necessary to seek HM Treasury approval.

12.3 ASSET REGISTERS

12.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance, Information and Estates concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

12.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Charges Manual and sufficient to meet audit standards.

12.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease / licence agreements in respect of assets held under a lease / licence.

12.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must

be validated by reference to authorisation documents and invoices (where appropriate).

12.3.5 The Director of Finance, Information and Estates shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

12.3.6 The value of each asset shall be in accordance with the Trust's valuation policy as determined by the Board of Directors.

12.3.7 The value of each asset shall be depreciated in accordance with the Trust's accounting policies and will be reflective of each asset's remaining life.

12.4 SECURITY OF ASSETS

12.4.1 The overall control of fixed assets is the responsibility of the Chief Executive. Each employee of the Trust has a responsibility to exercise a duty of care over the assets of the Trust.

12.4.2 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

12.4.3 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance, Information and Estates. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset; and

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.4.4 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance, Information and Estates.

12.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

12.4.6 Where practical, assets should be marked as Trust property.

13. STORES AND RECEIPT OF GOODS

13.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use), should be:

(a) kept to a minimum;

(b) subjected to annual stocktake;

(c) valued at the lower of cost and net realisable value.

13.2 Subject to the responsibility of the Director of Finance, Information and Estates for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance, Information and Estates. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oil of a designated estates manager.

13.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

13.4 The Director of Finance, Information and Estates shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

13.5 Stocktaking arrangements shall be agreed with the Director of Finance, Information and Estates and there shall be a physical check covering all items in store at least once a year.

13.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance, Information and Estates.

13.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance, Information and Estates for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance, Information and Estates any evidence of significant overstocking and of any negligence or malpractice (see also 14, Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 DISPOSALS AND CONDEMNATIONS

14.1.1 The Director of Finance, Information and Estates must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

14.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance, Information and Estates of the estimated market value of the item, taking account of professional advice where appropriate.

14.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose, as per the delegated limits in the Scheme of Delegation; and

(b) disposed of via the Supplies department, in accordance with the agreed procedure.

14.1.4 The Supplies department shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance, Information and Estates who will take the appropriate action.

14.2 LOSSES AND SPECIAL PAYMENTS

14.2.1 The Director of Finance, Information and Estates must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Director of Finance, Information and Estates must also prepare a “fraud response plan” that sets out the action to be taken both by persons detecting fraud and those persons responsible for investigating it.

14.2.2 Any employee discovering or suspecting a loss of any kind must immediately inform their Head of Department, who must immediately inform the Chief Executive and the Director of Finance, Information and Estates, or inform an officer charged with responsibility for responding to concerns involving loss or fraud confidentially. This officer will then appropriately inform the Director of Finance, Information and Estates and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance, Information and Estates must immediately inform the police if theft or arson is involved.

14.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance, Information and Estates must immediately notify:

(a) the Board, and

(b) NHS England.

14.2.4 Within limits delegated to it by HM Treasury and NHS England, the Board of the Trust shall approve the writing-off of losses.

14.2.5 The Director of Finance, Information and Estates shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.6 For any loss, the Director of Finance, Information and Estates should consider whether any insurance claim can be made.

14.2.7 The Director of Finance, Information and Estates shall maintain a Losses and Special Payments Register in which write-off action is recorded.

14.2.8 No special payments exceeding delegated limits shall be made without the prior approval of NHS England and HM Treasury.

15. INFORMATION TECHNOLOGY

15.1 The Director of Finance, Information and Estates, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

(e) The Director of Finance, Information and Estates shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.2 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trusts in a consortium wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance, Information and Estates:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

15.3 The Director of Finance, Information and Estates shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.4 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance, Information and Estates shall periodically seek assurances that adequate controls are in operation.

15.5 Where computer systems have an impact on corporate financial systems the Director of Finance, Information and Estates shall satisfy himself that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Director of Finance, Information and Estates staff have access to such data; and

(d) such computer audit reviews as are considered necessary are being carried out.

15.6 The Director of Finance, Information and Estates as Senior Information Risk Owner shall:

(a) devise and implement any necessary procedures to ensure adequate and reasonable protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act;

(b) ensure that adequate and reasonable controls exist over data entry, processing, storage, transmission, and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that adequate management and audit trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

16. PATIENTS' PROPERTY

16.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in

the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or deceased on arrival.

16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions;

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

16.3 The Director of Finance, Information and Estates must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance, Information and Estates.

16.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor in writing.

17. FUNDS HELD ON TRUST

17.1 INTRODUCTION

17.1.1 The discharge of this Body's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes. The Director of Finance, Information and Estates shall ensure that each fund is managed appropriately with regard to its purpose and to its requirements.

17.1.2 This Section of the SFIs shall be interpreted and applied in conjunction with the rest of these Instructions, subject to modifications contained herein.

17.1.3 The Board hereby nominates the Director of Finance, Information and Estates to have primary responsibility to the Board for ensuring that these SFIs are applied in close liaison with the Board's Legal Adviser.

17.2 EXISTING TRUSTS

17.2.1 The Director of Finance, Information and Estates shall arrange for the administration of all existing trusts in conjunction with the Legal Adviser. They shall ensure that a governing instrument exists for every trust and shall produce detailed codes of procedure covering every aspect of the financial management of funds held on trust, for the guidance of directors and employees. Such guidelines shall identify the restricted nature of certain funds.

17.2.2 The Director of Finance, Information and Estates shall periodically review the funds in existence and shall make recommendations to the Board regarding the potential for rationalisation of such funds within statutory guidelines.

17.2.3 The Director of Finance, Information and Estates may recommend an increase in the number of funds where this is consistent with this Body's policy for ensuring the safe and appropriate management of restricted funds, e.g., designation for specific wards or departments.

17.3 NEW TRUSTS

17.3.1 The Director of Finance, Information and Estates shall, in conjunction with the Legal Adviser, arrange for the creation of a new trust where funds and/or other assets, received in accordance with this Body's policies, cannot adequately be managed as part of an existing trust.

17.3.2 The Legal Adviser shall present the governing document to the Board for adoption as required in Standing Orders for each new trust. Such document shall clearly identify, inter alia, the objects of the new trust, the capacity of this Body to delegate powers to manage and the power to assign the residue of the trust to another fund contingent upon certain conditions, e.g. discharge of original objects.

17.4 SOURCES OF NEW FUNDS

17.4.1 In respect of **Donations**, the Director of Finance, Information and Estates shall:

(a) provide guidelines to officers of this Trust as to how to proceed when offered funds. These to include:

(i) the identification of the donors intentions;
(ii) where possible, the avoidance of new trusts;
(iii) the avoidance of impossible, undesirable or administratively difficult objects;
(iv) sources of immediate further advice; and
(v) treatment of offers for personal gifts; and

(b) provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into this Body's trust funds and that the donor's intentions have been noted and accepted.

17.4.2 In respect of **Legacies And Bequests**, the Director of Finance, Information and Estates shall:

(a) provide guidelines to officers of this Trust covering any approach regarding:

(i) the wording of wills;
(ii) the receipt of funds/other assets from executors;

(b) where necessary, obtain grant of probate, or make application for grant of letters of administration, where this Trust is the beneficiary;

(c) be empowered, on behalf of this Body, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty; and

(d) be directly responsible, in conjunction with the Legal Adviser, for the appropriate treatment of all legacies and bequests.

17.4.3 In respect of **Fund-raising**, the Director of Finance, Information and Estates shall:

(a) after consultation with the Legal Adviser, deal with all arrangements for fund-raising by and/or on behalf of this Trust and ensure compliance with all statutes and regulations;

(b) be empowered to liaise with other organisations/persons raising funds for this Trust and provide them with an adequate discharge. The Director of Finance, Information and Estates shall be the only officer empowered to give approval for such fund-raising subject to the overriding direction of the Board;

(c) be responsible, along with the Legal Adviser, for alerting the Board to any irregularities regarding the use of this Trust's name or its registration numbers; and

(d) be responsible, after due consultation with the Legal Adviser, for the appropriate treatment of all funds received from this source.

17.4.4 In respect of **Trading Income,** the Director of Finance, Information and Estates shall:

(a) be primarily responsible, along with the Legal Adviser and other designated officers, for any trading undertaken by this Trust as corporate trustee; and

(b) be primarily responsible, along with the Legal Adviser, for the appropriate treatment of all funds received from this source.

17.4.5 In respect of **Investment Income**, the Director of Finance, Information and Estates shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

17.5 INVESTMENT MANAGEMENT

17.5.1 The Director of Finance, Information and Estates shall be responsible for all aspects of the management of the investment of funds held on trust. The issues on which he/she shall be required to provide advice to the Board shall include:-

(a) in conjunction with the Legal Adviser, the formulation of investment policy within the powers of this Trust under statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers, and, where appropriate, fund managers and:

(i) the Director of Finance, Information and Estates shall agree, in conjunction with the Legal Adviser, the terms of such appointments; and for which

(ii) written agreements shall be signed by the Chief Executive;

(c) pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;

(d) the participation by this Trust in common investment funds and the agreement of terms of entry and withdrawal from such funds;

(e) that the use of trust assets shall be appropriately authorised in writing and charges raised within policy guidelines;

(f) the review of the performance of brokers and fund managers;

(g) the reporting of investment performance.

17.6 DISPOSITION MANAGEMENT

17.6.1 The exercise of this Trust's dispositive discretion shall be managed by the Director of Finance, Information and Estates in conjunction with the Board. In so doing he/she shall be aware of the following:

(a) The objects of various funds and the designated objectives;

(b) the availability of liquid funds within each trust;

(c) the powers of delegation available to commit resources;

(d) the avoidance of the use of exchequer funds to discharge trust fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time;

(e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of this Trust; and

(f) the definitions of "charitable purposes" as agreed by the Department of Health with the Charity Commission.

17.7 BANKING SERVICES

17.7.1 The Director of Finance, Information and Estates shall advise the Board and, with its approval, shall ensure that appropriate banking services are available to this Trust as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

17.8 ASSET MANAGEMENT

17.8.1 Assets in the ownership of, or used by, this Body as corporate trustee, shall be maintained along with the general estate and inventory of assets of the Body. The Director of Finance, Information and Estates shall ensure:

(a) in conjunction with the Legal Adviser, that appropriate records of all assets owned by this Trust as corporate trustee are maintained, and that all assets, at agreed valuations, are brought to account;

(b) that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;

(c) that donated assets received on trust rather than into the ownership of the Secretary of State shall be accounted for appropriately;

(d) that all assets acquired from funds held on trust which are intended to be retained within the trust funds are appropriately accounted for, and that all other assets so acquired are brought to account in the name of the Secretary of State.

17.9 REPORTING

17.9.1 The Director of Finance, Information and Estates shall ensure that regular reports are made to the Board with regard to, inter alia, the receipt of funds, investments, and the disposition of resources.

17.9.2 The Director of Finance, Information and Estates shall prepare annual accounts in the required manner which shall be submitted to the Board within agreed timescales.

17.9.3 The Director of Finance, Information and Estates, in conjunction with the Legal Adviser, shall prepare an annual trustees' report (separate reports for charitable and non-charitable trusts) and the required returns to the Charity Commission for adoption by the Board.

17.10 ACCOUNTING AND AUDIT

17.10.1 The Director of Finance, Information and Estates shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

17.10.2 The Director of Finance, Information and Estates shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He/she will liaise with external audit and provide them with all necessary information.

17.10.3 The Board shall be advised by the Director of Finance, Information and Estates on the outcome of the annual audit. The Chief Executive shall ensure that the Annual Audit Letter or its equivalent is considered by the Audit and Risk Committee prior to submitting it to the Board.

17.11 ADMINISTRATION COSTS

17.11.1 The Director of Finance, Information and Estates shall identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Board, shall charge such costs to the appropriate trust accounts.

17.12 TAXATION AND EXCISE DUTY

17.12.1 The Director of Finance, Information and Estates shall ensure that this Body's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

18. RETENTION OF DOCUMENTS

18.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with the Records Management Code of Practice for Health and Social Care (2016).

18.2 The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Documents held in accordance with the Records Management Code of Practice for Health and Social Care (2016) shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

19. RISK MANAGEMENT & INSURANCE

19.1 The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board.

19.2 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risk and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including, internal audit, clinical audit, health and safety review;

(f) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to make an Annual Governance Statement within the Annual Report and Accounts as required by NHS England.

19.3 The Director of Finance, Information and Estates shall ensure that insurance arrangements exist in accordance with the risk management programme.

APPENDIX 1

SCHEME OF DELEGATION

BUDGETARY DELEGATION

Revenue expenditure limits for existing budget / contracted expenditure

Level	Signatories	Limit
L1	Chief Executive and Director of Finance, Information and Estates **BOTH** signed	Above £750,000
L2	Chief Executive, Director of Finance, Information and Estates	Up to £750,000
L3	Executive Director (Board members) / Managing Director / Company Secretary	up to £500,000
L4	Care Group Directors / Director of Estates / Chief Information Officer	up to £300,000
L5	Clinical Director / Deputy Director / Associate Director / General Manager	up to £100,000
L6	Operational Service Manager / Head of Department	up to £50,000
L7	Team / Ward Managers	up to £10,000 (can be lower on request)

Capital Expenditure Limits (approved schemes)

Level	Signatories	Limit
L1	Chief Executive, Director of Finance, Information and Estates	Above £1,000,000
L2	Managing Director, Deputy Directors of Finance and Information, Director Estates, Chief Information Officer	up to £1,000,000
L3	Head of Financial Planning and Investment, Head of Capital Development Head of Information Services Head of Digital Transformation	up to £250,000
L4	Capital Project Leads	up to £100,000

Investment approval **Appendix 2**

A description of what is included in each investment decision heading is below the table. Limit is per annum for all apart from capital items, which are one off transactions.

Meeting	Investment Decision	Limit £000s	Comment
Board of Directors	*Tender for new services* *Capital expenditure* *Capital disposal* *Expenditure requiring additional budget* *Expenditure within existing budget*	Unlimited Unlimited Unlimited Unlimited Unlimited	*Material investment decisions are subject to NHSI approval, see narrative below table for limits.* *Significant transactions (see NHSI table below) require Council of Governors and Board of Directors joint approval)*
Strategy and Resources Committee	Tender for new services Capital expenditure Capital disposal Expenditure requiring additional budget Expenditure within existing budget	2,500 5,000 2,500 2,500 5,000	
Executive Directors Group	Tender for new services Capital expenditure Capital disposal Expenditure requiring additional budget Expenditure within existing budget	1,000 2,000 1,000 1,000 2,000	
Care Group Board	Tender for new services Capital expenditure Capital disposal Expenditure requiring additional budget Expenditure within existing budget	nil nil nil nil 750	*Decisions taken cannot increase agreed care group forecast expenditure position if overspending.* *If underspending, increase is capped at the lower of £750k, and residual underspend.* *Any service change (e.g. outsourcing) must be agreed by Executive Directors Group.*

Care Croup Senior Management Team	Tender for new services Capital expenditure Capital disposal Expenditure requiring additional budget Expenditure within existing budget	nil nil nil nil 500	*Decisions taken cannot increase agreed care group forecast expenditure position if overspending.* *If underspending, increase is capped at the lower of £500k, and residual underspend.* *Any service change (e.g. outsourcing) must be agreed by Executive Directors Group.*

Tender for new services
All decisions regarding tendering to provide new services (clinical and non-clinical). This includes additions to existing service scope.

Capital expenditure
The purchase of any property, plant or equipment that will be capitalised in the Trust's financial statements.

Capital disposal
The sale of any property, plant or equipment that was previously capitalised, and held on the trust's asset register.

Expenditure requiring additional budget
All expenditure for which new budget allocation is required.

Expenditure within existing budget
This includes all amendments to expenditure for which budget exists within teams. For example, an IT system contract renewal is for a reduced value and creates surplus budget. This surplus budget is subject to the above restrictions.
Where IT purchasing has been centralised, all orders must be placed using the established process. Local procurement is not permitted.
The budget virement process must be adhered to at all times (see section 3 above).

NHSI reporting requirements / approval
In line with NHSI's Transactions Guidance (link), all significant transactions that meet the review thresholds in the table below should be reported to the Trust's NHSI regional team for assessment and approval.

Ratio	Description	Non-Healthcare / International	Healthcare
Assets	The gross assets* subject to the transaction* divided by the gross assets of the trust	>5%	>10%
Income	The income attributable to the assets or contract associated with the transaction* divided by the income of the trust	>5%	>10%
Consideration to total trust capital	The gross capital** or consideration associated with the transaction* divided by the total capital of the trust following completion, or the effects on the total capital*** of the trust resulting from a transaction*	>5%	>10%

* Gross assets are the total of fixed assets and current assets.
** Gross capital equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets.
*** Total capital of the foundation trust equals taxpayers' equity.

APPENDIX 3
Tendering Thresholds

The procurement of **goods and services** must be carried out in line with the following procurement thresholds (updated 9th March 2022):

Anticipated Expenditure (life of contract or 4 years)	Procurement Route	Minimum Lead Time*
Less than £10,000	CARDEA catalogue items	Variable however where contracts are in place generic items should be handled within 7/14 days (to delivery)
£10,000 - £49,999	Competitive Quotation	1-3 months dependant on complexity of requirement.
£50,000 - £122,975	Formal Competitive Tender "Contracts Finder" Publication	3-8 months (Depending on complexity)
£122,976 and above	"Find a Tender Service" Publication	3-8 months (Depending on complexity)
Varying levels of expenditure (please seek advice from procurement team)	Mini Competition	1-3 months dependant on complexity of requirement (complex requirements may take significantly longer)

The procurement of **construction contracts** must be carried out in line with the following procurement thresholds (updated at as 9th March 2022):

Anticipated Expenditure (life of contract or 4 years)	Procurement Route	Minimum Lead Time*
Less than £100,000	Competitive Quotation	1-3 months dependant on complexity of requirement.
Less than £500,000	Competitive Quotation (*with approval from Director of Finance, Information and Estates, otherwise formal competitive tender*)	1-3 months dependant on complexity of requirement.

£500,000 to £4,733,252	Formal Competitive Tender “Contracts Finder” Publication	3-8 months (Depending on complexity)
£4,733,252 and above	“Find a Tender Service” Publication	3-8 months (Depending on complexity)

ITEM NO. 17

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**31st March 2022**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Company Secretary**
REPORT FOR:	**Information**

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

Report:

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

Ref.	Date	Document	Sealing Officers
420	24.2.22	Agreement under the provisions of Section 278 of the Highways Act 1980 relating to the development of Bacchus House, Osbaldwick Link Road, York	Brent Kilmurray, Chief Executive Phil Bellas, Company Secretary

Recommendations:

The Board is asked to receive and note this report.