AGENDA FOR THE SPECIAL MEETING OF THE BOARD OF DIRECTORS
TUESDAY 17TH SEPTEMBER 2019
VENUE: THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON
AT 9.30 A.M.

Apologies for Absence

Quality Items (9.30 am)

Item 1	To receive and note the annual report of the Responsible Officer for the revalidation of medical staff and to approve the signing off of the statement of compliance with The Medical Profession (Responsible Officers) Regulations 2010.	**AK**	**Attached**

Performance (9.45 am)

Item 2	To consider the Finance Report as at 31st August 2019.	**PM**	**Attached**

Governance (9.50 am)

Item 3	On the recommendation of the Audit Committee to approve the Trust's submission to NHS England on Emergency Preparedness, Resilience and Response.	**PM**	**Attached**
Item 4	On the recommendation of the Audit Committee to approve the Annual Report and Accounts of the Charitable Trust Funds for submission to the Charity Commission.	**PM**	**Attached**

Items for Information (10.10 am)

Item 5	To receive and note a report on the use of the Trust's seal.	**CM**	**Attached**

Confidential Motion (10.15 am)

Item 6 **The Chairman 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 the financial or business affairs of any particular person (other than 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.

The meeting will adjourn for a refreshment break

Miriam Harte
Chairman
11th September 2019

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

ITEM NO. 1

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**17th September 2019**
TITLE:	**Statement of compliance for medical appraisal year 2018-19**
REPORT OF:	**Dr Ahmad Khouja, Medical Director and Responsible Officer**
REPORT FOR:	**Approval**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	
To continuously improve to quality and value of our work	
To recruit, develop and retain a skilled, compassionate and motivated workforce	✓
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	

Executive Summary:

The Annual Statement of Compliance for Medical Appraisal and the Framework of Quality Assurance for Responsible Officers and Revalidation demonstrate that the organisation remains in good standing and provides assurance that the medical workforce can demonstrate its fitness to practice in accordance with regulations.

Recommendations:

1 The Board approves the 2018-19 Annual Statement of Compliance for Medical Appraisal and the Framework of Quality Assurance for Responsible Officers and Revalidation.

2 Supports the following quality improvements for next year (2019-20):
- An annual Board report into the number of disciplinary cases/low level concerns, their type and outcome, as well as an analysis of the protected characteristics of the doctors.
- To simplify the SARD system for medical appraisal.
- Support appraisers to develop a coaching approach.
- Undertake the peer review of appraisal summaries in July 2019.

MEETING OF:	**Board of Directors**
DATE:	**17th September 2019**
TITLE:	**Statement of compliance for medical appraisal year 2018-19**

1. INTRODUCTION & PURPOSE:

1.1 This paper is presented to provide assurance of compliance with medical appraisal. The Board is asked to approve the statement of compliance and the recommendations for the further improvement in the system of assurance.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Framework of Quality Assurance for Responsible Officers and Revalidation (FQA) is requested by NHS England each year and has been designed to assist Responsible Officers in providing assurance to their Board that the doctors working in their organisation remain up to date and fit to practice.

2.2 The template has been redesigned this year and has been combined with the Statement of Compliance for efficiency and simplicity. The Statement of Compliance should be signed off by the Chief Executive or Chairman (or executive if no board exists) of the Designated Body's Board or management team and submitted to NHS England by 27 September 2019.

2.3 The Statement of Compliance is much lengthier this year. In previous years there have been approximately 10 questions of which we have either answered yes or no to if we comply. This year there are more questions, split into seven sections, asking for comments to support our answers and an explanation of actions we propose to take for the next year. It also asks for actions from the previous year but as this is the first year that the report has been presented this way, this is not applicable to all questions.

3. KEY ISSUES:

3.1 The medical appraisal policy and procedure was reviewed and updated in 2018/19.

3.2 Appendix 1 details the 2018/19 figures for appraisal and revalidation. There continues to be excellent engagement by the medical workforce, with 152/154 consultants, 40/42 SAS doctors and 8/8 Trust doctors completing their appraisals (98 %). Four doctors did not undertake an appraisal in the year, due to sick leave (1), a career break (1) and maternity leave (2) and had been designated as 'approved missed'. There were no 'unapproved missed' or 'incomplete' appraisals.

3.3 The appraisal process is supported by 53 medical staff trained as enhanced appraisers. Appraisers undergo initial training and the undertake twice yearly update training. Appraisers are performance reviewed by their appraisees, and

are sent annually anonymised feedback. Furthermore there is a system of quality assurance of appraisal summaries, which is then used to improve the update training programme.

3.4 A successful initiative that has been run in 2018/19 has been the development of a MasterCoach to support doctors undertaking their appraisal (Dr Jenny Forge). This has evaluated extremely well, and has resulted in at least four doctors who had been considering leaving the Trust remaining within TEWV.

3.5 Regarding revalidation, all doctors who were due for revalidation in the 2018/19 year were revalidated successfully, apart from one who was on a career break and therefore was deferred until his return to work.

3.6 Two issues which we are in the process of addressing at our quarterly revalidation group are:

- Whether we should offer appraisals for doctors who are not currently employed by us but want an appraisal (usually former employees who have retired and do some independent work).
- The introduction of a more tailored approach for our Trust Doctors who are on a short-term contract and usually new to the appraisal process.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
This paper supports the Fundamental Standards of fit and proper staffing and having appropriate governance arrangements for staffing.

4.2 **Financial/Value for Money:**
The Trust has a statutory duty to ensure appropriate resources are made available for the Responsible Officer to carry out their duties. The Trust fully complies with that duty.

4.3 **Legal and Constitutional (including the NHS Constitution):**
No legal or constitutional implications have been raised.

4.4 **Equality and Diversity:**
The development of an annual report to the Board analysing disciplinary procedures for medical staff will provide assurance that the Board will be sighted on any variance or discrepancies.

4.4 **Other implications:**
None identified.

5. RISKS:

Medical appraisal and revalidation remains a low risk for the organisation.

6. CONCLUSIONS:

The Trust remains in good standing and assurance is provided that the medical workforce can demonstrate its fitness to practice in accordance with regulations.

7. RECOMMENDATIONS:

1. The Board approves the 2018-19 Annual Statement of Compliance for Medical Appraisal and the Framework of Quality Assurance for Responsible Officers and Revalidation.

2. Board supports the following quality improvements for next year (2019-20):
   - An annual Board report into the number of disciplinary cases/low level concerns, their type and outcome, as well as an analysis of the protected characteristics of the doctors.
   - To simplify the SARD system for medical appraisal.
   - Support appraisers to develop a coaching approach.
   - Undertake the peer review of appraisal summaries in July 2019.

Author: **Dr Ahmad Khouja**
Title: **Medical Director and Responsible Officer**

Accompanying Paper:

- **Report with statement of compliance**

APPENDIX 1

REVALIDATION / APPRAISAL ANNUAL REPORT
1st April 2018 – 31st March 2019

Management of Appraisal and Revalidation

Responsible Officer:	Dr Ahmad Khouja
Associate Responsible Officer:	Dr Ingrid Whitton / Dr Lenny Cornwall
Medical Development	Mr Bryan O'Leary
	Mrs Elaine Corbyn
Medical Membership	Dr Stephen Wright (DMD York & Selby)
	Dr Tolu Olusoga (DMD North Yorkshire)
	Dr Pratish Thakkar (DMD Forensic Services)
	Dr Suresh Babu /Dr Ingrid Whitton (DMD – Durham & Darlington)
	Dr Lenny Cornwall (DMD Teesside)
	Dr Jim Boylan (Director of Medical Education)
	Prof Joe Reilly (Director of Research & Development)

Activity Levels

Number of doctors that TEWV are responsible body	Consultant		SAS		Trust Doctors	
	2017–18	2018–19	2017-18	2018–19	2017 - 18	2018–19
Adult Mental Health	67	67	19	23	13	17
Mental Health Services for Older People	32	30	17	15	4	5
Child and Young Person's Services	38	38	5	4	1	0
Learning Disabilities	12	11	1	1	0	1
Forensic Services	19	18	5	5	1	0
Total	**168**	**164**	**47**	**48**	**19**	**23**
Comments: The figures show that we have net 4 consultants less than this time last year with a loss of 2 consultants in MHSOP. However, the number of SAS doctors remains fairly constant, with only one lost in MHSOP and one lost in CYPS. AMH has the same amount of consultants as last year but with increases in recruitment for SAS doctors (3 new) and Trust doctors (4 new).						

Number of doctors who were due for an appraisal	Consultant		SAS		Trust Doctors	
	2017-18	2018–19	2017-18	2018–19	2017 - 18	2018–19
Adult Mental Health	65	61	18	19	2	7
Mental Health Services for Older People	32	29	16	14	0	1
Child and Young Person's Services	37	36	4	4	0	0
Learning Disabilities	12	11	1	1	0	0
Forensic Services	19	17	4	4	0	0
Total	**165**	**154**	**43**	**42**	**2**	**8**
Comments: The above table shows the number of doctors that were due an appraisal with						

us. The reasons why people might not be due an appraisal are that they have already had one in another organisation in the appraisal year or they might not have been with us for the time period required to have one.

Number of doctors who have been appraised in the appraisal year	Consultant		SAS		Trust Doctors	
	2017-18	2018–19	2017-18	2018–19	2017 - 18	2018–19
Adult Mental Health	65	61	18	16	2	7
Mental Health Services for Older People	32	29	14	15	0	1
Child and Young Person's Services	35	34	4	4	0	0
Learning Disabilities	12	11	1	1	0	0
Forensic Services	19	17	4	4	0	0
Total	**163 (99%)**	**152 (99%)**	**41 (95%)**	**40 (95%)**	**2 (100%)**	**8 (100%)**

Comments: The figures in the table above show a lesser amount of consultants were due an appraisal this year compared to last year, this is in part due to the loss of some consultants, but also because we have had a number of new consultants join us from training who therefore did not qualify for an appraisal in this year. The reason the consultant figure is not 100% this year is due to two appraisals which didn't take place during the appraisal year (one due to sickness and one due to maternity leave, however, the doctor off sick has since returned to work and completed appraisal in May 2019.)

In relation to SAS doctors, there was only one less doctor due for appraisal this year compared to last year. Again we had two doctors who had not completed appraisal, one was due to being on a career break and another is on maternity leave.

Exceptions

The table below shows the 'approved missed or incomplete appraisals'. These are doctors that could not complete their appraisal in the appraisal year for a reason that was accepted and signed off by the Associate Responsible Officer on behalf of the Responsible Officer.

For an appraisal to be an 'approved missed or incomplete', the trust needs to be able to produce documentation to show they have agreed the postponement as being reasonable. These are requirements set out by NHS England.

Number of 'approved missed or incomplete appraisals'	Consultant	SAS	Trust Doctors
Adult Mental Health	0	2	0
Mental Health Services for Older People	0	0	0
Child and Young Person's Services	2	0	0
Learning Disabilities	0	0	0
Forensic Services	0	0	0
Total	**2**	**2**	**0**
Comment: These four approved missed appraisals were due to long term sickness, a career break and two doctors being on maternity leave.			

The table below shows the 'unapproved missed or incomplete appraisals'. These are doctors that have not completed their appraisal in the appraisal year however; they have not sought any agreement of this from the Associate Responsible Officer.

Number of 'unapproved missed or incomplete appraisals'	Consultant	SAS	Trust Doctors
Adult Mental Health	0	0	0
Mental Health Services for Older People	0	0	0
Child and Young Person's Services	0	0	0
Learning Disabilities	0	0	0
Forensic Services	0	0	0
Total	**0**	**0**	**0**
Comments: There were no unapproved missed or incomplete appraisals in 2018/19.			

Revalidation

Number of doctors completing revalidation cycle	Consultant		SAS		Trust Doctors	
	2017-18	2018–19	2017-18	2018–19	2017-18	2018–19
Adult Mental Health	10	13	0	5	1	0
Mental Health Services for Older People	4	6	1	7	0	0
Child and Young Person's Services	3	7	1	1	0	0
Learning Disabilities	3	2	0	0	0	0
Forensic Services	1	6	0	2	0	0
Other	2	0	0	0	0	0
Total	**23**	**34**	**2**	**15**	**1**	**0**
Number of doctors receiving revalidation recommendations	Consultant		SAS		Trust Doctors	
	2017-18	2018–19	2017-18	2018–19	2017-18	2018–19
Adult Mental Health	10	13	0	4	1	0
Mental Health Services for Older People	4	6	1	7	0	0
Child and Young Person's Services	3	7	1	1	0	0
Learning Disabilities	3	2	0	0	0	0
Forensic Services	1	6	0	2	0	0
Other	2	0	0	0	0	0
Total	**23**	**34**	**2**	**14**	**1**	**0**
Comments: All doctors who were due for revalidation in the 2018/19 year were revalidated successfully, apart from one who was on a career break and therefore was deferred until his return to work.						

Performance Review, Support and Development of Appraisers

Training of Appraisers

	Consultant		SAS	
	2017-18	2018-19	2017-18	2018-19
Number of enhanced appraisers	53	58	1	5
Number of enhanced appraisers carrying out appraisals in appraisal year	50	55	1	3
We had 53 enhanced appraisers in 2017/18, however these numbers have increased we trained 10 new appraisers in April 2018.				

Support and Development of Appraisers

Update/Support Sessions	Update/Support Sessions
22nd May 2018	21st November 2018
24th September 2018	27th February 2019
Comment:	

Performance Review of Appraisers

Each appraiser is performance reviewed by their appraisee after every appraisal that they complete. A set of standardised questions are sent to each appraisee of which they answer them on a scale from 'strongly agree' to 'strongly disagree'. On a yearly basis the feedback is anonymised, collated and fed back to the appraisers. We also have a form which allows the appraiser to reflect on the information fed back to them and include it in their own appraisal to contribute to any development discussions and/or PDP objectives.

Quality Assurance of Appraisals

All of the appraisal summaries from those doctors who were due for revalidation in 2018/19 were anonymised and then 12 appraisers were randomly selected to rate 8 summaries each as part of a quality improvement exercise. We asked for volunteers from our appraisers as well as our medical management structure and those who were not picked this year will be used next year. Each summary was rated by two different appraisers. Feedback from this will be provided to the appraisers at our next appraiser update session.

Ongoing Actions

Responding to Concerns – Remediation/Disciplinary

Our Responsible Officer, Associate Responsible Officer and Associate Director of Medical Development attend regular sessions with our GMC representative throughout the year. These sessions allow for any concerns to be raised and advice to be given from a GMC perspective – additionally to these sessions the representative from the GMC is always available to be contacted. Also, with regards to Remediation and Disciplinaries, these are addressed in our appraisal policy 'Medical Remediation & Disciplinary'.

Electronic IT System

SARD is used as the electronic system for appraisals and revalidation. All doctors in TEWV now use SARD. Our Associate Responsible Officer has put together a plan of how we can make SARD simpler to use and abandon some sections were there is duplication. These changes have been agreed at our medical directorate meetings and by our corporate services team who are working to implement the changes from 1st August 2019.

The revalidation team are currently piloting the Multi-Source Feedback function on SARD and this will be reviewed, along with other systems, in future revalidation steering group meetings. We are also currently looking at how the Job Planning function works within SARD and have recently piloted this with our senior medical managers. We have asked for feedback on this so that improvements can be made and the Job Planning function will hopefully be used by all of our doctors in 2020.

The SARD contract is due for renewal in October 2019, having been extended for a further year. The revalidation team will have to prepare for the re- tendering process in due course. The team are concerned that any move from the existing system would cause a major problem due to the time it has taken for doctors to be trained and to become familiar with SARD.

Learning from Revalidation

We continue to have a robust electronic system and team in place to help manage revalidation, which ensures the process runs efficiently.

We have carried out the second cycle of revalidation for a number of our doctors this year and we can report that things went very smoothly with no concerns highlighted.

Other Information:

Appraisal policy and procedure has been updated in 2018/19.

SARD Guidance has been updated and a guidance document on the new changes to SARD has been issued. We are running an event on 3rd July 2019 for anyone who has any questions in relation to the new changes.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of Tees, Esk & Wear Valleys NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 13/05/19 Action from last year: Comments: Action for next year:

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: N/A Comments: Yes. Dr Ahmad Khouja, Medical Director, was appointed Responsible Officer on 1st April 2018. Action for next year: Not expecting a change in RO.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes. TEWV as the designated body is supported by the medical development department with dedicated members of admin and an Associate Responsible Officer, to support the Responsible Officer. Action from last year: N/A Comments: The Trust ensures we have the funds and staffing to support the role of RO. Action for next year: None required.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: N/A Comments: Yes, this is done by the Medical Development team under the management of Dr Ahmad Khouja. Names are recorded via GMC Connect. Action for next year: Ongoing action as above.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Policy to be reviewed and updated.

Comments: Yes, these are reviewed every 3 years. The policy and associated procedures document was last updated on 16/01/19.

Action for next year: No action identified.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: We continue to send a feedback questionnaire to all doctors following their appraisal and this information is then fed back to appraisers anonymously at the end of the year.

Comments:

Action for next year: To undertake a peer review of a selection of appraisal summaries to review their quality. This will be done by a number of appraisers.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: N/A

Comments: We provide exit reports for all locum doctors upon leaving the Trust which states details of any leave / sickness / complaints / investigations and comments from line managers. Longer term locums are provided with time to complete the CPD. We provide supporting info to all our doctors (including those not prescribed to us) to enable them to input into their appraisal. For TEWV employed doctors they are provided with software to access appraisals, coaching, CPD etc.

Action for next year: No action identified.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: N/A

Comments: Yes. All doctors are appraised on their whole scope of work. They receive supporting information for their appraisal prior to this taking place, provided by the medical directorate, which details any involvement in PALS/complaints and SUIs. Appraisers are trained to elicit relevant information to support effective appraisal.

Action for next year: No action identified.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: N/A

Comments: We have an appraisal policy and procedure in place which is followed in this instance.

Action for next year: No action identified.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: N/A

Comments: Yes. The appraisal policy and procedure were approved at the Medical Directorate meetings and ratified at the Executive Management Team (EMT). The policy and procedure follows national guidance.

Action for next year: In the next year we hope to simplify our SARD system for appraisal, re-write our SARD guidance and incorporate this into SARD rather than being a separate document.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: N/A

Comments: Yes. There were 58 appraisers for 235 doctors 2018/19.

Action for next year: No action identified.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Same as current position.

Comments: Yes, there are four training sessions a year, of which appraisers must attend at least two.

Action for next year: We are will support our appraisers to develop a more coaching style by delivering sessions on this at our appraiser network events in May and September 2019.

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[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: N/A Comments: Our process is quality assured through the use of feedback questionnaires following appraisal and peer review. Action for next year: When we undertake the peer review next year, the findings will be fed back to the medical directorate group and will form part of the Board's annual report.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: N/A Comments: Yes. Good communications exist with no concerns raised from either side. In addition regular meetings occur between the Responsible Officer and the GMC's ELA which are minuted – these allow for ongoing concerns and low level concerns to be tracked and regularly reviewed. Action for next year: No action identified.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: N/A Comments: Yes, letters are sent to doctors following recommendations from the RO and if unable to make recommendation the doctor is contacted immediately. Action for next year: No action identified.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: N/A Comments: There are effective and well established processes in place for pre-employment checks, medical appraisal and revalidation, and responding to concerns. Within this, roles and responsibilities are clearly defined. The medical directorate has dedicated expertise and is adequately resourced to carry out its function.

Action for next year: No action identified.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: N/A

Comments: There is a disciplinary policy for maintaining high professional standards. Issues around conduct and performance can be identified from multiple sources, including formal complaints, SUIs, Guardian of Safe Working, and the Freedom to Speak up Guardian. Monitoring of any conduct and performance issue is undertaken within the medical development department. Processes are in place to allow this to be done under a variety of different formats, depending on the seriousness of the concern e.g. low level concerns and disciplinary investigations. The department receives PALS/Complaints and SUI reports each month and this is documented on the supporting information which is sent to doctors ahead of their appraisal. All doctors have a line manager who monitors performance.

Action for next year: No action identified.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: N/A

Comments: We have a medical remediation and disciplinary procedure for dealing with all concerns, including low level concerns, which is monitored.

Action for next year: No action identified.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year: N/A

Comments: Currently a quality assurance process is not in place, though no concerns have been raised and no appeals have been made regarding either process of outcome when we have responded to concerns.

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

Action for next year: An annual report including analysis will be provided to the medical directorate and to the Board which will include the number of disciplinary cases/low level concerns, type, outcome as well as an analysis of the protected characteristics of the doctors.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: N/A

Comments: We complete an MPIT form for doctors who work for us and are connected to us to pass to a doctor's new organisation. Medical development inform the RO of any concerns, who would then directly contact the doctor's new Designated Body. If there are issues concerning agency doctors, we would contact the agency and ask that our concerns are discussed with their RO. If they wanted to discuss with our RO we would arrange this.

Action for next year: No action identified.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: N/A

Comments: All doctors have clinical manager supervision, annual appraisal and annual job planning. Appraisal and job planning are separate meetings. Quality assurance systems are in place checking our processes. The medical revalidation group meet quarterly to discuss and agree issues in relation to appraisals and revalidation. All doctors are treated equally and any issues would be dealt with following our procedures. We have a PALS/complaints team and a dedicated medical development team that deal with all issues/concerns as they arise.

Action for next year: No action identified.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: N/A

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Comments: Yes, we ensure that all six NHS pre-employment check standards are completed. This is done by medical staffing.

Action for next year: No action identified.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of last year's actions:**
- None

- **Actions still outstanding**
- None

- **Current Issues:**

1. We are considering whether we should support the appraisal of doctors, usually retired former colleagues, who are not currently employed by us but would like to have access to our appraisal system including appraisers.
2. Trust doctors – we hope to introduce a tailored approach for doctors who are on short term contracts and new to the appraisal process.

- **New Actions:**

1. An annual report including analysis will be provided to the medical directorate and to the Board which will include the number of disciplinary cases/low level concerns, type, outcome as well as an analysis of the protected characteristics of the doctors.
2. We will undertake a peer review of appraisal summaries in July 2019.
3. In the next year we hope to simplify our SARD system for appraisal, re-write our SARD guidance and incorporate this into SARD rather than being a separate document.
4. We are also helping our appraisers to develop in a coaching style by delivering sessions on this at our appraiser network events in May and September 2019.

Overall conclusion:

Governance arrangements and assurance processes for doctors employed within TEWV remain robust and fit for purpose.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: **Tees, Esk and Wear Valleys NHS Foundation Trust**

Name: Mr Colin Martin Signed: _ _ _ _ _ _ _ _ _ _

Role: Chief Executive

Date: _ _ _ _ _ _ _ _ _ _

FOR GENERAL RELEASE **Item 2**
BOARD OF DIRECTORS

DATE:	**17 September 2019**
TITLE:	**Finance Report for Period 1 April 2019 to 31 August 2019**
REPORT OF:	**Patrick McGahon, Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	
To continuously improve to quality and value of our work	
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	✓

Executive Summary:

The comprehensive income outturn for the period ending 31 August 2019 is a surplus of £2,491k, representing 1.6% of the Trust's turnover and is £85k ahead of the NHSI plan.

Performance Against Plan – year to date (3.1 / 3.2)

The Trust is currently £85k ahead of its year to date financial plan.	**Variance £000**	**Monthly Movement £000**	**Movement**
	-85	-83	↑

Cash Releasing Efficiency Savings (CRES) (3.3)

Identified CRES schemes for the financial year are forecast to be £1,844k **ahead of** financial plan.	**CRES Type**	**Annual Variance £000**	**Movement**
	Recurrent	422	↑
	Non recurrent	-2,266	↑
	Target	0	
	Variance	-1,844	↑

Identified CRES schemes for the rolling 3 year period were £10,572k **behind** the £21,810k CRES target.	**CRES Type**	**Annual Variance £000**	**Movement**
	Recurrent	10,572	↓

A Waste Reduction Programme has been established to assist the Trust in delivering the current year CRES requirements in full, and a 3 year recurrent CRES plan.

Capital (3.4)

	Variance £000	Monthly Movement £000	Movement
The Trust is £119k **behind of** its capital plan.	-119	-402	↑

Expenditure against the capital programme to 31 August 2019 is £14,456k and is marginally behind plan by £119k, the monthly movement of £402k largely relates to adjustments made to the profiling of expenditure to the York and Selby inpatient facility (Foss Park Hospital).

Workforce (3.5)

	Variance £000	Monthly Movement £000	Movement
The Trust is £963k **in excess** of its agency cap (35%)	963	288	↓

Agency expenditure is 35% (July 31%) in excess of cap for August, with expenditure across all localities. Nursing (49%), Medical (33%) and Admin (13%) account for the majority of agency expenditure, which is used to support vacancies and enhanced observations with complex clients.

The additional in month expenditure has largely been within nursing; although there was an improvement in administration spend reduction.

Use of Resources Risk Rating (UoRR) (3.7)

	Plan	Actual	Movement
The Trusts UoRR is on plan which is rated 1 to 4 with 1 being good.	2	2	↑

The UoRR for the Trust is assessed as 2 for the period ending 31 August 2019 and is in line with plan (Table 4). The planned rating of 2 arises due to a loan repayment of £1.5m made in April 2019 being measured against five month's income and expenditure.

However, agency expenditure continues to exceed the NHSI cap by 35% and is rated as a 3. Should this position not improve then the Trust will not achieve its planned 1 rating. Recruitment options are being explored to reduce dependency on agency further, and progress continues to inform conversations with NHSI.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**17 September 2019**
TITLE:	**Finance Report for Period 1 April 2018 to 31 August 2019**

1. INTRODUCTION & PURPOSE:

This report sets out the financial position for 1 April 2019 to 31 August 2019.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This report will enable the Board of Directors to monitor the Trust's key financial duties and performance indicators which are both statutory requirements.

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

3. KEY ISSUES:

3.1 Key Performance Indicators

The Trust is ahead of plan against the control total set by NHSI.

The UoRR for the Trust is assessed as 2 for the period ending 31 August 2019 and is in line with plan (Table 4). The planned rating of 2 arises due to agency expenditure continuing to exceed the NHSI cap by 37% and is rated as a 3. Should agency improve to be within cap the UoRR would improve at the year end to a 1 rating.

3.2 Statement of Comprehensive Income

The comprehensive income outturn for the period ending 31 August 2019 is a surplus of £2,491k, representing -0.2% of the Trust's turnover and is £85k ahead of the NHSI plan. This is summarised in table 1 below:

Table 1	**Annual Plan £000**	**Year to Date Plan £000**	**Year to Date Actual £000**	**YTD Variance £000**	**Prior Month Variance £000**
Income From Activities	(347,489)	(141,035)	(141,484)	(449)	(283)
Other Operating Income	(15,344)	(6,540)	(6,246)	294	307
Total Income	**(362,833)**	**(147,575)**	**(147,730)**	**(155)**	**23**
Pay Expenditure	277,753	116,110	115,686	(424)	(217)
Non Pay Expenditure	70,550	25,338	26,004	666	319
Depreciation and Financing	8,920	3,719	3,550	(170)	(126)
Variance from plan	**(5,610)**	**(2,408)**	**(2,491)**	**(85)**	**(2)**

The overspend deterioration in non-pay expenditure is largely due to additional investment in IT infrastructure in preparation for the improvements

to the patient information system, and purchase of replacement furniture and fittings in clinical services.

3 Cash Releasing Efficiency Savings (CRES)

The Trust's performance against the 2019/20 CRES target is shown in Table 2 below. The Trust is anticipating being ahead of plan (£1,844k) at the financial year end and continues to identify schemes for future years.

	CRES Type	Annual Variance £000	Movement
Identified CRES schemes for the financial year are forecast to be £1,844k **ahead of** financial plan.	Recurrent	422	↑
	Non recurrent	-2,266	↑
	Target	0	
	Variance	-1,844	↑

3.4 Capital

Expenditure against the capital programme to 31 August 2019 is £14,456k and is £119k behind plan, the monthly movement of £402k largely relates to adjustments made to the profiling of expenditure to the York and Selby inpatient facility (Foss Park Hospital).

3.5 Workforce

Table 3 below shows the Trust's performance on some of the key financial drivers identified by the Board.

Table 3	**Pay Expenditure as a % of Pay Budgets**						
Tolerance	Tolerance August-19	Mar	April	May	June	July	August
Establishment (a) (90%-95%)	92.60%	92.38%	90.66%	90.89%	91.59%	92.32%	92.60%
Agency (b)	1.00%	3.51%	4.07%	3.50%	3.20%	3.10%	3.20%
Overtime (c)	1.00%	1.02%	1.20%	0.94%	0.90%	0.87%	0.87%
Bank & ASH (flexed against establishment) (100%-a-b-c)	5.40%	2.99%	3.10%	3.20%	3.50%	3.52%	3.59%
Total	**100.00%**	**99.98%**	**99.03%**	**98.51%**	**99.11%**	**99.11%**	**99.11%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for agency and overtime, and flexed in correlation to staff in post for bank and additional standard hours (ASH). For August 2019 the tolerance for Bank and ASH is 5.4% of pay budgets.

NHS Improvement monitors agency expenditure against a capped target. Agency expenditure at 31 August 2019 is £3,721k which is £963k (35%) in excess of the agreed year to date capped target of £2,758k. Nursing and Medical agency expenditure accounts for 81% of total agency expenditure, and is used to support vacancies and enhanced observations with complex clients. Whilst there has been a deterioration in August overall agency usage is reducing and continues to be monitored against the Trust's action plan.

Recruitment options are being explored to reduce dependency on agency further, and progress continues to inform conversations with NHSI.

3.6 Cash

Total cash at 31 August 2019 is £ 91,782k; this is £9,338k ahead of plan and is largely due to higher than anticipated creditor accruals (£8,288k) where invoices have not been received by the Trust and a reprofiling of the capital expenditure plan.

3.7 Use of Resources Risk Rating (UoRR) and Indicators

3.7.1 The UoRR for the Trust is assessed as 2 for the period ending 31 August 2019 and is in line with plan (Table 4). The planned rating of 2 arises due to agency expenditure continuing to exceed the NHSI cap by 37% and is rated as a 3. Should agency improve to be within cap the UoRR would improve at the year end to a 1 rating.

However, in addition the Trust is ahead of its income and expenditure target (£85k) despite the agency expenditure position. Recruitment options are being explored to reduce dependency on agency, and progress continues to inform conversations with NHSI.

Table 4: Use of Resource Rating at 31 August 2019

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%

TEWV Performance	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	1.60x	3	1.51x	3	
Liquidity	65 days	1	66.3 days	1	
I&E margin	1.69%	1	1.5%	1	
I&E margin distance from plan	-0.04%	1	0.0%	1	
Agency expenditure	£3,721k	3	£2,758k	1	
Overall Use of Resource Rating		**2**		**2**	

3.7.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.6x (can cover debt payments due 1.6 times), which is in line with plan.

3.7.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 65 days; this is slightly behind of plan, but still rated as a 1.

3.7.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 1.69%, which is ahead of plan and is rated as a 1.

3.7.5 The I&E margin distance from plan ratio assesses the I&E Margin against plan, excluding PSF income. The Trust I&E margin distance from plan is -0.04% which is on plan and rated as a 1.

The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is 35% higher than the capped target and is rated as a 3.

The margins on UoRR are as follows:

- Capital service cover - to improve to a 2 a surplus increase of £605k is required.
- Liquidity - to reduce to a 2 a working capital decrease of £60,749k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £211k is required.
- Agency Cap rating – to improve to a 2 a reduction in agency expenditure of £274k is required.

4. IMPLICATIONS:

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

5. RISKS:

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

6. CONCLUSIONS:

6.1 For the period ending 31 August 2019 the Trust is £85k ahead of its planned control total surplus (£2,408k) submitted to NHSI.

6.2 The amount of CRES identified for the financial year is ahead of plan and the Trust continues to identify schemes to ensure full delivery of recurrent CRES requirements for the 3 year rolling programme.

6.3 The UoRR for the Trust is assessed as 2 for the period ending 31 August 2019 and is in line with plan (Table 4). The UoRR is planned to improve throughout the financial year to a 1 rating.

7. RECOMMENDATIONS:

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

Patrick McGahon
Director of Finance and Information

Tees, Esk and Wear Valleys
NHS Foundation Trust

Item 3

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday 17th September 2019**
TITLE:	**NHS England Core Standards for Emergency Preparedness Resilience and Response**
REPORT OF:	**Patrick McGahon, Director of Finance and Information**
REPORT FOR:	**Assurance**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	
To continuously improve the quality and value of our work	
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.	✓

Executive Summary:

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

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

Recommendations:

Board of Directors is requested to accept the self assessment which gives assurance the Trust can demonstrate it can effectively respond to emergency planning and business continuity incidents whilst maintaining services to patients.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday 17th September 2019**
TITLE:	**NHS England Core Standards for Emergency Preparedness Resilience and Response**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

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

3. KEY ISSUES:

3.1 The core standards have domains specific to Mental Health which we need to adhere to.

3.2 The date for completion and submission of the self assessment initially to LHRP's is September 2019.

3.3 The core standards and details were amended by NHS England for the 2018 assessment and are amended every 3 years following a full review. As can be seen by reference to Appendix 1 of the 54 standards that apply to the Trust, we have assessed ourselves as Fully Compliant with 52 standards and partially compliant with 2 standards.

3.4 In addition to the core standards, we are required to complete a self assessment on a Deep Dive section. This year, the Deep Dive section covers severe weather and climate adaption. The Trust has assessed itself as Fully Compliant with 14 of these standards and partially compliant with 6 This section does not affect the Trust's compliance level.

3.5 The standards that are partially compliant as shown in amber on the appendices.

3.6 This year the self-assessment has been completed jointly with Internal Audit who have assessed a sample of the evidence for the Core Standards as they were reviewed and all of the Deep Dive section at the request of the Emergency Planning Lead. An action plan is being drawn up in conjunction with internal audit to address the partially compliant standards and implementation of this will be monitored by the Emergency Planning and Business Continuity Group.

The self-assessment has also been considered by the Audit Committee. Its views will be reported verbally to the meeting.

3.7 The overall assessment rating for the Trust is 'substantially compliant'.

3.8 Assurance that the Trust can respond to a range of emergency and business continuity issues can also be demonstrated by the programme of exercises that have taken place during the year. Two internal and Two external exercises have been held, covering a range of issues including Mass Casualty, Vulnerable Adults and IT Communication Routes. Action plans based on lessons learnt are drawn up and reviewed to ensure implementation by the Emergency Planning and Business Continuity Group.

4. IMPLICATIONS:

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

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

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

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

4.5 **Other implications:** None identified.

5. RISKS:

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

6. CONCLUSIONS:

The self-assessment gives assurance to Board of Directors that the Trust can demonstrate it can effectively respond to emergency planning and business continuity incidents whilst maintaining services to patients.

7. RECOMMENDATIONS:

Board of Directors is requested to agree the Statement of Compliance at Appendix 3, signed by the Director of Finance and Information as the Trust's Accountable Emergency Officer prior to submission to LHRP and NHS England.

Patrick McGahon
Director of Finance and Information

Attachments:

Appendix 1 : EPRR Core Standards Assessment

Appendix 2 : EPRR Deep Dive Assessment

Appendix 3 : Statement of Compliance

Appendix 1

Tees, Esk and Wear Valleys
NHS Foundation Trust

SUPPORTING EVIDENCE TO CORE STANDARDS 2019

Ref	Domain	Standard	Detail	Comments	Evidence
1	**Governance**	**Appointed AEO**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	The CEO is overall responsible for EPRR with the Director of Finance and Information nominated AEO and lead for the Trust. They are supported by Associate Director of Operational Services and a dedicated Emergency Planning Manager and cover from the Health and Safety Manager. It was a Trust decision not to have a non-executive board member in support. Support is given by other Trust Directors.	Command and Control Plan.
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Policy statements are included in the Trust's Business Continuity policy and supported by the Command Control Plan. The policy is reviewed annually and is version controlled and includes a responsibility matrix.	Trust Business Continuity Policy and Command and Control Plan.

3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	The Core standards assessment is reported through the Emergency Planning Group via Audit Committee then through to the Trust board. Core standard report include training exercises and major incidents will be reported direct to Trust Board by the Director of Finance together with lessons Learnt. Audit Committee and Trust board are advised of exercises and actions taken.	Audit Committee/Board of Directors Report.
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	An annual work plan is agreed by the Emergency Planning Group. The work plan is informed by assurance process, risks and exercises. The group monitors implementation of the work plan. Exercise reports and work plan available.	Emergency Planning and Business Continuity Group Work plan 2019/20.
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Policy and Command and Control plan identify resources available. EP Lead in post with cover provided by Health and Safety Manager and Associate Director of Operational Services. Emergency Planning leads in place in each locality to assist the Trust in ensuring EPRR standards are reached. These are tested through regular exercises.	Command and Control Plan. Command and Control Team.
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Action plans are developed to implement lessons identified during the exercises. Incidents and exercise debriefs are taken and discussed at the Emergency Planning Group	Exercise Turing. Pelican exercises.
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Copy of LHRP Risk Registers considered when developing Trusts Risk Register. Risk Register reviewed at Emergency Planning Group. Trust Risk Register in place and a specific one for Emergency Planning. Also working with two LHRP to ensure that risks are discussed and exercises	LHRP Risk Register Emergency Planning and Business Continuity Group Risk Assessment.

				undertaken to ensure that processes are in place.	
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	The Trust has a recorded method of reporting and recording incidents documented in its Command and Control Plan and Service BCP's. Trust Risk Register and Emergency Planning Risk Register in place.	Command and Control Plan. Service Business Plans. Action Cards.
9	**Duty to maintain plans**	**Collaborative planning**	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Attendance at LHRP's and LHRP sub groups in the North East and in Yorks and Humber. Joint exercises carried out to test plans across organisations	Exercise Turing and Pelican attendance.
11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	Plans are reviewed and tested regularly through exercises to ensure effective arrangements are in place.	Command and Control Plan and Service Business Continuity Plans. Exercise Turing Report.
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	Internal and External Plans in place and tested regularly. Command and Control and Service BCP's also in place.	External Major Incident Plan. Internal Emergency Plan. Command and Control Plans. Service Plans.
13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	Summer and Winter plan in place.	TEWV Summer and Winter. Preparedness Plan.

14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Summer and Winter plan in place.	Summer and Winter Preparedness Plan.
15	**Duty to maintain plans**	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	Pandemic Influenza Plan in place and reviewed on a regular basis but also as per Trust Policies every three years. Next review 2020.	Pandemic Influenza Plan.
16	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	Policies and Procedures in place and liaison with PHE, NHS England and Local Acute Hospitals.	Infection, Prevention and Control Policy. Infectious Diseases procedure.
17	**Duty to maintain plans**	**Mass Countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution e.g. mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependent on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	Presently undertaking this in conjunction with the two LHRP's, CCG's, NHS England and Public Health England. No further action required by Trust will be advised if required to assist with distribution dependent on incidents.	

18	**Duty to maintain plans**	**Mass Casualty - surge**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	Mass casualty to be incorporated within the Professional Allied BCP and has been tested in two exercises. Worked with LHRP to ensure it complies with framework	Partial compliant. Draft document.to be approved.
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	Decant facilities available and MOU for Forensic services. Information re decant facilities within the Director on call folder.	List of Trust Decant facilities.
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	Each service have BCP's which include lockdown arrangements and are updated annually to ensure continuity of service.	Service Business Continuity Plans.
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.	This is identified within the service BCP's for high profile patients and VIP visitors. Will test the process in October	Service Business Continuity Plans.

23	**Duty to maintain plans**	**Excess death planning**	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	Trust Emergency Planning Lead included in the planning process with the two LHRP and local authorities.	
24	**Command and control**	**On call mechanism**	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	24/7 arrangements are in place with On call. Escalation to Trust Director of Finance and Information or On call Director and Chief Executive if required. Process described in the Command and Control Plan.	Command and Control Plan.
25	**Command and control**	**Trained on call staff**	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Trust Directors/Senior Managers have undertaken training according to NHS England EPRR competencies.	Incident Management Training Report.
26	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Exercises in place and undertaken with appropriate staff in attendance. All Loggists have undertaken PHE training. All Directors and some Senior Managers have attended Incident Management training.	Business Continuity Policy details training requirements.

27	**Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Exercises undertaken with multi agencies for joint collaboration to test the plans. Outcome and actions discussed at the Emergency Planning Group and implementation of actions monitored. Communication Tests are undertaken by the Trust and NHS England on a regular basis minimum every six months. Command and Control tested as part of live exercise.	Exercise Turing Report. Exercise Pelican Report.
28	**Training and exercising**	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Directors attended strategic and tactical responder training. Exercises undertaken with key staff attending.	Exercise Turing attendees. Incident Management Training Report.
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has a pre-identified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Trust ICC in place and three locality ICC's. ICC'S tested and documentation exists for activation and operation.	Command and Control Plan Action Cards.
31	**Response**	**Access to planning arrangements**	Version controlled hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Plans in place on Intouch and hard copies in each Incident Co-ordination Centre. Services print off relevant section of service plans.	
32	**Response**	**Management of business continuity incidents**	The organisations incident response arrangements encompass the management of business continuity incidents.	Business continuity response plans in place and tested with Information taken to Emergency Planning Group meeting.	Command and Control Plan. Service Business Continuity Plans.
33	**Response**	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	List of Loggists are available in Directors folder. Loggist information in Command and Control Plan Training programme for Loggists exists.	Command and Control Plan Trained list of Loggists.

34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (Sitreps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Sitreps and action cards available in all plans.	Command and Control Plan. Service Business Continuity Plans.
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	The communications team will liaise with health partners and blue light services, Twitter, Facebook and website notices can also be utilised. Social media (Facebook and Twitter) and the website can be used to inform the general public and service users.	Command and Control Plan Action Card. Communication Lead. Member of Command and Control Team.
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	The communications team can place urgent messages and supporting information for staff on the Trust Intranet. It should be noted that a number of our staff also follow our social media activity. Contingency plans for loss of IT are outlined in the communications service continuity plan. Staff can also be contacted by text messaging via the information team.	Command and Control Plan Action Card. Communication Lead. Member of Command and Control Team.
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	The communications team will assist the directors in making statements to the media and preparing for media interviews where appropriate. It will also place information on the website and social media (Twitter and Facebook) for the media, general public and service users.	Command and Control Plan. Action Card. Communication Lead. Member of Command and Control Team.
40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	Director of Finance and Information or appropriate Deputy to attend northern LHRP and EP lead to attend the North Yorkshire LHRP. Minutes received for all meetings.	It has been agreed that a nominated representative will attend instead of Director if required.
41	**Cooperation**	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.	NHS England attend the LRF for all the Trusts and feedback is given via the LHRP and LHRP sub groups. LHRP attend Trust exercises and	

				Trust attends relevant exercise for other LHRP members.	
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	Mutual aid through MOU in Forensic Services. There is a working partnership with Local authorities and LHRP. The Trust does not have written agreements for mutual aid with other Trusts. Wards would decant to other locations within the Trust.	Partial compliance. Tobe reviewed by Emergency Planning and Business Continuity Group to agree if further agreements required.
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	Agreed processes for sharing information with LHRP partners in the event of a major incident in place.	Command and Control Plan.
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	Policy Statement in place.	Business Continuity Policy. Command and Control Plan.
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	Policy and Command and Control Plans in place and identify scope and objectives of BCMS and risk management process.	Business Continuity Policy. Command and Control Plan.
49	**Business Continuity**	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	BIA's checked as part of BCP updates. All BCP's reviewed regularly or annually to ensure that they are up to date. Sitrep of these given to the Emergency Planning group.	Command and Control Plan. Changes resulting from outcome BIA's.
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	The Trust has undertaken the new Data Security and Protection Toolkit. Internal audit complete annual audits of this includes GDPR.	Data Security and Protection Toolkit assessment.

51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	Command and Control and Service plans in place and regularly updated in line with exercises and change. Covers response recovery and management of critical elements including • people • information and data • premises • suppliers • IT	Service Business Continuity Plans. Command and Control Plan.
52	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	BCMs monitored via core standards assessments and exercises. Annual report taken to the Trusts Board by Director of Finance and Information with any reports of any major incidents taken as they occur. Core standards reflect KPI's.	. Board of Directors Report.
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Audited in 2019. Internal audit reviewed sample of core standards and Deep Dive standards.	Audit Report 2019.
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	Plans tested and action plans implemented to ensure continual improvement and core standard review.	Turing Exercise Report Core standard report and action plan.
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	Critical suppliers identified and Business Continuity plans available some suppliers included in exercises. Undertaken further assurance via Brexit preparation.	Suppliers BCP's. Brexit checks.
56	**CBRN**	**Telephony advice for CBRN exposure**	Staff have access to telephone advice for managing patients involved in CBRN exposure incidents.	Telephone advice from Public Health England. Contacts available to Public Health England through Command and Control Plan and Service Plans.	Command and Control Plan - Emergency Contact List.
57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are organisation specific HAZMAT/ CBRN planning arrangements (or dedicated annex).	Plans in place. The advice for staff is within the BCP's Action Cards.	Service Business Continuity Plans.

58	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Risk assessment taken place and action cards and response equipment circulated to risk areas identified.	Service Business Continuity Plans. Action Card.
60	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Response equipment available at key receptions in line with action cards. - Disposable paper suits - Paper towels - Plastic bags	Service Continuity Plans.
66	**CBRN**	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.	Full decontamination would not be carried out by Trust as emergency services would transfer to Acute Trust.. Action Cards used to advise staff on immediate actions to be taken.	Service Business Continuity Plans.
68	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Action Cards in Service Business Continuity Plans cover requirements to isolate	Service Business Continuity Plans.
69	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) 24 / 7.	The equipment will be accessed by IPCT through liaison with Public Health England, NHS England, LHRP and Local Acute Hospitals. Our Trust do not routinely do Aerosol generating procedures and so would not need to have FFP3 masks but in the rare cases that we might we would rely on our Acute colleagues for training and supply.	

Appendix 2

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Severe Weather											
Domain: Severe Weather Response											
1	**Severe Weather response**	**Overheating**	The organisation's heatwave plan allows for the identification and monitoring of inpatient and staff areas that overheat (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	The monitoring processes is explicitly identified in the organisational heatwave plan. This includes staff areas as well as inpatient areas. This process clearly identifies relevant temperature triggers and subsequent actions.	The Trust's summer and winter plan refers to DOH plans and informs guidance and joint working across agencies	Fully compliant				
2	**Severe Weather response**	**Overheating**	The organisation has contingency arrangements in place to reduce temperatures (for example MOUs or SLAs for cooling units) and provide welfare support to inpatients and staff in high risk areas (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	Arrangements are in place to ensure that areas that have been identified as overheating can be cooled to within reasonable temperature ranges, this may include use of cooling units or other methods identified in national heatwave plan.	Plans identify use of cool rooms and portable appliances	Fully compliant				
3	**Severe Weather response**	**Staffing**	The organisation has plans to ensure staff can attend work during a period of severe weather (snow, flooding or heatwave), and has suitable arrangements should transport fail and staff need to remain on sites. (Includes provision of 4x4 where needed)	Y	The organisations arrangements outline: - What staff should do if they cannot attend work - Arrangements to maintain services, including how staff may be brought to site during disruption - Arrangements for placing staff into accommodation should they be unable to return home	Plans advise services that can be suspended. Adverse events guidance on Intouch outlines what staff do if cannot attend work. 4 X 4 provision available.	Fully compliant				
4	**Severe Weather response**	**Service provision**	Organisations providing services in the community have arrangements to allow for caseloads to be clinically prioritised and alterative support delivered during periods of severe weather disruption. (This includes midwifery in the community, mental health services, district nursing etc)	Y	The organisations arrangements identify how staff will prioritise patients during periods of severe weather, and alternative delivery methods to ensure continued patient care	Partially compliant. Added to action plan to gain evidence of compliance	Partially compliant				
5	**Severe Weather response**	**Discharge**	The organisation has polices or processes in place to ensure that any vulnerable patients (including community, mental health, and maternity services) are discharged to a warm home or are referred to a local single point-of-contact health and housing referral system if appropriate, in line with the NICE Guidelines on Excess Winter Deaths	Y	The organisations arrangements include how to deal with discharges or transfers of care into non health settings. Organisation can demonstrate information sharing regarding vulnerability to cold or heat with other supporting agencies at discharge	Partially compliant Placed on action plan to gain evidence of compliance	Partially compliant				
6	**Severe Weather response**	**Access**	The organisation has arrangements in place to ensure site access is maintained during periods of snow or cold weather, including gritting and clearance plans activated by predefined triggers	Y	The organisation arrangements have a clear trigger for the pre-emptive placement of grit on key roadways and pavements within the organisations boundaries. When snow / ice occurs there are clear triggers and actions to clear priority roadways and pavements. Arrangements may include the use of a third party gritting or snow clearance service.	Contained in Estates plans	Fully compliant				
7	**Severe Weather response**	**Assessment**	The organisation has arrangements to assess the impact of National Severe Weather Warnings (including Met Office Cold and Heatwave Alerts, Daily Air Quality Index and Flood Forecasting Centre alerts) and takes predefined action to mitigate the impact of these where necessary	Y	The organisations arrangements are clear in how it will assesses all weather warnings. These arrangements should identify the role(s) responsible for undertaking these assessments and the predefined triggers and action as a result.	Summer and Winter plan	Fully compliant				
8	**Severe Weather response**	**Flood prevention**	The organisation has planned preventative maintenance programmes are in place to ensure that on site drainage is clear to reduce flooding risk from surface water, this programme takes into account seasonal variations.	Y	The organisation has clearly demonstratable Planned Preventative Maintenance programmes for its assets. Where third party owns the drainage system there is a clear mechanism to alert the responsible owner to ensure drainage is cleared and managed in a timely manner	No properties on flood plain maintenance programme to clear drains	Fully compliant				
9	**Severe Weather response**	**Flood response**	The organisation is aware of, and where applicable contributed to, the Local Resilience Forum Multi Agency Flood Plan. The organisation understands its role in this plan.	Y	The organisation has reference to its role and responsibilities in the Multi Agency Flood Plan in its arrangements. Key on-call/response staff are clear how to obtain a copy of the Multi Agency Flood Plan	Links with LHRP and other agency flood plans	Fully compliant				
10	**Severe Weather response**	**Warning and informa**	The organisation's communications arrangements include working with the LRF and multiagency partners to warn and inform, before and during, periods of Severe Weather, including the use of any national messaging for Heat and Cold.	Y	The organisation has within is arrangements documented roles for its communications teams in the event of Severe Weather alerts and or response. This includes the ability for the organisation to issue appropriate messaging 24/7. Communications plans are clear in what the organisations will issue in terms of severe weather and when.	Communication team and COO and EP Lead get copy to action/disseminate	Fully compliant				

11	**Severe Weather response**	**Flood response**	The organisation has plans in place for any preidentified areas of their site(s) at risk of flooding. These plans include response to flooding and evacuation as required.	Y	The organisation has evidence that it regularly risk assesses its sites against flood risk (pluvial, fluvial and coastal flooding). It has clear site specific arrangements for flood response, for known key high risk areas. On-site flood plans are in place for at risk areas of the organisations site(s).	No critical sites on flood plain	Fully compliant				
12	**Severe Weather response**	**Risk assess**	The organisation has identified which severe weather events are likely to impact on its patients, services and staff, and takes account of these in emergency plans and business continuity arrangements.	Y	The organisation has documented the severe weather risks on its risk register, and has appropriate plans to address these.	Plans in place in service BCP's e.g. shortage staff and supplies	Fully compliant				
13	**Severe Weather response**	**Supply chain**	The organisation is assured that its suppliers can maintain services during periods of severe weather, and periods of disruption caused by these.	Y	The organisation has a documented process of seeking risk based assurance from suppliers that services can be maintained during extreme weather events. Where these services can't be maintain the organisation has alternative documented mitigating arrangements in place.	BCP's in place Further assurance via Brexit	Fully compliant				
14	**Severe Weather response**	**Exercising**	The organisation has exercised its arrangements (against a reasonable worst case scenario), or used them in an actual severe weather incident response, and they were effective in managing the risks they were exposed to. From these event lessons were identified and have been incorporated into revised arrangements.	Y	The organisation can demonstrate that its arrangements have been tested in the past 12 months and learning has resulted in changes to its response arrangements.	Plans tested via exercise and actual events	Fully compliant				
15	**Severe Weather response**	**ICT BC**	The organisations ICT Services have been thoroughly exercised and equipment tested which allows for remote access and remote services are able to provide resilience in extreme weather e.g. are cooling systems sized appropriately to cope with heatwave conditions, is the data centre positioned away from areas of flood risk.	Y	The organisations arrangements includes the robust testing of access services and remote services to ensure the total number of concurrent users meets the number that may work remotely to maintain identified critical services	IT BCP and ICT Tool kit and can use other organisations	Fully compliant				
Domain: long term adaptation planning											
16	**Long term adaptation planning**	**Risk assess**	Are all relevant organisations risks highlighted in the Climate Change Risk Assessment are incorporated into the organisations risk register.	Y	Evidence that the there is an entry in the organiations risk register detailing climate change risk and any mitigating actions	Partially compliant Included in plans for new buildings Sustainability plan estates added to workplan to review Risk Register	Partially compliant				
17	**Long term adaptation planning**	**Overheating risk**	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling higherachy.	Y	The organisation has records that identifies areas exceeding 27 degrees and risk register entries for these areas with action to reduce risk	Partially compliant Taken into account new builds and cooling units available. Added to workplan to review risk register	Partially compliant				
18	**Long term adaptation planning**	**Building adaptations**	The organisation has in place an adaptation plan which includes necessary modifications to buildings and infrastructure to maintain normal business during extreme temperatures or other extreme weather events.	Y	The organisation has an adaptation plan that includes suggested building modifications or infrastructure changes in future	The Trust has a 5 year plan for properties and are progressing work on air condtioning for clinic room, added to action plan to review if further work required	Partially compliant				
19	**Long term adaptation planning**	**Flooding**	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	Y	Areas are identified in the organisations adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS	Added to action plan to review if further work required	Partially compliant				
20	**Long term adaptation planning**	**New build**	The organisation considers for all its new facilities relevant adaptation requirements for long term climate change	Y	The organisation has relevant documentation that it is including adaptation plans for all new builds	Included in plan for new buildings	Fully compliant				

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2019-20

STATEMENT OF COMPLIANCE

Tees, Esk and Wear Valleys NHS Foundation Trust has undertaken a self-assessment against the NHS England Core Standards (v2.3).

Following the self-assessment, and in line with the definitions of compliance stated below, the organisation declares itself as demonstrating the following level of compliance against the 2019-20 standards as: **Substantially compliant**

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are required to achieve.
Substantial	The organisation is 89-99% compliant with the core standards they are required to achieve.
Partial	The organisation is 77-88% compliant with the core standards they are required to achieve.
Non-compliant	The organisation compliant with 76% or less of the core standards they are required to achieve.

Where areas require further action, this is detailed in the organisations *EPRR Work Plan* and will be reviewed in line with the organisation's governance arrangements.

I confirm that the above level of compliance with the EPRR Core Standards has been or will be confirmed to the organisation's board / governing body.

Signed by the organisation's Accountable Emergency Officer

17/09/2019 — *Date of board / governing body meeting*

11/09/2019 — *Date signed*

Item no 4

FOR GENERAL RELEASE
BOARD OF DIRECTORS

DATE:	**17 September 2019**
TITLE:	**Approval of Annual Report and Accounts of the Charitable Trust Fund**
REPORT OF:	**Patrick McGahon, Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	
To continuously improve to quality and value of our work	
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	✓

Executive Summary:

The Charitable Trust Fund (CTF) accounts and report was an agenda item at Audit Committee on 12th September 2019. A verbal update will be provided to confirm that they were accepted and recommended to the Board for submission.

In year the CTF decreased by £21k, and had a closing balance of £427k.

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

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

Recommendations:

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

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

MEETING OF:	**Board of Directors**
DATE:	**17 September 2019**
TITLE:	**Approval of Annual Report and Accounts of the Charitable Trust Fund**

1. INTRODUCTION & PURPOSE:

This report sets out the closing financial position of the Charitable Trust Fund (CTF) for the financial year 2018/19, prior to upload to the Charities Commission.

2. BACKGROUND INFORMATION AND CONTEXT:

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

3. KEY ISSUES:

3.1 Appendix A contains the CTF annual report and accounts. In year the fund decreased by £21k, and had a closing balance of £427k.

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

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

A draft of the report is attached as appendix B.

3.3 The CTF accounts and report was an agenda item at Audit Committee on 12th September 2019. A verbal update will be provided to confirm that they were accepted and recommended to the Board for submission.

3.4 Following approval from the Board, the CTF accounts and report will be uploaded to the Charities Commission website. The deadline for upload is 31 January 2020.

4. IMPLICATIONS:

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

5. RISKS:

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

6. CONCLUSIONS:

6.1 In year the CTF decreased by £21k, and had a closing balance of £427k.

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

7. RECOMMENDATIONS:

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

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

Patrick McGahon
Director of Finance and Information

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Trust

General Charitable Fund

Fund Number: 1061486

Annual Report 2018-19

making a difference together

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Appendices

1 – Incoming resources

2 – Resources expended

Tees, Esk and Wear Valleys NHS Foundation Trust

General Charitable Trust Fund

Annual Report 2018-19

1. Tees, Esk and Wear Valleys NHS Foundation Trust General Charitable Trust Fund

The Charity is administered by Tees, Esk and Wear Valleys NHS Foundation Trust and was formed as the "umbrella" Charity for the former Tees and North East Yorkshire NHS Trust and County Durham and Darlington Priority Services NHS Trust charitable funds.

2. Objectives of the Charity

The Tees, Esk and Wear Valleys NHS Foundation Trust Charitable Trust Fund Deed (which is the governing document for the charitable funds) states the Charity's principal objectives as being:

"... for any charitable purpose or purposes relating to the National Health Service".

The governing document does not place any specific restrictions on the use of the funds other than that implied by the Charity's main object. All bids are made on an ad-hoc basis with no commitment or strategic deployment from any one individual fund.

All charities must demonstrate, explicitly, that their charitable purposes are for the public benefit and adhere to the following two key principles:

Principle 1: There must be an identifiable benefit or benefits

Principle 2: Benefit must be to the public, or section of the public

The Trustee confirms that they have had regard to the guidance contained in the Charity Commission's general guidance on public benefit when reviewing the trust's aims and objective and in planning future activities and setting grant making policy for the year. It is the opinion of the Trustee that it has followed this guidance by:

- Providing additional amenities, events or equipment for service users and carers, and employees of the Trust throughout the year.

- Ensuring there is no detriment or harm that, in their view, might arise from carrying out the charity's aims.

Further details of specific activities that have been provided can be referenced in Section 4 – Achievements and performance.

3. Organisational structure and relationships

3.1 Organisation structure

Tees, Esk and Wear Valleys NHS Foundation Trust is the sole corporate Trustee of the charity. Delegated responsibility is allocated to the executives and non-executive members of Tees, Esk and Wear Valleys NHS Foundation Trust Board. All those with delegated responsibility of the Trustee are legally co-opted from the Foundation Trust Board and training and development

needs are addressed through the Foundation Trust appraisal process.

Those with delegated responsibility of the Trustee received no remuneration or expenses, and no remuneration or expenses have been paid to any employee.

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

Mr C S Martin, Chief Executive
Mr D Kendall, Director of Finance and Information – left 31 March 2018
Mr P McGahon, Director of Finance and Information – joined 1 April 2018
Mr B Kilmurray, Chief Operating Officer and Deputy Chief Executive – left 19 August 2018
Mrs R Hill – started 1 August 2018
Mrs S Pickering, Director of Planning and Performance – left 30 September 2018
Mr D Levy, Director of Human Resources and Organisational Development – left 30 September 2018
Mrs L Bessant, Chairman of the Trust
Mr M Hawthorn, Non-Executive Director
Mr D Jennings, Non-Executive Director
Mr P Murphy, Non-Executive Director
Mr. R. Simpson, Non-Executive Director – left 30 September 2018

In order to safeguard the assets of the Charity and ensure income is applied appropriately the Trustee requires charitable funds procedures to comply with the Trust's Standing Financial Instructions and Scheme of Delegation.

For day to day operational and management purposes the Charity is divided into sub funds. These are managed by Trust officers who have delegated authority to apply the funds within the objects of the Charity.

The Financial Controller has overall responsibility for the administration of the funds, supplying regular reports to the Resources Committee and completing the annual accounts and annual report for the charitable funds.

An administration charge is levied at the sub funds to reflect the financial and clerical work that Tees, Esk and Wear Valleys NHS Foundation Trust provides. The basis of apportionment for this charge is the value of restricted and unrestricted funds as a percentage of the total funds held.

3.2 Relationships

The Charity's principal relationship is with Tees, Esk and Wear Valleys NHS Foundation Trust.

During the year no member of the Trust's Board had any related party transactions with the Charity.

4. Achievements and performance

The following funds had material movement in balances within the year:

Ridgeway café and shop
The purpose of this fund is to manage funds for Ridgeway café and shop for the benefit of users, carers and staff. The trading account shows an increase in funds of £3k.

LD Forensic Day services
The purpose of this fund is to facilitate the selling and purchasing of items with a therapeutic purpose. The trading account shows a decrease in funds of £6k.

Kilton View Day Service
The purpose of this fund is to raise money for the benefits of patients and staff within Kilton View. The fund increased in year by £3k due to a lottery grant (£10k) being greater than expenditure incurred to date on enhancing patient space in the garden area.

Rowan Ward
The purpose of this fund is to raise money for the relief of sickness of the Trust's patients. The fund decreased by £8k due to purchase of furniture for the ward.

Acomb Garth
The purpose of this fund is to provide activities and events to the Trust's patients. The fund decreased in year by £8k due to expenditure decorating the ward.

5. Review of activities

There were no new fund set up during the year, and three funds were closed due to either no further funds being available or balances being transferred to other more substantial funds within the same area / service.

An internal audit review was undertaken by Audit North in October 2016 which gave significant assurance. All recommendations have been implemented. Due to materiality a full internal audit review is completed every three years, however should any process change it is reviewed by internal auditors before being implemented.

6. Financial activity

A full set of accounts for the financial year 2018-19 are included with this report. Mazars LLP undertakes an independent examination of the accounts.

6.1 General review

The year under review saw a decrease of £21k in net resources due to expenditure on charitable activities being in excess of donations received. The overall balance of the funds as at 31 March 2019 was £427k.

Income is derived from donations, raising funds and investment income. Income from raising funds is received from the shop within the learning disabilities' day centre, and the shop and café at the Ridgeway Centre at Roseberry Park.

During the period 1 April 2018 to 31 March 2019 total investment income was £1k which was in line with the previous year. Investment income has continued to be less than the administration costs of the Charitable Funds – due predominantly to the current economic climate and low interest rates being available.

There are a number of funds administered by the Trustee for which bids can be made for goods or services where there is no individual specific Trust Fund to draw on. There were no bids approved by the Trustee in 2018-19, as the balance is currently fully committed.

The funds classed as "Others" in note 8 of the accounts are further broken down as follows:

	"Others" Balance	Number Of Funds	Average Fund Balance
Restricted	£172,450	98	£1,760
Unrestricted	£54,954	42	£1,308

6.2 Incoming resources

Total income for the year was £149k, an increase of £42k on last year. Actual figures were:

	2018-19 £000	**2017-18 £000**
Donations	24	14
Legacies	0	5
Other trading activities	114	87
Income from investments	1	1
Grants received	10	0
Total	**149**	**107**

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

6.3 Material donations and legacies

The Charitable Fund received no legacies in 2018-19, but received donations of £24k to various funds.

6.4 Resources expended

Expenditure for the year was £170k, a decrease of £16k when compared with £186k spent in the previous year.

Analysis of Expenditure:

	2018-19 £000	**2017-18 £000**
Purchasing goods for resale	81	88
Patients' welfare	71	77
Staff welfare	10	13
Governance costs	8	8
Total	**170**	**186**

Expenditure has decreased marginally from the previous financial year, mainly due to lower expenditure on goods to be used for charitable trading.

The costs of generating funds relate to the fundraising trading activities in Ridgeway café / shop, and LD Forensic Day Services.

See Appendix 2 for chart showing the split of expenditure categories.

6.5 Management and administration costs

The administration costs include the internal audit fee, an independent examination of the accounts and bank charges as well as the Trust cost of administering the funds. Charity Commission guidelines state that if a charity does not exceed £500k gross income in a financial year or does not have aggregate value of assets of more than £3,260k, it is eligible to have an independent examination rather than a full audit of its accounts. The Trust's charitable funds fall into both these categories.

Following discussions with the Trust's auditors, Mazars LLP, it was decided that it would be appropriate for the charitable funds to have an independent examination of the accounts. This means the overall management costs per annum are £8k, and account for 4.7% of total expenditure.

The basis of apportionment for the administration costs is the value of restricted and unrestricted funds as a percentage of the total funds held.

6.6 Material expenditure

There were 3 instances of material expenditure from the Charitable Funds (e.g. in excess of £5k) in 2018-19.

Fund	Expenditure £	Comment
LD Forensic Day Services	8,573	Purchase of furniture
Rowan Ward	6,659	Purchase of furniture
Acomb Garth	5,103	Decoration for ward

6.7 Going concern

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

The fund has maintained its level of financial resources due to its long standing policy of only funding one-off in-year applications to the fund, and has no future commitments to discharge other than accruals and creditors as disclosed in the balance sheet which reports £3k of debt compared to £430k of cash in hand.

The return on deposit account investments has been poor throughout the year due to low interest rates available on the market. The low return on investment has resulted in all funds suffering a charge to cover governance costs.

The Trustee's view is that the Charity is a going concern and can make the disclosure as recommended by the accounting standards board that:

After making enquiries, the Trustee has a reasonable expectation that the Charity has adequate resources to continue in operational existence for the foreseeable future. For this reason, it continues to adopt the going concern basis in preparing the annual report and accounts.

7. Funds managed for and on behalf of other NHS organisations.

Within the balances of the Funds held by the Tees, Esk and Wear Valleys NHS General Charitable Fund there were no balances relating to other NHS Organisations.

8. Policy on reserves and investments

8.1 Reserves

The Trustee considers that it should be the aim to hold sufficient reserves to be able to provide funds to meet charitable expenditure as it is incurred and to review the position on an annual basis. Access to the funds is encouraged so that cash is used often and the trust can bring the associated benefits to its patients.

There are limitations on expenditure that can be realised within restricted funds (as it must be related to the purpose of the fund), so a minimum level target is not appropriate for any fund classed as restricted. With unrestricted funds the balance is £92k; as this is not material in comparison with the Trust's turnover of £388,346k no minimum level target has yet been set.

8.2 Investments

8.2.1 Statement of policy on investments

The Charity's funds were invested in an interest bearing deposit account with Yorkshire Bank PLC at an agreed interest of 0.20%, with a minimal balance in a lower interest bearing account at Barclays Bank PLC.

Funds were invested in this manner, with the objective to provide maximum security and availability. This allows a flexible and prudent level of control over the charity's funds.

8.2.2 Exposure to risks

The Trustee has identified the major risks to the Charity. The main risks can be summarised as:

1. That the Charity is not operating within its objectives.
2. That accounting transactions are inappropriately or inadequately reported.
3. Expenditure is inappropriate, or inappropriately authorised or not spent for the purposes intended.
4. That income is not appropriated to specific sub-funds in accordance with the intention of the donor.
5. Investments are not properly safeguarded, resulting in loss of funds.
6. Registered fund holders do not respond to requests for actions relating to the timely and appropriate administration of funds.

The Trustee has established systems to ensure these risks are kept at a minimum. Namely:

1. The existence and compliance with Standing Financial Instructions.
2. An adequately qualified and resourced finance function.

3. The establishment of internal financial control systems which are reviewed annually by an Internal Audit Department.

4. Reporting and review of audit findings to an Audit Committee.

8.2.3 Planned future activities of the Charity

The NHS is an ever changing environment and the future direction of the Charity will be shaped by these changes. The priorities for spending charitable funds are determined primarily by the fund holders who are managers in the service. By delegating the responsibility of expending charitable funds to this level ensures that those able to make the decisions are best placed to know the exact needs of service.

9. Legal and administrative information

Registered charity number

1061486

Registered address
The Flatts Lane Centre
Flatts Lane
Normanby
Middlesbrough
TS6 OSZ

Trustee
Tees, Esk and Wear Valleys NHS Foundation Trust is the sole corporate Trustee of the Charity. Delegated responsibility for Trustee duties for the period covered by this report is allocated to members of the Board of Directors. These were:

Non-executive directors:
Mrs L Bessant (Chairman)
Mr R Simpson
Mr M Hawthorn
Mr Dr H Griffiths
Mr D Jennings
Mrs S Richardson
Mr P Murphy

Executive directors
Mr C S Martin
Dr N Land – left 31 March 2018
Dr A Khouja – started 1 April 2018
Mr B Kilmurray – left 19 August 2018
Mrs Ruth Hill – started 1 August 2018
Mrs E Moody
Mr D Kendall – left 31 March 2018
Mr P McGahon – started 1 April 2018

All Board of Directors appointments are made in accordance with the policy and procedures laid down in the NHS code of good practice.

The Secretary of State for Health, in line with statutory requirements approved the Chairman's appointment, and a panel comprising the minimum statutory members, including the Chairman

and an expert independent assessor, made the Chief Executive's appointment.

All other executive and non-executive appointments to the Trust Board were made following external advertisement and robust and transparent selection procedures.

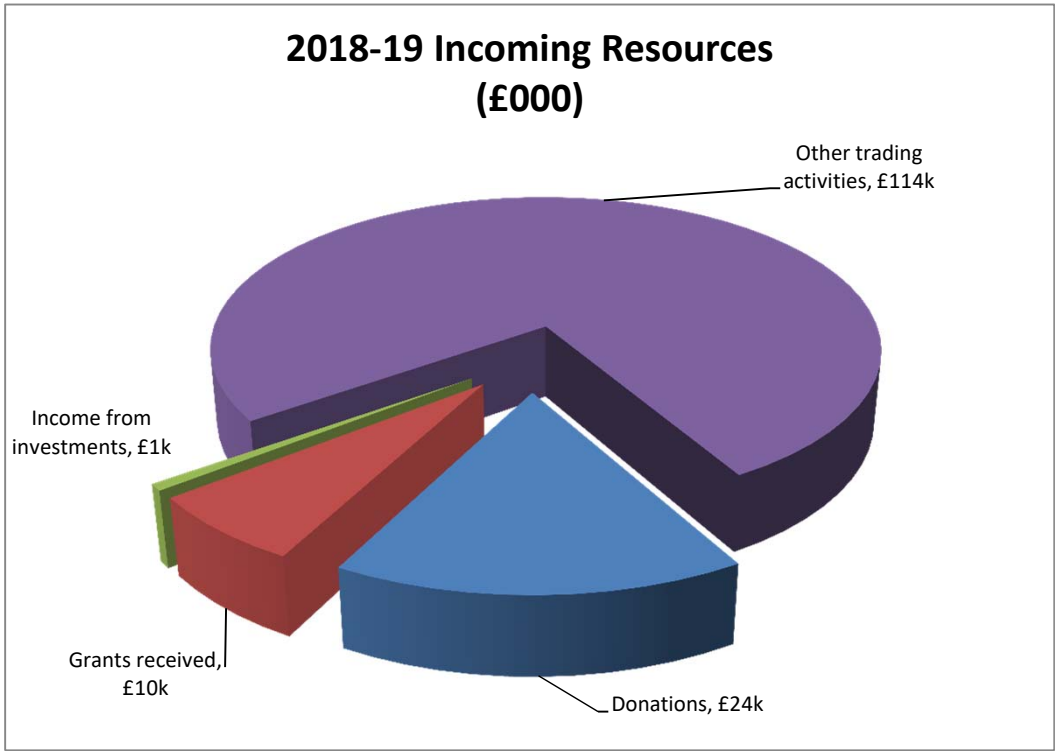
Independent examiners
Mazars LLP
Durham
Salvus House
Aykley Heads
Durham
DH1 5TS

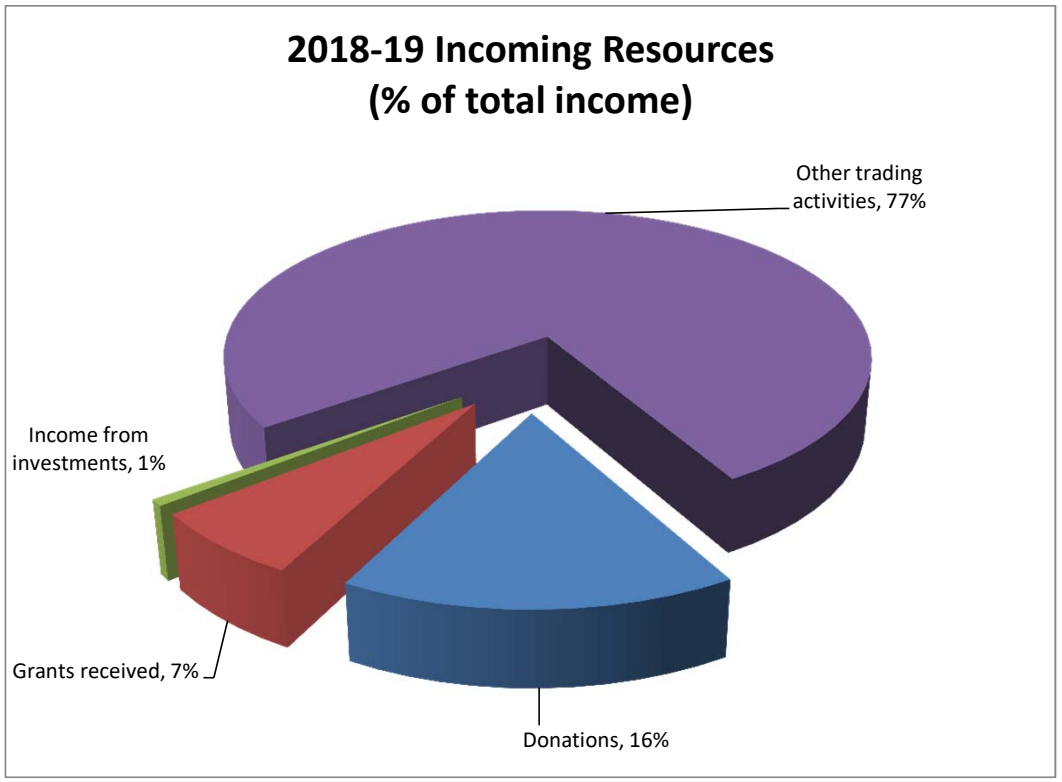
Legal advisors
Ward Hadaway
Sandgate House
102 Quayside
Newcastle upon Tyne
NE1 3DX

Bankers

Yorkshire Bank PLC	Barclays Commercial Bank
7 Linthorpe Road	PO Box 190, 2 Floor,
Middlesbrough	1 Park Row,
TS1 1RF	Leeds, LS1 5WU

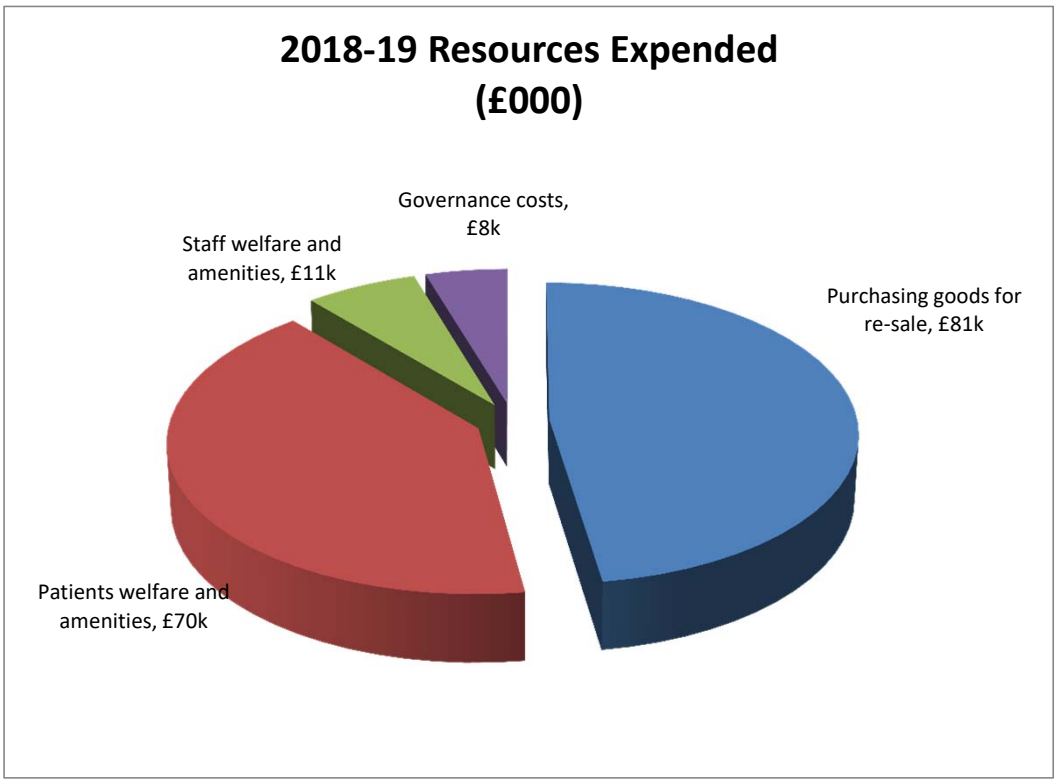
Analysis of incoming resources Appendix 1

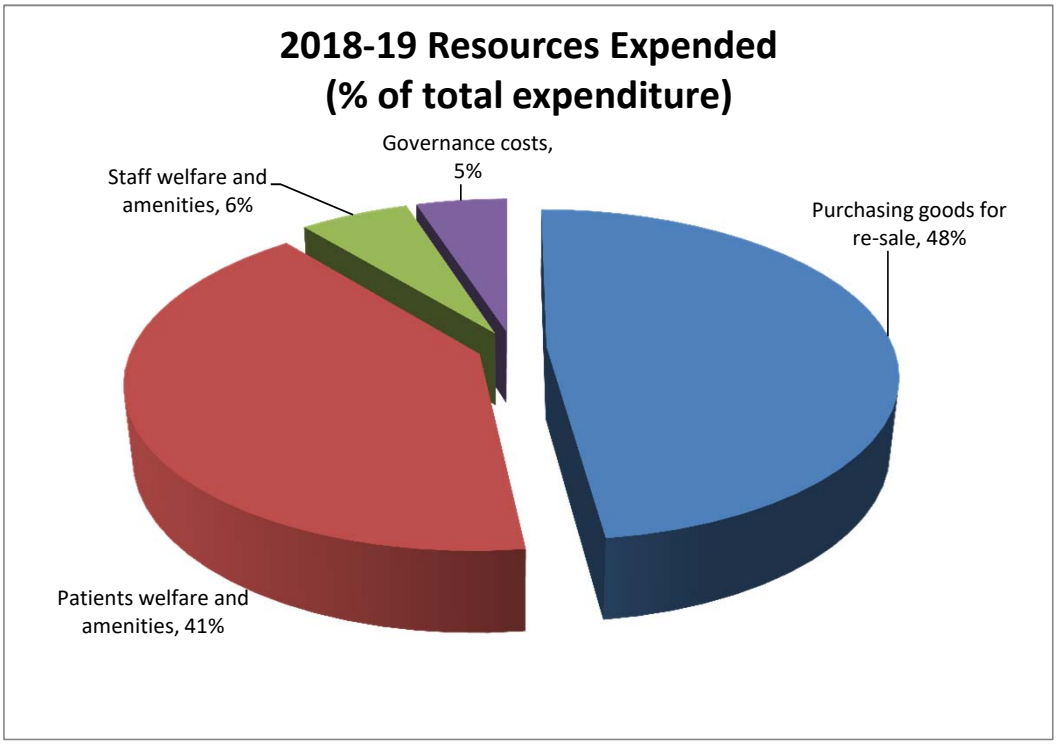




Analysis of resources expended

Appendix 2





CHARITABLE TRUST ACCOUNT - TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST - 2018-19	
Data entered below will be used throughout the workbook:	
This year	2018-19
Last year	2017-18
This year ended	2019
Last year ended	2018
This year beginning	1 April 2018
This year name	31 March 2019
Last year name	31 March 2018

Statement of trustee responsibilities

Tees, Esk and Wear Valleys NHS Foundation Trust is the sole corporate trustee of the fund. Delegated responsibility of the trustee is applied to executive and non executive members of Tees, Esk and Wear Valleys NHS Foundation Trust Board.

The trustee is responsible for preparing the trustees' Annual Report and financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

The law applicable to charities in England and Wales/Scotland/Northern Ireland requires the trustee to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period.

In preparing these financial statements the trustee is required to:

select suitable accounting policies and then apply them consistently;

observe the methods and principles in the Charities SORP;

make judgements and estimates that are reasonable and prudent;

state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements; and

prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the charity and enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the trust deed . It is also responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The trustee is responsible for the maintenance and integrity of the charity and financial information included on the charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

The trustee confirms that it has met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 1-9 attached have been complied from and are in accordance with the financial records maintained by the trustee.

By Order of the trustee, and those with delegated responsibility

Chairman……..…….. Date……

Executive Director ……..…… Date …….

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

I report on the accounts of the Charity for the year ended 31 March 2019, which are set out on pages 1 to 9.

Respective responsibilities of trustees and examiner

The charity's trustee is responsible for the preparation of the accounts. The charity's trustee considers that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 145 of the 2011 Act;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the 2011 Act; and
- to state whether particular matters have come to my attention.

This report, including my statement, has been prepared for and only for the charity's trustee as a body. My work has been undertaken so that I might state to the charity's trustee those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustee as a body for my examination work, for this report, or for the statements I have made.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustee concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the accounts present a 'true and fair view' and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

(1) which gives me reasonable cause to believe that in any material respect the requirements to keep accounting records in accordance with section 130 of the 2011 Act; and to prepare accounts which accord with the accounting records and comply with the accounting requirements of the 2011 Act have not been met; or

(2) to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Signed:

Name: Cameron Waddell (CPFA) for and on behalf of Mazars LLP
Relevant professional qualification or body: CPFA
Address: Salvus House, Aykley Heads, Durham DH1 5TS
Date: 12-Sep-19

Statement of Financial Activities for the year ended 31 March 2019

	Note	31 March 2019 Unrestricted Funds £000	31 March 2019 Restricted Funds £000	31 March 2019 **Total Funds £000**	31 March 2018 Total Funds £000
Incoming resources					
Income and endowments from:					
Donations		13	11	**24**	14
Legacies		-	-	**-**	5
Grants received	5.1	-	10	**10**	-
Income from investments	5.2	-	1	**1**	1
Other trading activities	5.3	3	111	**114**	87
Total income and endowments		**16**	**133**	**149**	**107**
Resources expended					
Expenditure on:					
Raising funds	3.3	-	(81)	**(81)**	(88)
Charitable Activities	3.1	(25)	(64)	**(89)**	(98)
Total resources expended	4	**(25)**	**(145)**	**(170)**	**(186)**
Net expenditure	6	**(9)**	**(12)**	**(21)**	**(79)**
Transfers between funds	6	(1)	1	-	-
Total transfers	6	**(1)**	**1**	**0**	**0**
Net movement in funds	6	**(10)**	**(11)**	**(21)**	**(79)**
Reconcilliation of funds:					
Fund balances brought forward at 31 March 2018		102	346	**448**	527
Fund balances carried forward at 31 March 2019		**92**	**335**	**427**	**448**

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

Balance Sheet as at 31 March 2019

	Notes	Unrestricted Funds £000	Restricted Funds £000	**Total at 31 March 2019 £000**	Total at 31 March 2018 £000
Current assets					
Short Term Deposit Investment		92	338	**430**	454
Total current assets		92	338	**430**	454
Current liabilities					
Creditors: Amounts falling due within one year	7	-	(3)	**(3)**	(6)
Total current liabilities		-	(3)	**(3)**	(6)
Total current assets less current liabilities		92	335	**427**	**448**
Total net assets		**92**	**335**	**427**	**448**
Funds of the Charity					
Income Funds:					
Restricted	8.1	-	335	**335**	346
Unrestricted	8.2	92	-	**92**	102
Total funds		**92**	**335**	**427**	**448**

Notes numbered 1 to 13 form part of the accounts.

Signed:

Date:

Notes to the Account

Accounting policies

1 The principal accounting policies are summarised below. They have been applied consistently through out the reporting year 2018-19 and throughout the comparators shown for the previous reporting year 2017-18.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention with items recognised at cost or transaction value unless otherwise stated in the relevant note(s) to these accounts. The accounts have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014, and with the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and with the Charities Act 2011.

The charity constitutes a public benefit entity as defined by FRS 102

1.2 Incoming resources

All incoming resources are included in full in the Statement of Financial Activities as soon as the following three factors are met:

entitlement - control over the rights or other access to the economic benefit has passed to the charity;

probable - it is more likely than not that the economic benefits associated with the transaction or gift will flow to the charity;

measurement – the monetary value or amount of the income can be measured reliably and the costs incurred for the transaction and the costs to complete the transaction can be measured reliably.

Legacies

Legacies are accounted for as incoming resources once the receipt of the legacy becomes reasonably certain. This will be once confirmation has been received from the representatives of the estate that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.

Offsetting

There has been no offsetting of assets and liabilities, or income and expenses.

Grants and donations

Grants and donations are only included in the SoFA when the general income recognition criteria are met.
No performance related grants were received.

Tax reclaims on donations and gifts

Gift Aid receivable is included in income when there is a valid declaration from the donor. Any Gift Aid amount recovered on a donation is considered to be part of that gift and is treated as an addition to the same fund as the initial donation unless the donor or the terms of the appeal have specified otherwise.

1.3 Resources expended and creditors

The Charity accounts are prepared in accordance with the accruals concept. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party.

Cost of generating funds

The cost of generating funds are the costs associated with generating income for the funds held on trust.

Governance costs

These are accounted for on an accruals basis and are recharges of appropriate proportions of the funds administration costs from Tees, Esk and Wear Valleys NHS Foundation Trust, plus Internal and External Audit charges for 2018-19. These costs are apportioned across the funds using the appropriate classification of fund. During 2018-19 the classification split was:

Restricted 78%, Unrestricted 22%.

Creditors

The charity has creditors which are measured at settlement amounts.

1.4 Structure of funds

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are classified as unrestricted funds. Funds which are not legally restricted but which the Trustees have chosen to earmark for set purposes are classified as restricted funds. The major restricted funds held within these categories are disclosed in note 8.

1.5 Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later).

1.6 Pensions contributions

The Charity does not employ staff and does not make pension contributions.

1.7 Change in the basis of accounting

There has been no change in the accounting policy or accounting estimates in the year.

1.8 Prior year adjustments

There are no prior year adjustments in these accounts.

1.9 Going concern

After making enquiries, the Trustee have a reasonable expectation that the Charity has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Please see section 6.7 within the Annual Report for further details

1.10 Stock

A small balance of stock is held to support the activities of the Ridgeway Cafe / Shop and LD Forensic Day Services however, having reviewed the balance of stocks held over time, the Trustee has confirmed that the stocks are both stable and immaterial in value. Consequently stocks are not recognised within the financial statements rather are treated as expenditure as they are purchased.

2 Related party transactions

During the year no members with delegated responsibility for the Trustee, or members of the key management staff or parties related to them has undertaken any material transactions with the Tees, Esk and Wear Valleys NHS Trust General Charitable Fund (2017-18, £nil).

The Charitable Fund does not have the facility to pay creditors therefore, Tees, Esk and Wear Valleys NHS Foundation Trust makes the payments on the Fund's behalf and is re-imbursed on a monthly basis by the Fund.

Certain income for the Charitable Fund is initially banked through Tees, Esk and Wear Valleys NHS Foundation Trust. This income is re-imbursed to the Fund on a monthly basis.

Tees, Esk and Wear Valleys NHS Foundation Trust is the sole corporate trustee of the fund. Delegated responsibility of the trustee is applied to executive and non executive members of Tees, Esk and Wear Valleys NHS Foundation Trust Board (names listed below). All are also members of Tees Esk and Wear Valleys NHS Foundation Trust.

Mrs L Bessant
Mr C S Martin
Mr P McGahon - started 01 April 2018
Dr A Khouja
Mrs E Moody
Mr B Kilmurray - left 19 August 2018
Mrs R Hill - started 01 August 2018
Mr D Jennings
Mr R Simpson
Mr M Hawthorn
Mr H Griffiths
Mr P Murphy
Mrs Shirley Richardson

3 Details of resources expended on charitable activities

3.1 Activities in furtherance of charities objectives

	Unrestricted Funds	Restricted Funds	**Total 2019**	Total 2018
	£000	£000	**£000**	£000
Patients welfare and amenities	(23)	(47)	**(70)**	(77)
Staff welfare and amenities	-	(11)	**(11)**	(13)
Governance costs (see 3.2 below)	(2)	(6)	**(8)**	(8)
	(25)	**(64)**	**(89)**	(98)

3.2 Analysis of governance costs

	Unrestricted Funds	Restricted Funds	**Total 2019**	Total 2018
	£000	£000	**£000**	£000
Establishment costs	(2)	(4)	**(6)**	(6)
Internal / External audit fee*	-	(2)	**(2)**	(2)
	(2)	**(6)**	**(8)**	(8)

*Independent examination of the accounts cost £480

3.3 Details of costs incurred in raising funds

	Unrestricted Funds	Restricted Funds	**Total 2019**	Total 2018
	£000	£000	**£000**	£000
Purchasing goods for re-sale	-	(81)	**(81)**	(88)
	-	**(81)**	**(81)**	(88)

4 Analysis of total resources expended

	Costs of raising funds	Costs of activities for charitable objectives	**Total 2019**	Total 2018
	£000	£000	**£000**	£000
Internal / External audit fee	-	(2)	**(2)**	(2)
Compliance costs for Trust Funds	-	(6)	**(6)**	(6)
Charitable activities	(81)	(81)	**(162)**	(178)
	(81)	**(89)**	**(170)**	(186)

5 Analysis of income

5.1 Grants received

A grant of £10k was received from the National Lottery Fund to install a summer house at Kilton View inpatient unit.

5.2 Income from investments

Income from investments of £1k (restricted) relates to interest received on individual fund balances held by the Charity.
These investments are held in the UK.

5.3 Details of other trading activities

The £114k income from other trading activities was delivered from the re-sale of goods purchased at a cost of £81k, and training provided that generated £5k income.

6 Changes in resources available for charity use

	Unrestricted Funds	Restricted Funds	**Total 2019**	Total 2018
	£000	£000	**£000**	£000
Net movement in funds for the year before transfers	(9)	(12)	**(21)**	(79)
Internal transfers	(1)	1	**-**	-
Net decrease in funds for the year	**(10)**	**(11)**	**(21)**	(79)

	Balance at 31 March 2019 £000	Balance at 31 March 2018 £000
7 Analysis of creditors		
Trade creditors	(3)	(6)
Total amounts falling due within one year	**(3)**	**(6)**

8 Details of material funds

8.1 Restricted funds	Balance 1 April 2018 £000	Incoming resources £000	Resources expended £000	**Balance 31 March 2019 £000**	**Description of the nature and purpose of each fund**
Ridgeway Activity Centre Café / Shop	36	69	(66)	**39**	To provide funds for the well being of patients within Ridgeway
Allinson Bequest	31	-	(1)	**30**	To provide funds for epilepsy services in the Durham area
LD Forensic Day Services	34	35	(41)	**28**	Facilitate the Selling and Purchasing of Items with a Therapeutic Purpose
Learning Disabilities	16	-	-	**16**	To provide funds for activities for patients with Learning Disabilities in York and Selby
Acomb Garth	23	-	(8)	**15**	To provide funds for activities for patients of Acomb Garth
Epilepsy Fund, Bankfields Court	10	2	-	**12**	To provide funds for epilepsy services in the Middlesbrough area
North of Tees MHSOP Charitable Account	11	-	-	**11**	To provide funds for Patient activities, comforts, diversional equipment
Learning Disability Medical Staff	10	-	-	**10**	To provide additional training and development opportunities
Others (98 Funds)	175	27	(28)	**174**	
Total	346	133	(144)	**335**	

8.2 Unrestricted funds	Balance 1 April 2018 £000	Incoming resources £000	Resources expended £000	**Balance 31 March 2019 £000**	
CDDPS General Fund	24	8	(8)	**24**	To provide general purpose funds for the patients being cared for in the Durham area
St Mary's General Fund	15	-	(1)	**14**	To provide general purpose funds for the patients being cared for at St Mary's Hospital
Others (42 Funds)	63	8	(17)	**54**	
Total	**102**	**16**	**(26)**	**92**	

9 Connected organisations

	2018-19		2017-18	
	Turnover of Connected Organisation £000	Net Surplus for the Connected Organisation* £000	Turnover of Connected Organisation £000	Net Deficit for the Connected Organisation** £000
The charity is administered by Tees, Esk and Wear Valleys NHS FT	**388,346**	**58,365**	350,349	(24,438)

* The surplus for 2018-19 includes material non recurrent items relating to incentivised provider sustainability funding (£32,288k), a technical benefit following termination of a PFI contract (£59,544k), and asset impairments (£43,680k). Excluding these items would result in a surplus of £10,213k

** The deficit for 2017-18 includes expenditure for unanticipated impairments of fixed assets totalling £41,238k. Excluding these non operation items would result in a surplus of £16,800k.

10 Other funds held for and on behalf of other NHS organisations

Within the balances of the Funds held by the Tees, Esk and Wear Valleys NHS General Charitable Fund there were no balances relating to other NHS Organisations.

11 Cash flow

The charity has taken advantage of the exemption available to it under section 7 of FRS102 not to produce a cash flow statement due to its size.

12 Taxation liability

As a registered charity, Tees, Esk and Wear Valleys NHS Charitable Fund is potentially exempt from taxation of income and gains falling within Part 10 of the Income Tax Act 2007 and s256 Taxation and Chargeable gains Act 1992. No tax charge has arisen in the year.

13 Post Balance Sheet events

There are no post balance sheet events to report.

Summary report of findings

Tees, Esk and Wear Valleys NHS Trust General Charitable Fund

Year ended 31 March 2019

Strictly private and confidential

MAZARS

CONTENTS

1. Summary report

Appendix – Draft independent examiner's report

MAZARS

1. SUMMARY REPORT

Purpose of this report

This document is to report the findings from our Independent Examination of Tees, Esk and Wear Valleys NHS Trust General Charitable Fund (the Charity) for the year ended 31 March 2019. It is addressed to Tees, Esk and Wear Valleys NHS Foundation Trust (the Trust) as corporate trustee of the Charity.

Our work has been undertaken in line with our Engagement Pack dated 20 August 2018, which we previously agreed with the Trust.

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

Status of our work and overall findings

At the time of issuing this report, we:

- anticipate issuing a standard unmodified independent examiner's report; and
- have not identified any significant matters from our independent examination of the Charity's financial statements for the year ended 31 March 2019 which we need to bring to the Trust's attention.

Our review identified two issues for which management has amended the accounts:

- The updated year-end control account reconciliation included £3k of charitable fund income on the Trust's ledger that was not included in the Charity's ledger as it was identified after the accounts had been prepared. The amendments comprise a £3k increase to income on the SOFA (Other trading activities - restricted funds) and a £3k increase to the bank balance (Short Term Deposit Investment - restricted funds), plus amendments to related notes to the accounts.
- 1 of the 20 items from our sample testing was found to have been allocated to the incorrect fund. Further investigation identified only one other similar item, the total impact being £2k. Both funds affected are restricted funds, so there is no impact on the SOFA or note 5, only on the analysis of funds in Note 8.1.

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

Fees

Our fees are in line with those set out in our engagement pack dated 20 August 2018, being £400 plus VAT.

APPENDIX – DRAFT INDEPENDENT EXAMINER'S REPORT

Independent examiner's report to the Trustee of Tees, Esk and Wear Valleys NHS Trust General Charitable Fund

I report on the accounts of the Charity for the year ended 31 March 2019, which are set out on pages 'x' to 'y'.

Respective responsibilities of trustees and examiner

The charity's trustee is responsible for the preparation of the accounts. The charity's trustee considers that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 145 of the 2011 Act;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the 2011 Act; and
- to state whether particular matters have come to my attention.

This report, including my statement, has been prepared for and only for the charity's trustee as a body. My work has been undertaken so that I might state to the charity's trustee those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustee as a body for my examination work, for this report, or for the statements I have made.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustee concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the accounts present a 'true and fair view' and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

(1) which gives me reasonable cause to believe that in any material respect the requirements to keep accounting records in accordance with section 130 of the 2011 Act; and to prepare accounts which accord with the accounting records and comply with the accounting requirements of the 2011 Act have not been met; or
(2) to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Signed:

Name: Cameron Waddell (CPFA) for and on behalf of Mazars LLP
Relevant professional qualification or body: CPFA
Address: Salvus House, Aykley Heads, Durham DH1 5TS
Date: xx xxx 2019

ITEM NO. 5

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**17th September 2019**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	
To continuously improve the quality and value of our work	
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.	✓

Executive Summary:

This report provides information on the use of the Trust Seal as required under Standing Order 15.6.

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**17th September 2019**
TITLE:	**Report on the Register of Sealing**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to inform the Board of Directors of the use of the Trust's Seal in accordance with Standing Orders.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 An entry of every sealing is made and numbered consecutively in a Register specifically provided for the purpose. It is signed by the persons who have approved and authorised the document and those who attested the seal.

3. KEY ISSUES:

3.1 The Trust Seal has been used as follows:

Number	Date	Document	Sealing Officers
353	09/08/2019	Deed of Variation and Release relating to Woodside Resource Centre, Marton Road, Middlesbrough	Colin Martin, Chief Executive Phil Bellas, Trust Secretary
354	09/08/2019	Deed of Guarantee – Interserve Group Ltd	Colin Martin, Chief Executive Phil Bellas, Trust Secretary

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** None identified.

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

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

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with Standing Orders.

7. RECOMMENDATIONS:

7.1 The Board is asked to receive and note this report.

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution
Seals Register