AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 22nd MAY 2018
VENUE: THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON
AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the special meeting held on **10th April 2018** and the last ordinary meeting held on **24th April 2018.**		**Attached**
Item 2	Public Board Action Log.		**Attached**
Item 3	Declarations of Interest.		
Item 4	Chairman's Report.	**Chairman**	**Verbal**
Item 5	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.45 am)

Item 6	To receive and note the annual report on research and development.	**Prof. Reilly to attend**	**Attached**
Item 7	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 8	To consider the monthly Nurse Staffing Report.	**EM**	**Attached**
Item 9	To receive and note a report on the delivery of the 2017/18 Composite Staff Action Plan.	**DL**	**Attached**
Item 10	To consider the report of the Mental Health Legislation Committee including to confirm the Scheme of Delegation in relation to the Mental Health Act.	**RS/EM**	**Attached**

Regulatory Items (10.50 am)

Item 11	**NHS Foundation Trust Annual Report and Accounts 2017/18:**		
	(1) To approve the Annual Report, including the Quality Report, and Annual Accounts 2017/18.	**CM/PM**	**Draft previously circulated**
	(2) To approve the Letter of Representation.		**Letter of Representation Attached**
	(3) To authorise the sign-off of: ▪ The Performance Report ▪ The Accountability Report ▪ The Statement on Quality ▪ The Statement on Directors' Responsibilities for Preparing the Quality Report ▪ The Annual Governance Statement ▪ The Remuneration Report ▪ The Statement on the Accounting Officer's Responsibilities ▪ The Statement of the Financial Position ▪ The Letter of Representation ▪ Any certificates relating to the above as required by NHS Improvement.		
	(4) To approve the submission of the Annual Report, including the Quality Report, and Annual Accounts, to NHS Improvement and Parliament.		
	(5) To authorise the submission of the Quality Account to the Department of Health and Social Care.		
	(6) To approve the Trust's statement under the Modern Slavery Act 2015.		
	(Notes: (1) The recommendations of the Audit Committee on the above matters will be reported verbally to the meeting.	**DJ**	**Verbal**
	(2) The report of the Director of Finance and Information on the Annual Accounts is provided).	**PM**	**Attached**

Item 12	To approve the Annual Report and Accounts of the Charitable Trust Funds for 2017/18.	**CM/PM**	**Attached**
	(Note: The recommendations of the Audit Committee on the above matters will be reported verbally to the meeting.)	**DJ**	**Verbal**

(Notes: With regard to items (11) and (12) above:

(1) A draft version of the Annual Report and Accounts has been placed in a reading room on Boardpad and a shared folder.

(2) The final draft version of the Annual Report and Accounts will be circulated following the Special meeting of the Audit Committee to be held on 18th May 2018 and a full copy of the document will be available at the meeting.

(3) Supporting documentation including the External Auditor's Audit Completion Report, the External Assurance Report on the Quality Report and the Summary of Findings of the Independent Review of the Charitable Funds prepared by Mazars LLP will be uploaded into a reading room on the Boardpad system and into a shared folder.

(4) Any additional information or updated documents will be tabled at the meeting).

Item 13	On the recommendation of the Audit Committee to sign-off the annual Board certificates required by NHS Improvement.	**PB**	**Attached**

Performance (11.15 am)

Item 14	To consider the Finance Report as at 30th April 2018.	**PM**	**Attached**
Item 15	To consider the Trust Performance Dashboard as at 30th April 2018.	**SP**	**Attached**
Item 16	To consider the Strategic Direction Performance Report for Quarter 4, 2017/18.	**SP**	**Attached**

Governance (11.40 am)

Item 17	To consider the publication of information on compliance with the public sector duty under the Equality Act 2010.	**DL**	**Attached**

Items for Information (11.50 am)

Item 18	To receive and note a report on the use of the Trust's seal.	**CM**	**Attached**
Item 19	Policies and Procedures ratified by the Executive Management Team.	**CM**	**Attached**

Item 20 To note that the next meeting of the Board of Directors will be held on Tuesday 3rd July 2017 in the Directors' Lounge, Middlesbrough Football Club Riverside Stadium, Middlesbrough, TS3 6RS at 9.30 am.

Confidential Motion (11.55 am)

Item 21 **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 a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.

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

Information relating to the financial or business affairs of any particular person (other than the Trust).

The amount of any expenditure proposed to be incurred by the Trust under any particular contract for the acquisition of property or the supply of goods or services.

Any terms proposed or to be proposed by or to the Trust in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services.

Information which, if published would, or be likely to, inhibit -
(a) the free and frank provision of advice, or
(b) the free and frank exchange of views for the purposes of deliberation, or
(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.

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

The meeting will adjourn for a refreshment break

Mrs. Lesley Bessant
Chairman
16th May 2018

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

MINUTES OF THE SPECIAL MEETING OF THE BOARD OF DIRECTORS HELD ON 10TH APRIL 2018 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00 PM

Present:
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Dr. H. Griffiths, Deputy Chairman
Mr. M. Hawthorn, Senior Independent Director
Mr. D. Jennings, Non-Executive Director
Mrs. S. Richardson, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Dr. A. Khouja, Medical Director
Mr. B. Kilmurray, Deputy Chief Executive
Mr. P. McGahon, Director of Finance and Information
Mr. D. Levy, Director of HR and Organisational Development (non-voting)

In Attendance:
Mr. P. Bellas, Trust Secretary
Mrs. R. Hill, Director of Operations for York and Selby (representing Mr. Brown)
Mrs. M. Pears, Partner, Ward Hadaway LLP

18/100 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr. P. Murphy, Non-Executive Director, Mrs. E. Moody, Director of Nursing and Governance, Mr. D. Brown, Acting Chief Operating Officer and Mrs. S. Pickering, Director of Planning, Performance and Communications.

18/101 CONFIDENTIAL MOTION

> ***Agreed*** *– that representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:*
>
> *Information relating to the financial or business affairs of any particular person (other than the Trust).*
>
> *Any advice received or information obtained from legal or financial advisers appointed by the Trust or action to be taken in connection with that advice or information.*

Following the transaction of the confidential business the meeting concluded at 3.05 pm.

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 24TH APRIL 2018 IN THE OLD SWAN HOTEL, SWAN ROAD, HARROGATE AT 9.30 AM

Present:
Mrs. L. Bessant, Chairman
Mr. C. Martin, Chief Executive
Dr. H. Griffiths, Deputy Chairman
Mr. M. Hawthorn, Senior Independent Director
Mr. D. Jennings, Non-Executive Director
Mr. P. Murphy, Non-Executive Director
Mrs. S. Richardson, Non-Executive Director
Mr. R. Simpson, Non-Executive Director
Mr. B. Kilmurray, Deputy Chief Executive
Mr. P. McGahon, Director of Finance and Information
Mrs. E. Moody, Director of Nursing and Governance
Mr. D. Brown, Acting Chief Operating Officer (non-voting)
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

In Attendance:
Mrs. H. Dixon, Public Governor for Harrogate and Wetherby
Mr. P. Bellas, Trust Secretary
Mr. T. Cate, Acting Director of Operations for North Yorkshire (minute 18/112 refers)
Mr. D. Williams, Freedom to Speak Up Guardian (minute 18/113 refers)
Dr. J. Whaley, Guardian of Safe Working (minute 18/114 refers)
Mrs. J. Jones, Head of Communications

Mr. C. Waller and Mr. G. Morris, Members of the Public

18/106 APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr. A. Khouja, Medical Director.

18/107 MINUTES

***Agreed** – that the minutes of the last ordinary meeting held on 27th March 2018 be approved as a correct record and signed by the Chairman.*

18/108 PUBLIC BOARD ACTION LOG

The Board received and noted the Public Board Action Log.

18/109 DECLARATIONS OF INTEREST

No interests were declared.

18/110 CHAIRMAN'S REPORT

The Chairman advised that there were no significant matters to bring to the Board's attention since its last meeting.

18/111 GOVERNOR ISSUES

No issues were raised.

18/112 LOCALITY BRIEFING – NORTH YORKSHIRE

Mr. Cate (Acting Director of Operations) gave a presentation on the key issues facing the North Yorkshire Locality.

A copy of the slides used in the presentation is attached as Annex 1 to these minutes.

Board Members recognised:
(1) The progress being made in the Locality, particularly in relation to cultural issues, and the improvements being delivered.
(2) The benefits of the band 4 programme and the potential introduction of a mental health nursing course, in Scarborough, with the University of Coventry.

Clarity was sought on:
(1) The outcomes arising from the Transforming Care Partnership.

It was noted that:
(a) A greater understanding of the location and requirements of service users was being developed.
(b) The Programme Board had received a presentation from the Head of Forensic LD Services on the secure outreach transitions team and an indication of the funding requirements was awaited.
(c) In general, funding flow agreements were, at present, not signed.
(d) A team was to be established to scrutinise cases for "step down" to locked rehabilitation services.

(2) Whether there were any persistent concerns or worries about the provision of services in the Locality.

It was noted that the number and level of serious incidents remained of concern and the Locality was seeking to further understand the reasons for them.

(3) Whether there was any learning which could be taken from the low sickness absence rates in the Locality.

Mr. Cate considered that the culture of the Locality including staff resilience and mutual support, particularly in isolated teams, contributed to low sickness absence rates; however, he recognised that these issues could also result in "presenteeism".

The Non-Executive Directors believed that building the resilience of teams could be of benefit elsewhere.

At the conclusion of the discussions, the Chairman asked Mr. Cate to inform the staff in the Locality that the Board recognised the challenges they faced and the progress they were making and to pass on its appreciation to them for their hard work.

18/113 REPORT OF THE FREEDOM TO SPEAK UP GUARDIAN

The Board received and noted the report of the Freedom to Speak Up Guardian (FTSUG).

The focus of the discussions was on a case study, provided in the report, concerning difficulties, including an unwelcoming environment, lack of support and empathy, and questioning of competencies, suffered by a very experienced practitioner who was redeployed into a small team delivering a speciality with which they were unfamiliar.

The Board noted that:

(1) Their experiences had eroded the practitioner's self-belief and led them to question their skills.

(2) They had eventually been offered an alternative placement where they felt a competent and valued team member.

(3) Following several meetings with the FTSUG they had reluctantly chosen to withdraw their concerns as they remained in the redeployment process; feared the consequences of being identified, due to the size of the specialist team; and were now working in another service.

Board Members expressed their concerns about the treatment experienced by the member of staff.

The following issues were raised during the debate:

(1) How the practitioner's concerns would be addressed as they had chosen not to take them forward.

It was noted that, in this case, the service manager had been asked, and had agreed, to look into the concerns; however, the difficulties of doing so, in a small team where the person raising the concern would be easily identifiable, was acknowledged.

Mr. Levy observed that the issues could reflect potential stigma arising from the redeployment process and undertook to consider this matter further.

(2) How the Trust compared to others in relation to staff feeling that they had suffered detriment as a result of raising concerns.

Mr. Williams advised that:

(a) Initial training provided within the Trust by Public Concern at Work suggested that 33% of staff raising a concern felt that they had experienced detriment from doing so.

(b) From discussions at the FTSUG regional network it appeared that there was a greater sense of detriment within acute trusts including that due to overt unpleasantness.
(c) Within the Trust detriment tended not to be intentional but was how people felt.

(3) How the Trust could address feelings of detrimental treatment by staff who had raised concerns.

Mr. Williams advised that:
(a) It was important to ensure that managers understood the difficulties faced by staff in raising concerns and this was explored during mandatory training.
(b) It was recognised that cultural issues would take time to address.
(c) As well as the person raising concerns, those staff against whom accusations had been made could also feel detriment (e.g. a loss of confidence in them from senior managers) and further thought was required on this matter.

(4) Whether staff had a choice if a redeployment opportunity did not work out.

Mr. Williams described his own positive experiences of the redeployment process.

It was noted that, typically, staff worked in a new role for approximately 4 weeks to see if it was suitable; however, a longer period could be provided if required.

(5) How teams were assisted to work together after a concern had been raised and whether there was anything constructive the Trust could do to facilitate discussions within the team.

Mr. Williams advised that the action plan in response to the concern, together with support provided by him, the organisational development team and the chaplaincy service, sought to provide a co-ordinated approach to developing trust within teams and making sure that issues were addressed in a sustainable way.

(6) How the Trust was focussing on broader cultural issues being raised from the cases reported to the FTSUG.

Mr. Williams responded that he wanted to improve the sharing of learning from cases and for people to feel that improvements had been made as a result of them raising concerns.

Mr. Martin advised that it was frustrating that compliance with training was not, consistently, at the required level and recognised the need for greater focus on this matter.

(7) Whether the issues raised to the FTSUG were appropriate or whether grievances were also being raised.

Mr. Williams advised that grievances and issues more relevant to other raising concerns processes continued to be raised with him.

(8) How the Trust could pull together various intelligence (e.g. from concerns raised to the FTSUG, the staff survey, the nurse staffing reports, etc.) to better understand cultural issues in the Trust.

It was noted that the improvement event in March 2018 involving, amongst others, the FTSUG, the employee support service, the staff psychology service, chaplaincy, the organisational development and the equality, diversity and human rights teams and staff from the HR department, marked the start of the Trust having a more systematic approach to sharing intelligence and towards developing a more proactive response to teams requiring cultural improvement/support.

(9) Whether there were issues being raised which impacted on the Workforce Strategy.

Mr. Levy advised that this matter would be reviewed once the network to support the new Bullying and Harassment Procedure had been established.

(10) How intelligence from the FTSUG fed into the "Making a Difference Together" Business Plan Priority.

It was noted that the new Bullying and Harassment Procedure was being developed as part of the Priority.

The Chairman thanked Mr. Williams for his report.

18/114 ANNUAL REPORT OF THE GUARDIAN OF SAFE WORKING

The Board received and noted the Annual Report of the Guardian of Safe Working.

In his introduction to the report Dr. Whaley drew attention to his overall conclusions that the Trust continued to comply with the 2016 Junior Doctor Contract; that Junior Doctors were submitting exception reports which were being handled appropriately; and that there were no immediate safety concerns.

Consideration was given to the proposal, included in the report, to acquire a "Hospital at Night" software package, as used by South Tees Hospitals NHS Foundation Trust, at no cost, which would support greater co-ordination of work and a reduction in inappropriate calls on the Junior Doctors.

In relation to this matter:

(1) Clarity was sought on how the system would work as there were considered to be benefits from staff being able to hold telephone conversations with the Junior Doctors.

Dr. Whaley advised that the system had been seen in operation by the Medical Development Department and assurances provided that it worked. The introduction of the system would also not prevent telephone conversations being held.

(2) From their own experiences, Board Members highlighted the benefits which could be provided by the system particularly in relation to fostering a team approach; improving communications and co-ordination; and increasing understanding amongst staff when issues arose.

In conclusion, the Chairman advised Dr. Whaley that there was support from Board Members for the "Hospital at Night" system but that its introduction was a matter for the Executive Management Team.

The Board also discussed the potential risks of adverse reactions from management, including fears, either real of apparent, of reprisal amongst Junior Doctors from the submission of exception reports.

In response Dr. Whaley:

(1) Provided assurances that:
  (a) The systems operated by the Trust, including the involvement of the Medical Staffing Department, reduced the potential risks of adverse reactions from management to the receipt of an exception report.
  (b) Time had also been spent to ensure that managers understood and recognised that it was uncomfortable for Junior Doctors to make exception reports.

(3) Recognised that a key element of his role was to ensure understanding of the need for safe working and to seek to address any issues which arose.

(4) Advised that:
  (a) From Guardian forums it was evident that the Trust had a more positive culture to reporting than many other trusts.
  (b) The positive responses from management and clinical supervisors had been fed back to local Junior Doctor forums to raise confidence in exception reporting.

The Board thanked Dr. Whaley for his report.

18/115 "HARD TRUTHS" MONTHLY NURSE STAFFING EXCEPTION REPORT

The Board received and noted the exception report on nurse staffing for March 2018 as required to meet the commitments of "Hard Truths", the Government's response to the Public Inquiry into Mid Staffordshire NHS Foundation Trust (the "Francis Review").

Arising from the report:

(1) It was suggested, noting the expectation for Trusts to submit monthly data on Care Hours per Patient Day (CHPPD) for nursing staff from April 2018, that it might be also useful for the Board to receive information on the metric for the whole clinical team.

Mrs. Moody advised that the benefits of providing the broader information were recognised; however, at present, the requirement related to nursing staff only; the work of certain staff who worked across teams (e.g. some occupational therapists) could skew the results; and multidisciplinary rosters would need to be developed to enable the information to be provided.

(2) Clarity was sought on the reasons for Elm Ward having the highest severity score for March 2018.

The Board noted that the severity score of the ward was unsurprising as it, together with Maple Ward, had a number of issues, including high levels of admissions, activity and incidents. These had been recognised and action plans and staffing had been put in place, through the West Park Review, to seek to address them.

(3) Concerns were raised about Acomb Garth which had the highest use of agency staff within the reporting period at 60.1%.

Mrs. Moody advised that:

(a) The recruitment of registered nurses in MHSOP in York continued to be challenging; however, it was hoped that the development of the new hospital would make working in the speciality more attractive and improve the situation.
(b) Additional staff were being rostered above establishment and a small team put together to review practice and consider any additional actions that could be taken.
(c) Recruitment of nurses in the speciality was also a national issue.
(d) High fill rates were required for enhanced observations in relation to falls reduction and the Trust, although “green” on falls, was reviewing the introduction of zonal observation, from another trust, which had reportedly reduced staffing requirements by half.

Mr. Brown highlighted that pressure on staff, due to the greater acuity of patients, had increased.

He considered that the zonal observation needed to be examined particularly in the context of challenging behaviour, arising from close observation, being part of the problem; however, a balance needed to be achieved.

18/116 REPORT OF THE QUALITY ASSURANCE COMMITTEE

The Board received and noted the report of the Quality Assurance Committee including:

(1) The confirmed notes of the informal meeting held on 8th March 2018 (Annex 1 to the report).

(2) The key issues considered by the Committee at its informal meeting held on 5th April 2018.

Dr. Griffiths, the Chairman of the Committee, drew attention to:

(1) Further to minute 18/37 (27/3/18), the findings of the third clinical re-audit of emergency response bags which showed that, although there had been an improvement with 31 teams achieving compliance on all the audit criteria, 5 teams remained non-compliant.

He reported that, in response, the Committee had agreed that both quarterly re-audits and fortnightly random sampling by the Modern Matrons within their localities should be undertaken.

Dr. Griffiths also advised that discussions had also been held on the Trust's policy on the provision of emergency response bags in non-clinical areas and community teams and it had been agreed that a report on this matter should be provided to the meeting of the Committee to be held on 6th September, 2018.

(2) The concerns highlighted at the meeting with regard to the quality of agency staff and the impact of illicit substances, in inpatient areas, on violence and aggression towards staff.

Mrs. Moody advised that the former issue had been discussed by the EMT with the culture and attitude of agency staff at night being of particular concern.

18/117 THEMATIC REVIEW IN RELATION TO "FEELING SAFE"

Further to minute 17/307 (28/11/17), consideration was given to a report on the findings of a thematic review which had been undertaken following concerns expressed by patients and their carers, in patient experience feedback, with regard to not "feeling safe".

Arising from the report Board Members:

(1) Sought clarity on the reasons for the high negative score, arising from the patient and carer experience survey completed during Quarter 4, 2017/18, in relation to environmental issues at the Westwood Centre as this was a new unit.

Mrs. Moody undertook to look into this matter.

Action: Mrs. Moody

(2) Considered that every patient had their own experiences and unless these, and how they affected them, were known it was difficult to understand the situation on the wards.

(3) Noted that:

(a) The number of patients feeling unsafe was relatively very low with only 1.13% of comments, received from the Quarter 4 patient experience survey, being coded negatively against the "felt safe" category.

(b) Discussions had been held at EMT about the significant impact that the behaviour of patients could have on others.

Mr. Brown provided assurance that:

- These circumstances were infrequent; were addressed, to the extent they were able to, by teams; and efforts were made to seek to make sure that there were no surprises.
- Operational services were aware of all the issues included in the report.

(4) Supported the proposal to involve the Experts by Experience in working with each Locality on this matter in order to continually refresh staff awareness and understanding of patient experience.

Agreed – *that the proposal to enhance the work already underway within operational clinical services, by inviting the Experts by Experience to work with each Locality to further develop strategies whereby patient experience concerns can be highlighted and escalated accordingly within the Trust, be supported.*

Action: Mrs. Moody

18/118 SUMMARY FINANCE REPORT AS AT 31ST MARCH 2018

The Board received and noted the Finance Report as at 31st March 2018 including the Trust's Quarter 4, 2017/18, submission to NHS Improvement.

The discussions focussed on the deterioration in the comprehensive income outturn at year-end with a deficit of £27,983k (£38,059k behind the planned £10,076k surplus).

It was noted that the deficit position included £41,086k of unplanned asset impairments largely due to a revaluation of Roseberry Park to reflect the cost of the required rectification works.

On this matter:

(1) Mr. McGahon confirmed that the asset impairments were technical adjustments and would not impact on the Trust's segmentation under NHS Improvement's Single Oversight Framework.

(2) The Non-Executive Directors, whilst recognising that the impairment arose from the annual revaluation of the major Trust sites, sought clarity on the reasons for the devaluation of Roseberry Park not being made 12 months earlier.

Mr. Martin advised that further information would be provided in the Quarterly Finance Report (minute 18/C/132 refers).

In addition:

(1) In response to questions, it was noted that:
   (a) The improvement in the assessment of the Trust's position on the use of resources metric, to "1", reflected the increase in the Trust's operating surplus, excluding the impairments, to £3,027k ahead of plan.
   (b) The operating surplus was ahead of plan due to a number of non-recurrent items including the release of 0.5% of CQUIN funds held by the CCGs as a risk reserve and lower than planned PDC dividend payments as a consequence of the revaluation of Roseberry Park which offset the CRES position and other recurrent operational pressures.

(2) The Chairman, noting the variance between planned and actual performance on the delivery of CRES, observed that the Trust needed to ensure that realistic plans were in place so that the position was not repeated.

Mr. McGahon assured the Board that this was a key area of focus and a team was being established to reinvigorate processes and make them more rigorous.

***Agreed** – that the Trust's Quarter 4, 2017/18 submission to NHS Improvement, in accordance with the results detailed in the above report, be approved.*

Action: Mr. McGahon

18/119 PERFORMANCE DASHBOARD AS AT 31ST MARCH 2018

The Board received and noted the Performance Dashboard Report as at 31st March 2018.

Mrs. Moody reported that, at a recent meeting of the Directors of Nursing of Mental Health Trusts, it had been noted that some trusts had seen an increase of approximately 20% in the number of unexpected deaths over the last year. It was, therefore, considered that the Trust's position on KPI 11 (above the expected level) was not unusual; however, the Patient Safety Annual Report would provide greater focus on the analysis and understanding of the learning in relation to those deaths.

In response to a question, it was noted that all trusts were now required to publish information on unexpected deaths in their Quality Accounts; however, whilst the Trust had improved the robustness of its data, there was still significant variation, nationally, in the classification of deaths.

Mr. Martin highlighted that, in the context of continuing financial pressures and increased activity and demand, the levels of performance shown in the report were of credit to staff.

Board Members supported Mr. Martin's comments recognising:

(1) The prevalence of "green" rated indicators and improving trends shown in the report.
(2) The improvements made on mandatory training and appraisals over the last year.

(3) The unprecedented rate of growth in referrals over the last three years particularly the disproportionate increase in activity in CAMHS.

The Board formally recorded its appreciation of staff for their hard work during 2017/18.

18/120 PROPOSED TARGETS FOR THE TRUST DASHBOARD METRICS

Consideration was given to a report which set out proposals from the EMT:

(1) On the targets for the Trust Dashboard Metrics for 2018/19 (as set out in Appendix A to the covering report).

(2) To change or update some of the KPIs (as detailed in the report) to be included in the 2018/19 Trust Dashboard, agreed by the Board under minute 17/306 (28/11/17).

The Board noted that targets for seven, new or revised, metrics had not been proposed, at present, as work to build them on the Integrated Information Centre and to identify baselines was continuing. Suitable targets for these indicators would be proposed once the baselines were known.

Board Members sought clarity on:

(1) Whether a national definition had been agreed for KPI 3 ("The total number of inappropriate OAP days over the reporting period") and was being used by the Trust.

Mrs. Pickering explained that:

(a) A national definition was in place; however, it was still open to interpretation.

(b) It was clear that the national focus was on external out of area placements (OAPs) and not internal ones.

(c) The interim quarterly targets provided in the report, based on the year 1 trajectory submitted by the Trust, were for inappropriate internal OAPs.

(d) It would be exceptional for the Trust to have any external OAPs.

In response to questions, Mrs. Pickering:

(a) Assured the Board that the Trust had been very clear with NHS England on its interpretation of internal and external OAPs.

(b) Undertook, to aid understanding, to provide information on the split between internal/external definitions in the Performance Dashboard Reports and to highlight, by exception, if the Trust had any external OAPs.

Action: Mrs. Pickering

(c) Advised that:

- External OAPs were those outside the Trust's boundaries whilst internal OAPs were those as defined by the Trust.
- The distance from where a patient lived, as previously proposed by the Government, had not been included in the national definition of OAPs.

(2) How the agreed improvement benchmarks for HoNOS total scores and SWEMWBS (KPIs 6 & 7) had been determined in order to provide understanding of the degree of stretch on the targets.

The Board noted that the targets had been proposed following discussions by the EMT and the Speciality Development Groups.

Agreed –

(1) that the proposed targets for the Trust Dashboard indicators, as set out in Appendix A to the above report, be approved;

(2) that the changes to the Trust Dashboard indicators, as detailed in the above report, be approved; and

(3) that further proposals on those indicators, where work to obtain baseline positions is ongoing, be awaited.

Action: Mrs. Pickering

18/121 SINGLE OVERSIGHT FRAMEWORK

The Board received and noted the report on the Trust's indicative position against NHS Improvement's Single Oversight Framework for Quarter 4, 2017/18.

18/122 BOARD GOVERNANCE ARRANGEMENTS

The Board received and noted a report which provided summaries of:

(1) The results of the Board Performance Evaluation Scheme for 2017/18.

(2) The progress being made on the recommendations arising from the External Governance Review undertaken by Grant Thornton LLP in 2017 (as set out in Annex 2 to the report).

In relation to the actions proposed by the Board's Committees in response to the findings of the BPES (as set out in Annex 1 to the report):

(1) Mr. Simpson, the Chairman of the Mental Health Legislation Committee, reported that, at its meeting held on 19th April 2018, there had been general agreement that the operation of the Committee had developed considerably since the assessment had been undertaken and it was far more well-sighted and assured.

He expected the changes introduced would have a significant impact on the results of the next annual evaluation.

(2) The Chairman advised that, from its discussions, the Resources Committee had identified the need for a more effective approach to training for Board Members, akin to continuing professional development, and that discussions would be held with the Trust Secretary on this matter.

18/123 POLICIES AND PROCEDURES RATIFIED BY THE EXECUTIVE MANAGEMENT TEAM

The Board received and noted the report on the Executive Management Team's ratification of policies and procedures.

Board Members questioned the need to "… clarify the definition of Rapid Tranquillisation" in relation to the minor change to the Rapid Tranquillisation Policy (ref: CLIN-0014-v7.1).

In response it was noted that the changes to the policy related to ensuring the standardisation of requirements across specialties.

18/124 DATE OF NEXT MEETING

It was noted that the next meeting of the Board of Directors was due to be held at 9.30 am on Tuesday 22nd May 2018 in the Board Room, West Park Hospital, Darlington.

18/125 CONFIDENTIAL MOTION

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

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

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

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.

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

Following the transaction of the confidential business the meeting concluded at 1.12 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

North Yorkshire Locality Board Presentation

24th April 2018

Tim Cate

Acting Director of Operations

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To provide excellent services, working with the individual users of our services and their carers to promote recovery and well being

- Proud
  - CQC Feedback
  - Awards
  - Service developments
    - T3 CAMHS eating disorders
    - Single Point of Access in CAMHS
  - IAPT performance improvement
  - Staff resilience
  - Clinical & service Leadership
- Progressing
  - All age crisis triage & response
  - Clinical Leadership
  - Capital development decisions
  - Transforming mental health (Hambleton/Richmondshire and Harrogate)
  - Accountable Care Partnership

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To continuously improve the quality and value of our work.

- QIS
  - PPCS
    - Daily lean Management / Huddles / Report outs
- Transforming Care Partnership
- Performance
  - Delayed Transfers of Care (DTOCs)
  - Electronic Discharges
  - MHSOP Waiting times

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To recruit, develop and retain a skilled, compassionate and motivated workforce

- Recruitment Issues
  - Qualified nursing staff
  - Medical staff in certain geographic areas
  - Agency staffing
  - Working arrangements with NYCC
- Retention Issues
  - Retirements
  - Career progressions
- Skill, compassion and motivation issues
  - Compassion in practice
  - Nurse development programme
  - Inpatient development days

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To have effective partnerships with local, national and international organisations for the benefit of our communities.

- Local
  - Harrogate Alliance
  - MHCCC
  - Links with NYCC
- National
  - IAPT
- International
  - No formal links internationally

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To be recognised as an excellent & well governed foundation trust that makes best use of its resources for the benefit of our communities.

- Performance
  - CAMHS waiting times / CAMHS Eating Disorders
  - Access performance
  - Financial balance – locum and agency costs
  - Improved position with DTOC
  - Out of Area admissions reducing
  - Geographical challenges linked to workforce
- LMGB
  - Structured oversight & quality assurance
  - QUAGs – managing a broad range of issues
  - Good sense of team
- Culture work

making a difference together

ITEM NO. 2

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**22nd May 2018**
TITLE:	**Board Action Log**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information/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:

This report allows the Board to track progress on agreed actions.

Recommendations:

The Board is asked to receive and note this report.

Board of Directors Action Log

RAG Ratings:

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

	Minute No.	Action	Owner(s)	Timescale	Status
28/03/2017	17/62	The potential for expanding the proposed managers' tool, for recording concerns raised to the Freedom to Speak Up Guardian to cover all concerns raised by staff, to be explored	DL	May-18	Completed
26/09/2017	17/228	Consideration to be given to reviewing the targets in the Strategic Direction Performance Report for 2018/19	SP	Jul-18	
26/09/2017	17/230	Reviews of the operational arrangements of the Quality Assurance, Resources and MHL Committees to be undertaken	PB	~~May-18~~ Jul-18	
31/10/2017	17/268	An update report on the Temporary Staffing Service to be presented to the Board	DL	~~May-18~~ Jul-18	
28/11/2017	17/295	A paper to be provided to Board Members describing the controls covering commercial studies	Prof. JR	May-18	See agenda item 6
28/11/2017	17/299	The outcome of the workshop held by the MHLC to be included in the review of the operational arrangements of the Board's committees	PB	~~May-18~~ Jul-18	
28/11/2017	17/300	A report to be presented to the Board to provide an update on progress towards the completion of the 2017/18 composite staff action plan and to enable consideration of a proposed 2018/19 action plan	DL	May-18	See agenda item 9 (The actions for 2018/19 will be included in the Workforce Strategy)

	Minute No.	Action	Owner(s)	Timescale	Status
28/11/2017	17/301	A further progress report on the implementation of the Recruitment and Retention Action Plan to be presented to the Board	DL	Jul-18	
28/11/2017	17/305	A briefing to be provided to the Board on the event in 2018 in relation to sickness absence and whether further action can be taken to support the health and wellbeing of staff	DL	Jul-18	
19/12/2017	17/327	A report to be presented to the Board on the outcome of the review of the 12 hour shift system	DL	Jan-19	
30/01/2018	18/08	A report to be presented to the Board on the use of enhanced observations (including trends) together with information on contemporary best practice in this area.	EM	Jul-18	
30/01/2018	18/08	A report on the use of prone restraint to be provided to the Quality Assurance Committee	EM	May-18	See agenda item 7
30/01/2018	18/10	The limitations of the national approach, through the EDS2, to be raised with the Equality and Diversity Council, possibly in conjunction with other Trusts	DL	May-18	Completed
27/02/2018	18/39	Consideration to be given, for the next Learning from Deaths report, on the most appropriate ways of: - Reformatting the Dashboard so that the total number of deaths can be fully reconciled with the review process or other response taken by the Trust to them - Providing assurance, possibly in the form of a flowchart, on how learning is linked to other quality improvement processes	EM	Jul-18	
27/02/2018	18/40	The need for guidance on how the starting point on the Ladder of Participation will be chosen to be raised with the Recovery Programme	DL	~~May-18~~ Jul-18	
27/03/2018	18/71	A further progress report on tackling the abuse of staff, taking into account the comments made at the meeting, to be presented to the Board	DL	19/07/2018	

	Minute No.	Action	Owner(s)	Timescale	Status
27/03/2018	18/73	A university to be invited to undertake a project for the Trust in relation to variations in outcomes, and the reasons for them, between different types and sizes of wards	EM	Sept-18	
24/04/2018	18/117	The reasons for the high negative score, arising from the patient and carer experience survey completed during Quarter 4, 2017/18, in relation to environmental issues at the Westwood Centre to be looked into	EM	-	Completed
24/04/2018	18/117	To note that the Board supported the proposal to enhance the work already underway within operational clinical services by inviting the Expert's by Experience to work with each Locality to further develop strategies whereby patient experience concerns can be highlighted and escalated accordingly within the Trust	EM	-	To note
24/04/2018	18/118	Approval of the Trust's Quarter 4, 2017/18 financial submission to NHS Improvement	PM	-	To note
24/04/2018	18/120	To note the Board's agreement: - Of the proposed Performance Dashboard targets for 2018/19 as set out Appendix A to the report - To receive further proposals on those KPIs where work is still ongoing to obtain baseline positions	SP	-	To note
24/04/2018	18/120	To aid understanding information on the spllit between internal/external definitions of out of area placements (OAPs) to be provided in the Performance Dashboard Reports and any external OAPs to be highlighted	SP	-	To note

ITEM 6

CONFIDENTIAL

BOARD OF DIRECTORS

DATE:	**22nd May 2018**
TITLE:	**Research and Development Annual Report 2018**
REPORT OF:	**Dr Ahmad Khouja, Medical Director**
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:

The Trust is committed to supporting and promoting research opportunities across all of our services and localities. The more research active we are as a Trust the better care we will provide. Our involvement in large-scale clinical trials continues to give service users and carers access to treatments at the forefront of knowledge. In our work with the National Institute for Health Research (NIHR) and our collaboration with national and international academic partners, we contribute to the worldwide evidence base for mental health care. We seek to create a culture of enquiry within our services which welcomes innovation and challenge. Research conducted in the Trust is compliant with the UK Framework for Health and Social Care Research and meets required quality and governance standards. The Trust's 2015-2020 R&D strategic priorities are being implemented, including the critical area of academic partnership development with the University of York. This report outlines activity for the period April 2017 to March 2018.

Recommendations:

The Board is asked to receive the 2018 Annual Research and Development Report.

MEETING OF:	**Board of Directors**
DATE:	**22nd May 2018**
TITLE:	**Research and Development Annual Report**

1. INTRODUCTION & PURPOSE:

- To report on Research and Development activity for the period April 2017 to March 2018.

2. BACKGROUND INFORMATION AND CONTEXT:

In November 2015 the Board approved a new 5 year Trust R&D Strategy with the following five goals:

1. Maintain excellent performance in the governance, management and delivery of research.
2. Move from collaboration to leadership in research.
3. Ensure that our research drives improvement in care.
4. Embed research access and participation in all geographies and specialties of the Trust's services
5. Substantial growth in research-related income for the Trust

In April 2017, the Trust entered into a 12 month Mental Health Research scoping project with the University of York to consider future options for ambitious collaborative working. 0.5WTE strategic project management support was provided by both organisations to develop and support this project.

3. KEY ISSUES:

3.1. Research Governance activity

All research is now reviewed and approved by the National Health Research Authority which includes an ethical review for studies involving service users as participants in addition to a governance review for all studies. Following Health Research Approval, local R&D assessment of Capacity and Capability must be confirmed prior to a research study opening in our Trust. Quarterly Research Governance Group meetings oversee the activity and governance of the Research and Development activities in the Trust including performance and finance activity.

During March 2018 a research integrity investigation was concluded and presented to the Trust's Quality and Assurance Committee following a report from an international journal raising concerns about an article submission which included work conducted in the Trust. The investigation demonstrated that research had been conducted using clinical data without the consent of service users and without either independent ethical approval or research governance approval within the Trust. As this study used only pre-existing electronic record data, there was no evidence that patient safety was compromised or that person-identifiable data left the Trust. There were significant learning points for the Trust from this incident. There

was a need to raise awareness for all staff who have any contact with research conducted in their services, that it is appropriate and to be encouraged that they ask researchers about their approvals for research, and that they can ask the R&D Department for confirmation of this. This learning was disseminated to all services across the Trust. A Standard Operating Procedure for the conduct of research integrity investigations was developed.

In 2017/18 a total of 39 research studies were confirmed for conduct in the Trust. Of these 18 were on the NIHR portfolio, the national list of externally funded studies of high quality. 21 non-portfolio studies (most frequently undertaken as part of a postgraduate masters or doctoral qualification) were confirmed. The time from when the Trust is selected as a site to run the study to local confirmation of capacity and capability for conduct in the Trust is externally monitored by the NIHR CRN. In 2017/18, the national target was 40 days; the Trust achieved an average approval time of 22 days.

The Trust's Standard Operating Procedures for research were reviewed and updated in February 2018 to incorporate the Framework for UK Health and Social Care research. All SOPs are published on the intranet. Principal Investigators agree compliance to these procedures on taking responsibility for a study.

National guidance has been updated for Good Clinical Practice (GCP) and whilst researchers conducting clinical trials are required to undertake this training, for researchers working on other research studies this is an optional training requirement. The Health Research Authority clearly states in study approval letters if GCP training is required for individual studies. The R&D team continues to work with local research staff and will still recommend GCP training where required for less experienced research staff.

3.2. Research study activity

Recruitment to NIHR (National Institute of Health Research) studies in 17/18 totalled 1,321 participants which is the highest recruitment number recorded to date for our Trust. This high recruitment number included a one particularly high recruiting study, Outcome evaluations of Liaison and Diversion schemes which recruited 771 participants alone, as this study ended recruitment in October 2017, we are anticipating a reduction in overall recruitment for 18/19 as we are not aware of any similar large recruiting studies.

TEWV R&D department continued to receive funding for staff to recruit to studies in other NHS Trusts in the region, including 28 participants to Parkinson's disease studies from South Tees NHS Foundation Trust.

As outlined in our R&D strategy our aim is in collaboration with academic partners, to develop and host more research studies from our own Trust. The CHEMIST study, a large-scale Chief Investigator-led grant was won by Dr Dave Ekers, Senior Lecturer and Nurse Consultant in 2016. His study of collaborative care for depression will use community pharmacies as an innovative site of delivery of this intervention. TEWV are sponsoring this research which is not only generating the grant income for the

£467,000 over the duration of the study but also attracts a further 30% of the grant income as Research Capability Funding which will enable us to support future studies through to grant application awards.

3.3. Contribution to NIHR Clinical Research Network.

In addition to the NIHR participant recruitment activity demonstrated above, the Trust have had representation in a number of Clinical Research Network groups. The Trust's Non-Executive Director Dr Hugh Griffiths represents the Trust at the Network's Non-Executives' group, Sarah Daniel is a member of the Building Careers Oversight group which is one of the strategic themes of the network, Professor Joe Reilly is the representative at the Partnership group, Lesley Hodge, attends the CRN regional HR managers group, Angie Hardy attends the regional CRN pharmacy group and Maninder Kaur represents TEWV on the Local Portfolio Management System group.

The Trust has continued to participate in a consortium arrangement for CRN-funded research support with Northumberland, Tyne and Wear NHSFT and Cumbria Partnership NHSFT. This Mental Health and DeNDroN (Dementia and Neurodegenerative Diseases) Delivery Partnership is recognised regionally and nationally as an example of excellence in research collaboration across trust boundaries.

Dr Dave Ekers was appointed as the new regional Mental Health Specialty group lead for the Clinical Research Network: North East and North Cumbria in October 2017. This role is key in increasing and supporting Principal Investigators in the region and links to the national mental health specialty.

3.4. University of York Research Partnership

A 12 month scoping project with the University of York and TEWV commenced in April 2107 with 0.5WTE project management support allocated from each organisation. The final recommendations will be complete by June 2018 and shared with both organisations to progress the sustainability of this partnership. Key areas of progress achieved during the initial 12 month project are outlined below:

- Bi-monthly meetings of the joint working group have met throughout the year to provide support and guidance for this collaboration
- A leadership meeting was held in December 2017 with Colin Martin, Chief Executive, TEWV and Koen Lamberts, Vice Chancellor University of York where the 6 month interim project report was reviewed and a 15 year partnership memorandum of understanding was signed.
- £39,410 funding awarded from Centre for Future Health, University of York for 'A mixed methods evaluation of the impact of extending working hours in a large mental health Trust: assessing employee and organisational outcomes' This project was led by David Levy, Director of HR and Jane Suter, University of York. The project is underway and results will be reported during 2018. TEWV will be participating in an 'Impact Factor' film with the University where this project will be used as a showcase example.

- £20,000 TEWV Research Capability Funding awarded for 'Identifying and linking individual patient data to assess alternative service designs for pharmacy services in TEWV'. This study is being led by Chris Williams, Chief Pharmacist and Professor Gerry Richardson, University of York.
- £26,631 ESRC funding awarded from University of York with matched funding from TEWV and Northumberland Tyne and Wear NHS Foundation Trust for 'Catalysing Knowledge Exchange between the University of York, Tees Esk and Wear Valleys NHS Foundation Trust and Northumberland Tyne and Wear NHS Foundation Trust' This project is collaborating with library services in both mental health Trusts to build on and develop enhanced methods of knowledge exchange, led by Rachel Churchill, Professor of Evidence Synthesis in the University's Centre for Reviews and Dissemination.
- A Clinical Research Facility has been included in plans for the new hospital in York with agreed investment from the University of York. This shared facility has shared office space for academics and clinicians to build on relationships to develop future research ideas and grant applications and provide accommodation for staff working on current research studies. The treatment room, two consultation rooms and clinical trials pharmacy room will provide state of the art facilities to offer new treatment and therapy studies to our service users and carers and in addition attract further commercial research activity and income. Discussions are also in progress on providing research accommodation for children and young peoples' research studies in appropriate locations.
- The Trust, the University and Hull York Medical School have appointed Christina Van Der Feltz-Cornelis as Professor of Mental Health and Epidemiology. An epidemiologist and liaison psychiatrist of international repute, Prof Cornelis takes up her clinical academic post in July 2018.
- To ensure equity of access to University of York partnership, research hubs in locations in the Trust are being developed. The first hub in Durham and Darlington has been launched with an interactive consultation event involving Trust staff and key academics.
- A successful World Mental Health D ayevent was held at the University of York in partnership with TEWV on 10th October. Key speakers included Trust Clinicians Dr Dave Ekers, Prof Simon Gilbody and Dr Lina Gega. Innovative virtual reality environment technologies were showcased along with short films produced by the University and Trust. Three TEWV PPI representatives were invited to the event and a specific programme to introduce them to key academics at the University was arranged. We have invited these representatives to join our TEWV/UoY working group to help shape the development of the partnership.
- Scoping has identified a key area for development in the Trust to support a research Grants and Contracts Manager to provide support for grant applications and to manage finance and invoicing for active contracts to ensure we have full cost recovery to enable future growth. This post will work closely with the Trust R&D and Finance teams.
- Needs have also been identified to develop future CPD courses and apprenticeship schemes with the University for Trust staff to access to develop research capability.
- Patient and Public Involvement has been an essential element of the partnership work with two PPI members on our working group and involved in

a range of linked activity. Mark Eltringham is a co-applicant on a grant application led by Professor Rowena Jacobs to develop a research PPI group between the Trust, University of York and York acute Trust.

- Both the Trust and the University of York are considering the recommendations from this scoping work to develop business plans in each organisation to sustain and grow this partnership to impact on the future health care of our populations.

3.5. Patient and Public Involvement

We have two PPI representatives on our Research Governance Group and the same two members support our University of York/TEWV partnership working group. One of our members is supporting us with our website development by writing lay summaries from research protocols.

We also ensure that we have PPI representation on study oversight working groups for our local research teams and this has proved valuable in considering recruitment methods and reviewing study materials.

We have collaborated on a grant application to work in partnership with York Acute Trust and the University of York for PPI research and one of our PPI members was a co-applicant on this grant application.

3.6 Research Results

The Trust contributes to a wide range of clinical trials and other high-quality studies during the course of each year. We have set a standard that wherever possible, the results of research conducted in the Trust should be shared with service users and local services within one year of the study completion date. A number of NIHR-funded studies reported during the past year; two are highlighted in this report.

Results from the **LABILE clinical trial 'Lamotrigine and Borderline Personality Disorder: Investigating Long Term Effectiveness'** were published in the American Journal of Psychiatry (https://doi.org/10.1176/appi.ajp.2018.17091006) and the NIHR HTA Journal (https://www.journalslibrary.nihr.ac.uk/hta/hta22170/#/abstract), and shared with study participants.

- No difference was found between lamotrigine and treatment as usual in the symptoms of borderline personality disorder at 12 months.
- We concluded that lamotrigine is not a useful treatment for people with borderline personality disorder and therefore we do not recommend that people with borderline personality disorder are prescribed lamotrigine.
- Evidence was also found that over time, the level of distress that people diagnosis with borderline personality disorder experience reduces. This result supports that of other studies that have shown that most symptoms of borderline personality disorder gradually reduce over time.

Results from the **Transitions study ' How health services can contribute most effectively to the successful transition of young people with complex health needs from childhood to adulthood'** were presented at a results meeting in London in October 2017 and further information and presentations can be found at https://research.ncl.ac.uk/transition/ Some of the key implications for this study were:

- Transitional care should be commissioned by commissioners of adult services as well as by commissioners of child services.
- A framework to provide 'Developmentally Appropriate Healthcare' across NHS organisations should be commissioned, with the stipulation that this is owned at Chief Executive and Board level.
- NHS organisations should adopt a Trustwide approach to implementation of better transitional care. A Transition Steering Committee, chaired by a Trustwide Transition Coordinator, can facilitate this.
- Child clinicians should plan Transition procedures jointly with the relevant named adult clinicians and general practitioners.
- Child and adult healthcare providers should explore with a young person how they approach Transition and personalise the clinical approach thereafter.
- The features 'Appropriate parent involvement', 'Promotion of young people's confidence in managing their health condition (health self-efficacy)' and 'Meeting the adult team before transfer' were associated with greater satisfaction with services, participation, subjective wellbeing and measures of disease control.
- Maximal service uptake would be achieved by a service which encouraged parental involvement, ensured the same staff were seen at each clinic, emphasised the importance of good communication with young people, and encouraged young people to make decisions about their care.
- Good value for money would be offered by a service which provided: 'Parental involvement that suited both parent and young person', and a 'Protocol for promotion of young people's confidence in managing their health condition'.

Other published research from work conducted in the Trust during the past year includes:

- Keetharuth AD, Brazier J, Connell J, et al, on behalf of the ReQoL Scientific Group: Recovering Quality of Life (ReQoL): a new generic self-reported outcome measure for use with people experiencing mental health difficulties. British Journal of Psychiatry 212(1), pp 42-49, Jan 2018
- •Richards DA, Rhodes S, Ekers D, McMillan D, Taylor RS, Byford S, et al. Cost and Outcome of BehaviouRal Activation (COBRA): a randomised controlled trial of behavioural activation versus cognitive behavioural therapy for depression. Health Technol Assess 2017;21(46)
- •Finning,K ,. Richards, D,. Moore, L,. Ekers, D,. McMillan,D,. Farrand,P et al. Cost and outcome of behavioural activation versus cognitive behavioural therapy for depression (COBRA): a qualitative process evaluation. BMJ Open. doi:10.1136/bmjopen-2016-014161
- •Gilbody,. S, Lewis, H., Adamson J., Atherton, K., Bailey, D., Birstwistle, J et al. Effect of collaborative care vs. usual care on depressive symptoms in older adults with subthreshold depression: The CASPER Randomized Clinical Trial. JAMA 2017, 317, 728-737

- Bosanquet, K., Adamson, J., Atherton , K., Bailey, D., Baxter, C., Beresford-D et al. CollAborative care for Screen-Positive ElderRs with major depression (CASPER plus): a multicentred randomised controlled trial of clinical effectiveness and cost-effectiveness. Health Technology Assessment 2017, 21(67), 1-252
- Peckham, E., Arundel, C., Bailey, D., Callen, T., Cusack, C., Crosland, S on behalf of the SCIMITAR+ collaborative. Successful recruitment to trials: findings from the SCIMITAR+ Trial. Trials 2018, 19(1), 1-6. DOI: 10.1186/s13063-018-2460-7
- Crawford H, Wilkinson H. The Novel Use of Life Grids in a Phenomenological Study of Family Carers of People With Profound Intellectual and Multiple Disabilities and Dysphagia. Qual Health Res. 2018 Mar. doi: 10.1177/1049732318761028. [Epub ahead of print]
- Beattie S, Crampton PES, Schwarzlose C, Kumar N, Cornwall PL. Junior doctor psychiatry placements in hospital and community settings: a phenomenological studyBMJ Open. 2017 Sep 27;7(9):e017584. doi: 10.1136/bmjopen-2017-017584
- Barnes TR, Leeson VC, Paton C, Marston L, Davies L, Whittaker W et al. Amisulpride augmentation in clozapine-unresponsive schizophrenia (AMICUS): a double-blind, placebo-controlled, randomised trial of clinical effectiveness and cost-effectiveness. Health Technol Assess. 2017 Sep;21(49):1-56. doi: 10.3310/hta21490
- Read J, Harper D, Tucker I, Kennedy A. Do adult mental health services identify child abuse and neglect? A systematic review. Int J Ment Health Nurs. 2018 Feb;27(1):7-19. doi: 10.1111/inm.12369.
- Stain HJ, Mawn L, Common S, Pilton M, Thompson A. Research and practice for ultra-high risk for psychosis: A national survey of early intervention in psychosis services in England. Early Interv Psychiatry. 2017 Jun 14. doi: 10.1111/eip.12443.
- Kitchen CEW, Lewis S, Tiffin PA, Welsh PR, Howey L, Ekers D. A focused ethnography of a Child and Adolescent Mental Health Service: factors relevant to the implementation of a depression trial. Trials. 2017 May 25;18(1):237. doi: 10.1186/s13063-017-1982-8.
- McMurran M, Day F, Reilly J, Delport J, McCrone P, Whitham D et al. Psychoeducation and Problem Solving (PEPS) Therapy for Adults With Personality Disorder: A Pragmatic Randomized-Controlled Trial. J Pers Disord. 2017 Dec;31(6):810-826.
- Hudson NA, Mrozik JH, White R, Northend K, Moore S, Lister K, Rayner K. Community football teams for people with intellectual disabilities in secure settings: "They take you off the ward, it was like a nice day, and then you get like medals at the end". J Appl Res Intellect Disabil. 2018 Mar;31(2):213-225. doi: 10.1111/jar.12359.

3.7 Commercial Research

A separate paper detailing the assurance controls for commercial studies has been provided to the Trust Board in response to Action 17/295 and is attached to this report as Appendix 1. Commercial study activity over the year was as follows:

- **MK4305-061 Insomnia study for Alzheimer's disease – PI Dr Tolu Olusoga** In March 2017, we opened as a site for this study with a recruitment target of one participant. Study recruitment has proved challenging nationally for this study and to date we have not managed to recruit any participants to this study. Our site has however been commended for the amount of effort put into screening potential participants for this study. This has been a great learning experience for us and also opened the door to being selected as a site for a further Alzheimer's Disease commercial research study.

- **Takeda study for Treatment Resistant Depression. A randomized, Double Blind, Placebo Controlled Study to Evaluate the Efficacy and Safety of TAK-653 in the Treatment of Subjects with Treatment-Resistant Depression Efficacy and Safety of TAK-653 in Treatment-Resistant Depression – PI Dr Baxi Sinha.** We have been selected as a site for this study and recruitment is due to start mid-2018. Study participants will be seen at the Ryedale suite, Roseberry Park and our agreed recruitment target is 2 participants.

- **A phase III, multicentre, randomised, double-blind, placebo controlled, parallel group, efficacy and safety study of Gantenrumab in patients with prodromal to mild Alzheimer's Disease (Graduate study). PI Dr Tolu Olusoga** Study setup is in progress with an agreed recruitment target of 2 participants. Study participants will initially have study visits at the Briary Wing, Harrogate and study visits for this study will be transferred to the new research facility at York Hospital once open and operational.

- **Janssen GYAO2603 Treatment Resistant Depression cohort study in Europe – PI Dr Sumeet Gupta** TEWV have recruited the first study participant in the UK within one month of opening which is a great achievement which will be acknowledged and celebrated in senior meetings at the Local Clinical Research Network. We have agreed a target of 10 participants for this study and we understand this study will lead on to a future treatment study for this cohort of participants.

3.8 Excess Treatment Costs

At the NHS England public board meeting on 30th November 2017, NHS England and the National Institute for Health Research (NIHR) published a joint statement that committed to 12 actions to support and apply research in the NHS.

Between November 2017 and February 2018, NHS England, working with the Department of Health and Social Care, the Health Research Authority and the NIHR launched a public consultation on proposals to better manage excess treatment costs.

Following the consultation it has been announced that a new process for managing ETCs will be implemented. This will be based on Total (cumulative) Excess Treatment Cost threshold per Trust, per financial year based on Trust income. The

Trust incomes will be banded to offer stability around the threshold year on year. Therefore for all non-commercial studies that have ETC, Trusts will be required to absorb ETCs up to their threshold. Once the provider has absorbed their threshold for that year, they will have additional applicable ETCs funded through new arrangements.

There is a planned implementation period with the new system planned to be fully operational by 1st April 2019.

4. IMPLICATIONS/RISKS:

4.1 Compliance with the CQC Fundamental Standards:

Research activity in the Trust is compliant with CQC Fundamental Standards.

Of particular note is the introduction of a research measure as part of CQC standards expected to be formally introduced during the course of 2018. This new CQC standard for Trusts will assess:

- How we promote research awareness for patients
- How we facilitate research
- How we show equity of access and improvement in support for research.

4.2 Financial/Value for Money:

The Trusts external research income for 17/18 was £841,941 which was an increase in income from the 16/17 external income of £579,215. This increase in income was partly due to the transfer of sponsor responsibilities from the University of Durham to TEWV. The following table shows the type and funding source for external income for 17/18. We anticipate that the income for 18/19 will continue to grow with continued income for the CHEMIST study, additional Research Capability Funding for sponsorship of this study, and further externally funded research with the University of York.

Description	Funder	Amount
Research support funding	NIHR Clinical Research Network North East and North Cumbria	£421,910
Research Capability Funding	Department of Health	£20,000
Journeying through Dementia Excess Treatment costs	York CCG and Harrogate and Rural District CCG	£12,424
Journeying through Dementia Study income	University of Hull and Sheffield Health and Social Care Trust	£13,043
SCIMITAR + grant funding	NIHR Health Technology Assessment	£57,088
CYGNUS grant funding	Innovate UK	£37,338
Esketamine commercial funding	Janssen Pharmaceuticals	£11,250

CHEMIST grant funding	NIHR Public Health Research	£180,252
Insomnia AD study	Merck, Sharpe and Dohme	£29,736
Additional grant funding	Various	£58,900
Total		**£841,941**

4.3 **Legal and Constitutional (including the NHS Constitution):**

The Trust's responsibility for the monitoring and standards of research activity involving its service users, carers and staff are laid down in the Framework for UK Health and Social Care Research. The R&D office processes are designed to ensure compliance by all involved via the Trust's Standard Operating Procedures for research. The Trust R&D strategy and its implementation seek to fulfil the NHS Constitution commitment to make research participation accessible to as many service users, carers and staff as possible.

4.4 **Equality and Diversity:**

The Trust's R&D strategy explicitly seeks to ensure that wherever possible there is equity of access to research for service users and carers across the Trust's specialties and geographies.

4.4 **Other implications:**

None

5. RISKS:

Finance management. The increase in R&D activity and complexity of contracts and invoicing processes for commercial and non-commercial interventional studies is a both welcome, and a rapidly growing challenge. There is a risk without additional specialist research grants and contracts officer support that costs will not be fully recovered for research activity which is required to continue our growth of activity. We plan to mitigate this risk in 18/19 by appointing a research grants and contracts officer who will work as part of the R&D team to manage the contracts and liaise closely with the finance team to manage the invoicing and oversight of the R&D budget.

6. CONCLUSIONS:

The Trust's Research and Development activity continues to enable service users and carers across all Trust localities to access new research opportunities for research involvement. We have made substantial progress with the University of York partnership to develop an academic collaboration based firmly on shared interests and priorities.

7. RECOMMENDATIONS:

The Board is asked to receive and approve the 17/18 R&D annual report.

Professor Joe Reilly
Clinical Director for Research and Development

Appendix 1- Assurance Paper for Trust Board re controls covering commercial research studies in Tees, Esk and Wear Valleys NHS Foundation Trust

Appendix 1

Assurance Paper for Trust Board re controls covering commercial research studies in Tees, Esk and Wear Valleys NHS Foundation Trust (Sarah Daniel R&D Manager, Angie Hardy Clinical Trials Pharmacist, May 2018)

Background

The government's Life Sciences Industrial Strategy outlines a shared objective of industry and Government to deliver outstanding patient outcomes. The arguments for more interaction between industry and the NHS in the evaluation of products are clear. UK patients and clinicians would benefit from innovative product use in the clinical trial setting knowing that, should the value be proven, the medicine would rapidly become more widely available, helping drive the spread of these innovations at pace and scale. The NHS would benefit from clinical trial revenues, early clinical experience and setting a global trend by using best standards of care, supporting improved planning and budgeting.

Locally, we have a responsibility to ensure that our service user populations have appropriate and equitable access to the potential opportunities that such collaborations can offer. Following a paper to EMT to support a Clinical Trials function in 2014, we now have a fully operational Clinical Trials pharmacy and the infrastructure to support such commercial research studies.

Working with the commercial pharmaceutical industry to host clinical trials involving investigational medicines or medical technologies, will bring income and recognition for TEWV, however this must be entered into on a 'not for profit or incentive' basis.

An agreement to participate in a study must be made in the best interests of our service user population, and senior clinicians in the area of specialism of the study must endorse both the rationale and clinical appropriateness for the research.

As part of the feasibility assessment Research and Development and Pharmacy will ensure that pharmaceutical industry apply ethical and quality standards to the medicinal products and processes for the safe conduct of the study.

Controls covering commercial studies

1) National Institute for Health Research Portfolio Adoption

All research studies in England must comply with the Department of Health and Social Care established eligibility criteria for commercial and non-commercial research to qualify for Clinical Research Network support. All studies, regardless of type, must meet the definition of research (as outlined in the Department of Health and Social Care eligibility criteria) as follows:

Research can be defined as the attempt to derive generalisable or transferable new knowledge to answer or refine relevant questions with scientifically sound methods. This

excludes: audit; needs assessments; quality improvement and other local service evaluations. It also excludes routine banking of biological samples or data except where this activity is integral to a self-contained research project designed to test a clear hypothesis. In addition, all studies must have appropriate ethical approval; and Health Research Authority (HRA) Approval where required and have full research funding (i.e. funding to meet all Research Costs in compliance with the AcoRD guidance) – see below for further details.

2) Financial

Clause 13 of the Code of Practice for the UK pharmaceutical industry, endorsed by the Association of British Pharmaceutical Industry, (ABPI), states that for clinical trial and interventional studies; *any remuneration must be reasonable and reflect the fair market value of the work.*

The National Institute of Health Research (NIHR) provide national costing templates that industry sponsors must use to ensure fair and equal payment for research activities within research sites in the NHS. This ensures that no extra local or individual incentives are paid. The template costs are then written into the contract between industry and the Trust, ensuring transparency and traceability.

Any inducements for individuals or the Trust above the national approved fees would be a red light and a breach of the code of practice.

3) Clinical Appropriateness

The R&D department receive requests to participate in commercial research either by approach from the NIHR Clinical Research Network or by direct approach from the company to the R&D office/ clinician in the Trust. Commercial companies request that interested sites complete an expression of interest form outlining the Trusts capability to participate in the study taking into account the population being researched, expertise of staff and facilities available in the Trust. If shortlisted as a potential site, the Trust will receive a visit from the commercial sponsor at which time the R&D team and appropriate clinicians will meet together to discuss in depth the details of the study.

At the point of assessing feasibility to participate in a particular study, the SDG research lead is contacted to ensure the research is clinically appropriate, that there is an area of need that the results of the research may expand the evidence base. Research that is not considered appropriate to the needs of the relevant service user population would not be engaged with or progressed.

If a research study using a new investigational medicine is accepted, and there is a mechanism for purchasing the medicine at the end of the study for patients who have benefitted from the product then this will need to be approved by the Drug and Therapeutics Committee in the same way as any new product, to ensure there is no 'back door' entry for new products.

4) Free from Inducements

As an organisation and as individuals in R&D we have a duty to ensure that all our dealings are conducted to the highest standards of integrity, and nothing is entered into that could potentially harm the reputation of TEWV. At the point of feasibility, or expressing an interest in a study, Research and Development will ensure that participation in the study does not constitute an inducement to prescribe, supply, administer, recommend or buy any medicine, medical device, equipment or service.

If a TEWV clinician approaches R&D with a research idea linked to a commercial product, then as part of the feasibility assessment they will be asked to declare any conflicts of interest, and if necessary a written declaration made of any grants, speaker fees or shares with the commercial company.

5) Ethical

There is a rigorous process in the UK for ensuring research is conducted ethically. The Health Research Authority (HRA) protects and promotes the interests of patients and the public in health and social care research.

All commercial research is required to be approved be the HRA following the UK policy framework for health and social care research (2017) which sets out principles of good practice in the management and conduct of health and social care research that take account of ethical standards and legal frameworks.

All commercial research involving investigational medicinal products, or licensed medicines used in unlicensed indications require clinical trial authorisation from the regulatory body, the Medicines and Healthcare Regulatory Authority (MHRA).

References

ABPI Code of Practice for the Pharmaceutical Industry (2016)

Code of practice for working with the Pharmaceutical industry – TEWV SOP PHARM-0002-009

Managing Conflicts of Interest in the NHS –TEWV Policy HR-0020

UK Policy Framework for Health and Social Care Research, Health Research Authority (2017)

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 22 May 2018**
TITLE:	**Assurance report of the Quality Assurance Committee**
REPORT OF:	**Dr Hugh Griffiths, Chairman, Quality Assurance Committee**
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:

The purpose of this report is to update the Board of Directors on any current areas of concern in relation to quality and to provide assurance on the systems and processes in place.

Assurance statement pertaining to the informal QuAC meeting held on 03 May 2018:

The Quality Assurance Committee has consistently reviewed all relevant Trust quality related processes, in line with the Committee's Terms of Reference. Issues to be addressed have been documented, are being progressed via appropriate leads and monitored via the appropriate sub-groups of QuAC.

Key matters considered by the Committee are summarised as follows:

- The Locality areas of Forensic Services and York and Selby services and top concerns.
- Report from the Patient Safety Group.
- Update report on progress with clinical supervision implementation and reporting.
- CQC compliance and Safeguarding & Public Protection assurance updates.
- CPA Audit Report.
- The six monthly update reports from Equality, Diversity and Human Rights Steering Group and the Research Governance Group.
- A presentation on Positive and Safe by Stephen Davison.

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 03 May 2018.
- Note the confirmed notes of the informal meeting held on 05 April 2018 (Annex 1).

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 22 May 2018**
TITLE:	**Assurance report of the Quality Assurance Committee**

1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of the key issues, concerns, risks, exceptions and the mitigating actions in place to address these, together with assurances given, considered by the Quality Assurance Committee, at its meeting held on 03 May 2018.

2. BACKGROUND INFORMATION AND CONTEXT

This report makes reference to the regular assurance reports from the clinical governance infrastructure, which includes the Locality Management and Governance Boards, together with the corporate assurance working groups of the Quality Assurance Committee, including progress reports. Monthly compliance with the Care Quality Commission regulatory standards, with copies of assurance reports to support the regulatory standards were also considered.

3. KEY ISSUES

The Committee received updates from the Locality Directors of Operations around the principal risks and concerns, together with assurances and progress from Forensic and York and Selby Services.

4. QUALITY ASSURANCE - EXCEPTIONS/ASSURANCE REPORTS FROM THE LOCALITY MANAGEMENT GOVERNANCE BOARDS (LMGBS) AND SUB-GROUPS OF THE COMMITTEE

The Committee received key assurance and exception reports from LMGBs and standing Sub-Groups of the Committee, highlighting any risks and concerns.

4.1 FORENSIC SERVICES LMGB

The Committee discussed the LMGB report for Forensic Services.

The top areas of concern discussed were:

1. Roseberry Park Rectification and disquiet over uncertainty around time lines of any changes.
2. CQC preparation.
3. Triangle of Care and the challenges with engaging staff.

Assurance was provided that following discussions at LMGB and QuAG any mitigating actions were being monitored through LMGB to minimise risk to the organisation.

4.2 YORK AND SELBY LMGB

The Committee discussed the LMGB report for York and Selby.

The top areas of concern discussed were:

1. Capacity and demand issues with ongoing problems with CAMHS services and IAPT.

2. Staffing with gaps in the workforce.
3. Commissioning expectations and meeting the contract requirements in the current financial restraints.

Members of the Committee expressed concerns over level 3 safeguarding training compliance, which was currently at 82%.
Assurance was provided that additional training courses have been planned and all mitigating actions were being monitored through LMGB and QuAG to minimise risks.

4.3 Patient Safety

The Committee received the assurance report of the Patient Safety Group and the Patient Safety Group Quality Report for the period 1 to 28 February 2018.

Arising from the discussions it was noted that:

- The Patient Safety Group has agreed two revised KPI's in relation to the frailty pathway.
- Care will be taken around secretaries generating prescriptions for clinicians to sign with clear guidelines put in place.
- Any trustwide patient safety issues resulting from either the Directors Panel or another group in the organisation will be discussed at the Patient Safety Group going forward with an assigned owner to take any actions forward.

Members sought clarification on the reduction in the level of self-harm incidents given the rising acuity of the individuals that are cared for and further detail will be provided to the Committee in June 2018.

4.4 **Safeguarding and Public Protection**

The Committee received the exception report of the Safeguarding and Public Protection Sub-Group.

Arising from the discussions it was noted that:

- There are a number of serious case reviews underway, particularly in Durham, which has seen unusually high numbers lately; however they are all appropriate and quite different in presentation.

- A targeted inspection of Stockton Local Authority has taken place by OFSTED regarding their permanence planning for children and young people, with extremely positive feedback.

Assurance was provided that the Trust is meeting its legal requirements for safeguarding adults and children within the current legislative framework.

4.5 **Progress with Clinical Supervision Implementation and Reporting**

The Committee received an update on progress with Clinical Supervision Implementation and reporting.

Arising from the discussions it was noted that:

- Following the introduction of the new policy and process introduced in 2016 to improve the uptake and awareness of clinical supervision there are still inconsistencies with implementation.
- This important quality and safety topic is currently a focus of the CQC and it is vital that senior managers and the Executive team have sight of progress around compliance with the policy.
- Ongoing summary updates will be reported to QuAC through the Clinical audit and effectiveness group report.
- Following a recent Kaizen event focused on the Tees locality area there will be a pilot of model supervision with key actions including training and the upskilling of staff including a two day supervision course.

5. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

5.1 Compliance with CQC Requirements Report

The Committee received the position of compliance with the CQC and Ofsted registration requirements.

The key matters discussed were:

- The timelines and process around preparations for the CQC well-led announced inspection. There was a visit in April 2018 from the CQC Lead Inspector, who attended three EMT report out sessions, which was positively received.
- Each locality will prepare a presentation for the CQC to showcase the quality of patient care, who will attend as part of the inspection on 1 June 2018.
- There has been one MHA review inspection in the last month to North Yorkshire locality, Rowan Ward, MHSOP, however at the time of QuAC the report had not been received.

Members of the Committee expressed concern over CQC findings on Newtondale, Forensic MH where a door was locked, however staff were unclear of the reasons.

Assurance was provided to the Committee that there has been a review of the blanket restriction policy following discrepancies around locked doors, and the importance of staff awareness.

- There have been two CQC prison inspections to MH Prison Low Newton and HM Prison Deerbolt Young Offenders Institution and feedback was awaited.

5.2 Clinical Audit of the Care Programme Approach (CPA) Principles

The Committee received a clinical audit of the CPA principles.

The key matters highlighted were:

The audit is designed to assess the practice of clinicians with regards to the practices and processes associated with the Care Programme Approach policy.

Whilst there was some evidence of good practice the results so far were disappointing with 61% of care planning with no documented evidence of involvement and one third (32%) of cases not meeting the standards set out in the harm minimisation policy.

Members of the Committee expressed their disappointment that the fundamental principles of the recovery approach are not embedded and there are variations across the localities.

Assurance was provided to the Committee that work is underway to make improvements, such as the co-production work stream to make changes to the care plan template and that the CPA principles will be linked into the triangle of care work as well as the recovery programme with an update back to QuAC in due course.

5.3 **Equality, Diversity and Human Rights**

The Committee received an update on the outcome of the Equality, Diversity and Human Rights steering group from January 2018 – April 2018.

Arising from discussions it was noted that:

- Localities continue to work with their equality objectives and all actions for the 2017/18 scorecard have been completed.

- Work was underway to try to address the issue of the differing outcomes and experience for BAME staff compared to white staff, through the support of EMT.

- A procedure is being developed to address metric 5 in the WRES which is the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. A dignity and respect work statement has been drafted and following comments from the Committee this will be implemented to communicate the message to staff that there will be zero tolerance to aggressive and violent behaviour.

- There are concerns over the deterioration of metric 6 – percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.

  It was interesting to note that there has been an increase in the number of incidents reported during February and March 2018, which could be due to the presentations at the Leadership and management networks, which highlighted the need to record incidents of abuse related to race, sexual orientation, gender etc.

5.4 **Research Governance**

The Committee received a six monthly update from the Research Governance Group.

The Trust continues to be compliant with the Research Governance Framework and from 7 November 2017 the 'UK policy framework for health and social care research' replaced the Research Governance Framework.

The key areas to note are:

- The updated policy framework for health and social care research and Good Clinical Practice (GCP) training guidelines, a consultation paper from NHS England published in November 2017 – 'Supporting Research in the NHS' and the portfolio of new studies.

- The collaboration between TEWV and the University of York was progressing well with the signing of a Memorandum of Understanding on research collaboration with a 15 year vision.

The Committee requested a report on earlier pieces of research and the outcomes, which will be reported back to QuAC in November 2018.

5.5 Positive and Safe

The Committee received a presentation from Mr Stephen Davison, Lead Nurse Positive and Safe on reducing the use of restrictive interventions.

The Committee expressed concerns around the high numbers in the use of rapid tranquilisation in CAMHS and incidents of restraint and it was noted that whilst there has been a lot of support into the service there were presently 66% of staff that were newly trained with less than two years' experience.

It was agreed that further work will be undertaken to look into the details around these matters and QuAG will be asked to facilitate this led by a Clinical Director. The outcome will be reported to QuAC in the next quarter.

5.8 **Issues that impact on the Trust's strategic or key operational risks.**

There were no issues that will impact on the Trust's strategic or operational risks.

6. IMPLICATIONS

6.1 **Quality**

One of the key objectives within the QuAC terms of reference is to provide assurance to the Board of Directors that the organisation is discharging its duty of quality in compliance with section 18 of the Health Act 1999. This is evidenced by the quality assurance and exception reports provided, with key priorities for development and actions around any risks clearly defined.

6.2 **Financial/value for money**

There were no direct financial implications arising from the agenda items discussed.

6.3 **Legal and Constitutional (including the NHS Constitution)**

The terms of reference, reviewed annually, outline compliance requirements that are addressed by the Quality Assurance Committee.

6.4 **Equality and Diversity**

There are no issues to note.

7. CONCLUSIONS

The Quality Assurance Committee considered the corporate assurance and performance reports during the informal meeting. The Committee were assured that as far as practicable, all risks highlighted were being either managed or addressed with proposed mitigation plans.

8. RECOMMENDATIONS

That the Board of Directors is asked to:

(i) Note the issues raised at the Quality Assurance Committee meeting on 03 May 2018.

(ii) Note the confirmed notes of the informal meeting held on 05 April 2018.

Jennifer Illingworth
Director of Quality Governance
May 2018

Annex 1

NOTES OF THE INFORMAL MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 5 APRIL 2018, IN STAFF MEETING ROOM 2, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Dr Hugh Griffiths, Chairman of the Committee
Mrs Lesley Bessant, Chairman of the Trust
Dr Ahmad Khouja, Medical Director Designate
Mr Colin Martin, Chief Executive
Mrs Elizabeth Moody, Director of Nursing & Governance
Mrs Shirley Richardson, Non-Executive Director
Mr Richard Simpson, Non-Executive Director

In attendance:
Mrs Karen Atkinson, Head of Nursing, Teesside
Dr Suresh Babu, Clinical Director, Durham & Darlington
Mr Chris Lanigan, Head of Planning & Business Development
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Mrs Cathy Byard, Observer
Mrs Lorraine Ferrier, Head of Nursing, Durham and Darlington
Mr Chris Williams, Chief Pharmacist
Mr Dominic Gardner, Director of Operations, Teesside
Dr Lenny Cornwall, Deputy Medical Director, Durham and Darlington
Mr Patrick Scott, Director of Operations, Durham and Darlington
Mr Stephen Davison, Lead Nurse, Nursing and Governance

18/33 APOLOGIES FOR ABSENCE

Apologies for absence were received from: Mrs Karen Agar, Associate Director of Nursing and Governance, Dr Ingrid Whitton, Deputy Medical Director, Dr Stephen Wright, Deputy Medical Director, Durham & Darlington, Mrs Jennifer Illingworth, Director of Quality Governance, Mr David Levy, Director of Human Resources, Organisational Development and Mr David Brown, Acting Chief Operating Officer.

18/34 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 01 February 2018 and 08 March 2018 were agreed as true and correct and signed by the Chairman.

18/35 ACTION LOG

The Committee discussed the QuAC Action Log, noting the following updates:

17/135 Drug & Therapeutics report – to include in the next report progress with use of unliscensed drug Clozapine injection.

Completed

17/163 Patient Safety Group Report – to include more detail in next report on the significant increase in the number of restrictive practices in children and young people.

Completed

17/170 Present more detail in Drug & Therapeutics report on STOMP-LD.

Completed

18/04 Re-describe risk number 380 in the D&D LMGB report around CAMHS and Tier 4.

Completed

18/05 Provide more information around the number of people committing suicide where finance has been a significant factor.

Completed

18/07 Patient Experience Report – Establish how users and carers are involved in PEG and whether this is representative.
This action would be deferred to the May 2018 QuAC meeting when Dr Wright would be present.

18/10 Compliance audit of emergency response bags to be repeated in March 2018 and brought back to QuAC in April 2018.

Completed

18/36 DURHAM AND DARLINGTON SERVICES LMGB REPORT

The Committee received and noted the Durham and Darlington Services LMGB Report.

Arising from the report it was highlighted that the top concerns at present were:

(1) Tier 4 services being unable to respond to the needs of complex young people, which had resulted in a 16 year old being admitted to an adult ward for a period of 14 nights.

Assurance was provided that this matter was being discussed at EMT and within the Tees locality to try and make improvements; however the issues were wide ranging and were also impacted by the national CAMHS provision.

(2) Substance misuse on inpatient adult wards
There had been a number of instances in recent months of substance misuse on wards which had resulted in near misses, episodes of violence and inpatient deaths.

The Committee acknowledged that this was a serious growing problem, not only in Durham and Darlington but also in Teesside and actions would be taken to look at preventing the supply of drugs onto wards.

Mrs Moody advised that a drug detection dog would be brought onto wards and security of the perimeter of wards would also be reviewed. In addition the adult SDG would be holding an event to consider the risks and associated actions.

Committee members expressed their concerns around drugs coming on to the Wards, not only to the detriment of patients but also the impact this would have on staff due to violence and aggression from patients.

Agreed: *that this should be added to the locality risk register and the Board risk on violence and aggression be reviewed.*

Action: Mr P Bellas

(3) CQC visits to Maple Ward and Elm Ward
There had been considerable negative feedback from the CQC following a mock quality visit regarding Maple Ward, predominantly around processes and the environment.

Assurance was provided to the Committee that there had been a change in the Ward leadership and there would be work undertaken to ensure more robust processes were being adhered to.

With regards to Elm Ward, feedback from the CQC on a recent MHA Inspection revealed that patients had verbally raised concerns about staff sleeping on night duty.

On this matter it was noted that following an extensive review of CCTV footage there had been no conclusive evidence of staff sleeping, however some concerns had been raised over the standard of work ethic around agency and a small number of permanent staff.

This has been followed up with random night visits – there would be further review of CCTV footage along with the appointment of a Duty Nurse Coordinator who would provide an on-site presence at night.

(4) The Committee welcomed the agreement of funding for ASD for a two site model for a rapid assessment process based at Stanley Health Centre and Holly Unit. This had been the outcome of a successful brief pilot period where the team had gone from a concept to a working model within five weeks.

18/37 TEES SERVICES LMGB REPORT

The Committee received and noted the Tees Services LMGB Report.

Arising from the report it was noted that the top concerns at present were:

(1) Drug related serious incidents.
There had been two drug related deaths involving inpatients on the same ward at Roseberry Park Hospital. One had occurred on the ward whilst the other took place whilst the patient was on leave.
The locality would be feeding into discussions at SDG level around the management of substance misuse including drugs being brought onto hospital sites.

(2) Medical vacancies.
There were issues in MHSOP due to medical staffing availability for Westerdale South which was a concern.
Assurance was provided to the Committee that remedial actions were being taken.

(3) Nursing Homes
There continued to be problems with the lack of nursing homes for older people leading to referrals into nursing homes that were not as efficient as they should be.

Following discussion the Committee expressed their concerns that the issue of the standards from agency staff had been raised also by the Tees locality.
It was noted that this had been escalated to EMT with plans for a contract review meeting on 26 April 2018 where these and other localities concerns would be fed back.

The Chief Executive asked that all individual case details concerning the standards from agency staff be sent to him for review.

Action: Mrs E Moody

The Committee acknowledged the dedicated team of staff on Westerdale South who faced many challenging and complex patients, yet morale remained high.

18/38 PATIENT SAFETY REPORT

The Committee received and noted the assurance report of the Patient Safety Group, the Patient Safety Quality Report for the period 1 to 31 January 2018 and the Never Events List 2018.

Arising from the report it was noted that:

(1) Concerns had been raised about staff access to patients moving and handling risk assessments and the risk that this could pose to patients and staff.
On this matter assurance was provided that this would be discussed further at the Clinical Leaders Group.

(2) There were ongoing issues regarding competency monitoring for bank and agency staff, in particular around engagement and observation processes.
Risks and potential remedies had been considered and this would be discussed further at OMT.

(3) The Mortality Review data for February 2018 using the Mazars tool for death categorisation had identified 22 expected deaths for patients on CPA reported in February 2018; at the time of the meeting the causes of death for 15 patients were still awaited.

(4) Deaths from September 2017 to January 2018 for which cause of death had now been established had been reviewed and further investigation would be needed for three of the incidents reviewed.

(5) A 13 month breakdown of the number of incidents requiring physical intervention by locality had revealed that during the reporting period Tier 4 CAMHS Services reported the most incidents requiring the use of physical intervention with 283 incidents reported in total which was an increase of 16 compared to the figure reported in December 2017.
On this matter it was noted that two patients accounted for the high level of this activity.

Following discussion the following matters were raised:

(1) The number of restraints for children, on page 10 of the report had been rising quite substantially from September 2017, however this was now showing a reduction.
It was noted that there had been a considerable amount of intervention and support put into this area and that some restraints were regarding the need to restrain one service user up to three or four times a day.

Mrs Moody advised that the inputting of this data onto Datix was currently undergoing some developments and that this information would be disaggregated for future QuAC reports.

(6) Considering ‘always events’ and how other Trusts were looking at this in terms of a cultural change to make staff think differently.
Mrs Moody noted that a good example of this was the standard work around Section 17 leave, where considerable improvements had been made.

18/39 PATIENT EXPERIENCE GROUP REPORT

The Committee received the Patient Experience Group assurance report for information.

Since there was no representation at the meeting from the Patient Safety Group, the Patient Experience Report was noted for information and a full report would be considered at the May 2018 QuAC meeting.

18/40 SAFEGUARDING & PUBLIC PROTECTION REPORT

The Committee received and noted the report for Safeguarding and Public Protection.

Arising from the report it was noted that:

(1) There had been a significant amount of activity with external partners around safeguarding and a number of serious case reviews that were taking place, which the Trust was involved with, particularly involving the Durham locality.

(2) A domestic homicide review had commenced in Middlesbrough where the perpetrator was the son of the victim. The Trust had only had contact with the victim and had completed the IMR. Recommendations received for the Trust had been around Domestic Abuse training and the raising of awareness and these had mostly been completed.

Assurance was provided that the Trust continued to meet its legal requirements for safeguarding adults and children within the current legislative framework.

18/41 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

The Committee received and noted the Compliance with CQC Registration Requirements Report.

Arising from the report it was noted that:

(1) The Trust had received the formal Provider Information Request (PIR) on 13 March 2018 and preparations were underway to collate all the necessary documentation.

(2) There had been six MHA review inspections in the last month with recurrent issues still being reported, such as restrictive practices and blanket restrictions.

(3) Work was on-going to ensure that blanket restrictions and restrictive practices are agreed, recorded and reviewed through QuAGs.

It was noted that there were instances when the Trust might take a different view to the CQC such as a recent visit where it had been advised that the courtyard door could be left open at night with additional lights outside.

The Trust has taken the position to lock the external doors at night once patients were in bed for security and safety reasons and that patients could have facilitated access dependant on individual needs.

Following discussion the committee expressed concerns that there seemed to be inconsistency between the outcomes of Trust peer reviews and MHA reviews.

It was acknowledged that it could be that restrictive practices were being reported under environmental issues.

Agreed: *to undertake some analysis around any inconsistencies between the outcomes of Trust peer reviews and MHA reviews.*

Action: Mrs J Illingworth

18/42 DRAFT QUALITY ACCOUNT 2017/18

The Committee received and noted the draft Quality Account for 2017/18.

Arising from the report it was noted that:

(1) Stakeholders had been involved in the priority setting and commenting on the detailed improvement actions.
(2) Following comments from the Quality Assurance Committee the Quality Account would be discussed further at the Governor Task and Finish Group on 13 April 2018 and comments incorporated before being distributed to stakeholders.
(3) Formal stakeholder comments would be included verbatim in the final version which would be considered by the Audit Committee and the Board of Directors in May 2018.

Following discussion members of the Committee suggested the following amendments:

1. Page 61: table of single oversight framework to be amended to explain that the Trust had not placed people inappropriately out of the Trust, only out of the locality area.
2. Page 57: provide further explanation around patients feeling safe on the Ward and to explain how the stretch targets work.
3. Page 42: learning from deaths and the number of patients that have died, to include the age profiles and in context with the patients we treat.

Action: Mr C Lanigan

Non-Executive Directors welcomed the Quality Account 2017/18, which clearly sets out the excellent standards of care being provided by the Trust and improvements being made.

18/43 CLINICAL RE-AUDIT OF EMERGENCY RESPONSE BAGS

The Committee received and noted the re-audit of Emergency Response Bags.

Arising from the report it was noted that:

- There had been improvement with 31 teams achieving compliance levels for all audit criteria. There were however still five teams that remained non-compliant.
- The key areas of risk for the non-compliant areas were one instance out of six adult/children areas, where the proper equipment was not in place. It had also been found that there was a lack of daily checks of equipment taking place.

  On this matter the Committee was assured that the equipment had now been ordered.

Following discussion the Committee expressed ongoing concerns around:

(1) The inability to bring this audit up to full compliance and discussed future plans for the monitoring of this audit.
(2) The Trust criteria for the location of Emergency Response Bags in community bases and staff expectations in areas where the bags were not cited.

Agreed: (i) *That there should be ongoing focus in the locality areas via Matrons fortnightly random sampling.*
(ii) *That a quarterly re-audit would be undertaken of the emergency response bags, which would be reported back to QuAC.*
(ii) That a report on the Trust criteria for the location of the response bags in community bases and staff expectations where no bags were cited be reported back to QuAC in September 2018.

18/44 DRUG AND THERAPEUTICS REPORT

The Committee noted the report of the Drug and Therapeutics Committee, together with the Pharmacy & Medicines Optimisation Annual Plan.

The key matters raised were:

(1) The TEWV policy for medicines had been revised and approved by EMT.
(2) New national guidance had been produced regarding the safe transfer of prescribing responsibilities between secondary and primary care, which was broadly in line with the existing TEWV Safe Transfer of Prescribing Guidance.
(3) The Annual Plan for Pharmacy and Medicines Optimisation would focus on six key areas aligned to the strategic priorities of the Trust business plan and NICE medicines optimisation guidance.

18/45 POSITIVE AND SAFE

The Committee noted that this report would be deferred to the 3 May 2018 QuAC meeting.

18/46 ANNUAL COMMITTEE PERFORMANCE RESULTS

The Committee considered the results of the annual Committee performance assessment.

Arising from the results it was noted that the key areas to focus on were:

(1) The boundaries between the QuAC and the Mental Health Legislation Committee and any overlap in reporting to provide robust assurance to each Committee.
(2) The communication between QuAC and the LMGBs and the flow of information and reporting in order to standardise and streamline reports and to ensure that the Committee is being provided with the key lines of assurance.

The Chairman noted that this work was currently ongoing and under development with a further meeting due to take place with the Director of Nursing and Governance and the Chairman of the Trust. It was pleasing to acknowledge however that the overall results of the assessment had been very positive and lots of improvement had been made in the last year.

Following discussion the Medical Director noted that there were plans to hold a Kaizen event with localities and this would be put on hold until the further meeting around QuAC development had taken place.

18/47 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no exceptions to report.

18/48 ANY MATTERS DISCUSSED TO BE ESCALATED TO THE BOARD OF DIRECTORS THAT MIGHT IMPACT ON THE TRUST'S STRATEGIC OR KEY OPERATIONAL RISKS.

The Committee noted that the main issue that could impact on the Trust's risks was around the supply and misuse of drugs in inpatient areas and the effect this would have both on patients and staff.

The other area of concern was the quality of agency staffing.

18/49 ANY OTHER BUSINESS

The Committee thanked Mrs Lorraine Ferrier, Head of Nursing in Durham and Darlington for her contribution and hard work in the locality and wished her well in her forthcoming retirement.

18/50 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 3 May 2018, 2.00pm – 5.00pm in the Board Room, West Park Hospital.

The meeting concluded at 4.25pm

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ITEM 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**22nd May 2018**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance/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 purpose of this report is to present to the Board by 'exception' the monthly safe staffing information as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review). This report refers to April 2018 data.

Key issues during the reporting period can be summarised as follows:

- The number of rosters equates to 72 inpatient wards (includes those inpatient wards not submitted to UNIFY for internal assurance).
- The number of 'red' fill rate indicators highlights Registered Nurses on Days as having the highest number of 'reds' equating to 16 wards, a reduction of 10 when compared to the previous month.
- North Yorkshire locality had the highest level of 'red' fill rates (6 in April)
- The lowest fill rate indicators in April related to Talbot Direct Care (support is being provided by Holly which is reflective in their fill rates), Birch Ward (maternity and a leaver), and Bankfields Court the Flats (support is being provided by neighbouring wards)
- The Highest fill rates in April were observed by Westerdale South (high patient acuity), Acomb Garth (high patient acuity/frailty) and Bedale (enhanced observations and seclusion)
- In relation to bank usage there were no wards identified who were utilising in excess of 50% bank during April. The highest bank user was in relation to Clover / Ivy with 45% bank usage (reasons for bank included: vacancies, enhanced observations and special leave)

- Agency usage equated to 5.9% in April. The highest user of agency within the reporting period related to Acomb Garth with 57.5% of the total hours worked within this ward (reasons for agency included: enhanced observations, unknown and vacancies)
- In terms of triangulation with incidents and complaints the full analysis can be found on pages 7 and 8 of this report. All complaints were categorised in relation to 'treatment and care, Personal Property and Consultant' although they did not highlight specific concerns with regards to staffing levels there was 1 in relation to staff attitude, this is currently being investigated. From those serious incidents that went to Directors Panel in April, 1 highlighted concerns regarding agency nursing competency.
- There were 532 shifts allocated in April where an unpaid break had not been taken, this is a reduction when compared to the previous month. From those shifts where breaks were not taken the majority were in relation to day shifts (366 shifts).
- There were 15 incidents raised in April citing concerns in relation to staffing levels, 13 of which related to Inpatient Services.
- A severity calculation has been applied and highlights any areas of concern from a safe staffing point of view. In April Westerdale South had the highest score with 10 points awarded. The top 10 for April can be found on page 10 of this report along with an explanation of severity scores and appendix 3 shows all scores for all wards. Appendix 4 shows the severity scores by speciality. Appendix 5 shows the year to date position with Clover / Ivy being cited as having the highest score of 89.
- Care Hours per Patient Day has been reported for the first time in May utilising April's data. This is listed in full for each inpatient ward at Appendix 6; consideration needs to be given with regards to the presentation of this data in future reports.

Recommendations:

That the Board of Directors note the outputs of the report and the issues raised for further investigation and development.

MEETING OF:	**Board of Directors**
DATE:	**22nd May 2018**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**

1. INTRODUCTION & PURPOSE:

1.1 To advise the Board of the exceptions arising from the monthly information on nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review). This report refers to April 2018 data.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Further to the emergent lessons from the Francis review there were a number of issues raised about the impact of the nurse staffing arrangements upon the poor quality of care and increased patient mortality exposed in that organisation.

2.2 The commitments set by the DH response to the Francis Report (Hard Truths, November, 2013 and subsequent update of the guidance in 2016) are for NHS providers to address specific recommendations about nursing staff. The Trust has met these directives as required including the publication of this report and a dedicated web page on nurse staffing. (http://www.tewv.nhs.uk/site/content/About/How-well-are-we-doing/Nurse-staffing). The full monthly data set of day by day staffing for each of the 72 areas split in the same way is available by web link on the Trust Nurse Staffing webpage.

3. EXCEPTIONS:

3.1 Safe Staffing Fill Rates – April 2018

3.1.1 The daily nurse staffing information aggregated for the month of April 2018 are presented at Appendix 1 of this report.

The highest numbers of red fill rate indicators relate to Registered Nurses on day shifts which equates to 16 in April. This is a decrease of 10 when compared to March 2018.

The top 3 inpatient areas within the reporting periods where a low staffing fill rate has been reported along with an explanation for each is as follows:

Ward	Fill Rate Indicator	Comments
April 2018		
Talbot Direct Care	54% RN on Days 0% HCA on Days 100.1% RN on Nights 0% HCA on Nights	Talbot always has a registered nurse on duty 24 hours a day. This is supported by CAMHS team managers, 3 shifts per week from Holly and the

		Ward Manager. Each shift is also supported by two PIPS HCA staff. A new roster template has been added and will be effective from 28th May 2018.
Birch Ward	68.6% RN on Days 133.9 HCA on Days 93.3% RN on Nights 173.3% HCA on Nights	The shortfall of RN's is due to having 2 staff nurses on maternity leave and 1 having left for an alternative post. The over establishment of HCA's is due to having additional staff in post following the closure of Lincoln Ward.
Bankfields Court, The Flatts	126.7% RN on Days 69.8% HCA on Days 114.2% RN on Nights 100.0% HCA on Nights	The shortfall of HCA's was covered by a neighbouring ward.

It is also important to review the fill rates that exceed the budgeted establishment (shown in blue). In April there were 67 fill rate indicators that had staffing in excess of their planned requirements to address specific nursing issues.

The top 3 inpatient areas whereby a staffing fill rate indicator in excess of the budgeted establishment along with an explanation for each is as follows:

Ward	Fill Rate Indicator	Comments
April 2018		
Westerdale South	437.2% HCA on Nights 88.5% RN on Nights 299.6% HCA on Days 98.8% RN on Days	The over establishment is in relation to high patient acuity with 6-7 enhanced patient observations daily. In addition the ward has experienced RN sickness and maternity leave.
Acomb Garth	398.1% HCA on Nights 96.7% RN on Nights 239.8% HCA on Days 104.8% RN on Days	The ward continues to experience high acuity and high levels of enhanced engagement and observation. This acuity is seen in both frailty/vulnerability/high care needs and agitation. Staffing needs are reviewed each weekday in the locality and a plan is in place to support the unit more intensively.
Bedale Ward	221.3% HCA on Nights 85.3% RN on Nights 139.1% HCA on Days 102.7% RN on Days	The ward has advised that the reason for the additional staffing was as a result of 2:1 enhanced observations and having a patient in seclusion. In addition the ward have appointed to 2 RN vacancies, anticipated start date September 2018.

3.2 Bank Usage

There are recognised risks in high use of bank and agency working although these are mitigated by the use of regular bank and agency staff who know the clinical areas.

There were no wards reporting 50% or above for bank usage in April.

The highest user of bank in April related to Clover / Ivy reporting at 45%. The reasons Clover / Ivy gave for requesting bank are as follows:

- Establishment Vacancies (114 shifts)
- Enhanced Observations (39 shifts)
- Special Leave Cover (26 shifts)
- Sickness (21 shifts)
- Overbooked (3 shifts)
- Redeployment (2 shifts)
- Unknown (2 shifts)
- Training (1 shift)

The ward has advised that they have created additional night shifts due to an individual requiring eyesight/arms reach observations in addition to safeguarding issues. The final beds on Eagle/Osprey collapsed at the end of March (last reporting period) and vacancies were being held on Clover/Ivy for HCA's therefore it is anticipated this position will improve in future reports once the electronic systems have been updated.

Wards reporting over 25% and above for bank usage in April are detailed below:

Clover/Ivy	45.0%
Mandarin	43.1%
Westerdale South	34.4%
Mallard Ward	33.3%
Newtondale Ward	31.6%
Birch Ward	29.9%
Hamsterley Ward	28.9%

Bank usage is shown in full within the appendices of this report alongside the staffing fill rate.

3.3 Agency Usage

When considering staffing levels it is also important to consider the amount of agency worked within the reporting period.

In April the agency usage equated to 5.9% a reduction of 0.1% when compared to March.

The highest user of agency within the reporting period related to Acomb Garth equating to approximately 57.5% of the total hours worked on this ward. The reasons Acomb Garth gave for requesting agency are as follows:

- Enhanced Observations (317 shifts)
- Unknown (10 shifts)
- Establishment Vacancies (4 shifts)
- Annual Leave (1 shift)
- Sickness (1 shift)

The ward is using regular agency where possible as there is limited availability of bank nurses within the York locality and North Yorkshire locality. This can be seen in the wards below where 8 of the top 10 are in these areas of the trust.

Wards reporting 4% or more agency usage in April are detailed below:

Acomb Garth	57.5%
Cedar Ward (NY)	44.4%
Cherry Tree House	23.1%
Rowan Ward	20.3%
Westerdale South	19.5%
Meadowfields	18.3%
Westerdale North	13.3%
Springwood	10.7%
Rowan Lea	10.5%
Danby Ward	9.1%
Birch Ward	8.7%
Ceddesfeld Ward	7.7%
FLD Eagle ASD	7.2%
Oak Rise	6.8%
Minster Ward	6.5%
Elm Ward	6.1%
Bedale Ward	6.0%
Maple Ward	4.6%
Ward 15 Friarage	4.5%
Ebor Ward	4.0%
Newberry Centre	4.0%

Although agency usage remains relatively low within the Trust; this is significantly higher when compared to the usage 12 months ago. The greatest percentage expenditure patient safety remains on agency HCA's at 78% for the period. Band 5 demand has remained consistent with the previous months. Directors of Operations with Heads of Nursing for each locality have reviewed and considered the pattern of unregistered nursing use and a number of posts are being recruited to that are over-establishment with the aim to reduce this cost and improve consistency and quality. In Durham locality 11 HCA posts have been approved to go out to advert.

There has been an average monthly spend of £241k from Oct – Apr 2018 across the trust on nurse agency with an increase over this reporting period of £18k on last month. The trusts agency provider reported there have been no agency price cap breaches.

3.4 Quality Data Triangulation

The triangulation of the staffing data against a range of quality metrics has been undertaken for the month of April with the following reporting as an exception:

- There were 2 Serious Incidents (SI) that occurred within inpatient areas during the month of April. 1 of which related to Rowan Ward who have been cited in this report for having agency usage in excess of 4%.
- From those incidents that were reviewed at Directors Panel in April, there was 1 case (2018-3650) following a fall which resulted in a fractured neck of femur. The case highlighted agency workers and their competency.
- There was 1 level 4 incident reported in April which was also reported as a SI. This ward has not been cited in this report to date.
- There were 3 level 3 incidents (self-harm) that occurred in April with the following featuring in this report as follows:
  - Cedar (NY) – 1 incident – cited in this report for agency usage greater than 4%
  - Maple Ward – 1 incident – cited in this report for agency usage greater than 4%.
- There were 6 complaints raised in April, the following is of relevance:
  - Cedar (NY) - 1 complaint - cited in this report for having agency usage greater than 4%.
  - Minster Ward – 1 complaint - cited in this report for having agency usage greater than 4%.
  - Cherry Tree – 1 complaint – cited in this report for having agency usage greater than 4%. This complaint was in relation to staff attitude and is currently being investigated.
- There were 21 PALS related issues raised with the following featuring within this report as follows:
  - Bedale (1 issue) – cited in this report for having a high fill rate, agency usage greater than 4%, a L3 self-harm incident and 2 complaints.
  - Elm Ward (1 issue) – cited in this report for having agency usage greater than 4%.
  - Newberry (2 issues) – cited in this report for having agency usage greater than 4%. In addition a complaint has been raised.
  - Clover/Ivy (2 issues) – cited in this report for bank usage in excess of 25%
  - Mallard (5 issues) – cited in this report for having bank usage in excess of 25%
  - Mandarin (1 issue) – cited in this report for having bank usage in excess of 25%

- Cherry Tree (1 issue) – cited in this report agency usage greater than 4% and for having a complaint.
- Rowan Lea (1 issue) – cited in this report having agency usage greater than 4%

A number of incidents requiring control and restraint occurred during April. The highest user was the Evergreen Centre with a total of 90 incidents. This ward has not been cited in this report to date.

3.5 Missed Breaks

The working time directive guarantees the right for all workers to have a rest break during working hours if the worker is on duty for longer than 6 hours. Inadequate rest time taken during duty hours is linked to staff burn out, exhaustion and the risk that this may ultimately impact on patient care.

A thorough analysis of the HealthRoster system has identified that there were 532 shifts in April where an unpaid break had not been taken. This is a decrease of 78 when compared to March.

The majority of the shifts where breaks were not taken occurred on day shifts (366 shifts). The number of night shifts where breaks were not taken equated to 166 shifts in April.

The detailed information in relation to missed breaks continues to be shared with the localities for discussion and monitoring at their Performance Improvement Groups.

Following discussion with staff-side representatives and discussion at EMT, directorates have been asked for evidence of any of the requirements that are laid down within the Trust's rest break guidance not being met in practice within individual wards, departments or units.

Where such evidence exists, services have been asked to confirm:

- What the relevant rest break requirements are that are not being met:
- The number and type of staff affected;
- The locations affected;
- Whether the situation described is continuing and what actions have been taken, or are planned, to ensure that the requirements of the rest breaks guidance can be met in the future.

This request is made as part of efforts to improve understanding about the scale of these issues. A new target has been agreed that will form part of the EMT report out. This will focus on those wards who have achieved less than 98% compliance with breaks in a monthly period.

3.6 Incidents raised citing Staffing Levels

It is also important to look at the number of incidents that have been raised and categorised in relation to staffing levels. There were 15 incidents reported in April on Datix citing issues with staffing. 13 of those incidents raised were in relation to inpatient services.

All staffing incidents are reviewed and shared with Heads of Nursing to identify themes across wards and address any issues arising from these. Concerns related to staffing incidents over the reporting period were as follows:

Key themes:

- 54% (7) of incidents citing staffing levels were for night duty
- Staff Shortages especially over Easter period
- Enhanced observations increasing staffing requirements
- Staff failed to turn up for shift 1 x TEWV staff member and 2 x Agency staff
- Wards not running on required staffing levels/skill mix.

Issues reported:

- Staff and patient safety compromised
- Quality of service impaired.
- Observations not carried out
- Dangerously low staffing levels
- Unable to respond to planned restraint

3.7 Severity

Utilising the data contained within this report it is possible to assign a scoring system to highlight any potential areas of concern. The total score for each inpatient area is contained within Appendix 3 with a speciality view at Appendix 4. The higher the score the higher the number of episodes they have been cited in relation to the number of 'red' fill rate indicators, any over establishment, bank & agency usage and the quality metrics.

The severity rating has been compiled on a very basic model as follows:

A 'red' fill rate = 2 points given for each occurrence
A 'blue' fill rate = 1 point given for each occurrence
Missed breaks = where there was no improvement from the previous month = 1 point awarded
Any episode of agency worked = 1 point
Bank usage = amber score = 1 point and a red rated score equals 2 points
SUI = 1 point
Level 4 = 1 point

Level 3 = 1 point
Complaint = 1 point
Control and Restraint – 11 and 39 incidents requiring C&R = 1 point; 40+ incidents of C&R = 2 points.

The top 10 wards cited utilising the above scoring mechanism is identified below for the reporting period:

WARD	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	Serious Incidents	Level 4 Incidents	Level 3 Incidents	Complaints	Control & Restraint	TOTAL SCORE (Apr)
Westerdale South	2	2	1	1	2	0	0	0	0	2	**10**
Cedar Ward	4	0	0	1	1	0	0	1	2	1	**10**
The Lodge	8	0	1	0	0	0	0	0	0	0	**9**
Bedale Ward	2	2	1	1	1	0	0	0	0	1	**8**
Birch Ward	2	2	0	1	2	0	0	0	0	0	**7**
Evergreen Centre	2	2	0	1	0	0	0	0	0	2	**7**
Mandarin	2	3	0	0	2	0	0	0	0	0	**7**
Clover/Ivy	0	2	1	1	2	0	0	0	0	1	**7**
Cedar Ward (NY)	0	2	1	1	0	0	0	1	1	0	**6**
Newberry Centre	0	3	0	1	0	0	0	0	0	2	**6**
The Orchards (NY)	4	2	0	0	0	0	0	0	0	0	**6**
Talbot Direct Care	6	0	0	0	0	0	0	0	0	0	**6**
Willow Ward	2	1	1	1	1	0	0	0	0	0	**6**

In terms of looking at the year to date position (April-April) the following are the top 5 wards cited:

WARD	Locality	Speciality	YTD Total Score (Apr - Apr)
Clover/Ivy	Forensics	Forensics LD	**89**
Cedar Ward	Durham & Darlington	Adults	**85**
Newberry Centre	Teesside	CYPS	**84**
Westerdale South	Teesside	MHSOP	**84**
Bedale Ward	Teesside	Adults	**82**

The year to date position for all inpatient wards has been included in full at appendix 5 of this report.

3.8 Care Hours per Patient Day (CHPPD)

From April 2018, all MH trusts reported CHPPD for the first time to NHS Improvement. This is the first step in developing the methodology as a tool that can contribute to a review of staff deployment. Work has begun to consider appropriate application of this metric in other healthcare groups such as allied health professionals (AHP's). We will be submitting pilot data in relation to AHP's that are rostered in TEWV in July 2018.

This metric tracks the total number of direct nursing care hours compared to the number of patients as a count at midnight. The trusts first submission can be found at Appendix 6.

Presentation of this additional information needs to be considered carefully by the Trust to ensure that like for like comparisons can be made. It is felt that the data could be most useful to be shown by locality and/or by grouping similar wards together.

It is important to highlight that the NQB guidance states that CHPPD should never be viewed in isolation but as part of a local quality dashboard that includes patient outcome measures alongside workforce and finance indicators. This will be further developed as part of the Right Staffing Programme and will be considered in more detail within the 6 monthly safe staffing report.

3.9 **Other**

North Yorkshire has the highest number (6 wards' in April) of 'red' fill rates for registered nurses on day shifts.

In May 2018 Durham and Darlington LMGB received a paper regarding flexible staffing usage. The paper outlined a proposal to increase the number of unregistered nurses within inpatient services to reduce bank and agency spend whilst increasing quality and consistency in care delivery. The proposal had no allocated funding therefore the proposal was designed not to increase financial expenditure. The following was recommended:

- AMH Assessment and Treatment wards to increase establishments and rosters in accordance with additional investment identified with effect from 1st April 2018.
- MHSOP Organic Wards to increase HCA posts by 11.44 WTE to cover organic ward additional staffing requirements.
- All inpatient services to ensure that rosters reflect funded rotas and establishment. In particular AMH assessment and treatment following agreed changes, MHSOP organic wards (assuming LMGB approval) and eating disorders inpatient wards and ALD units.
- That investment to inpatient staffing resource will be evaluated in conjunction with N&G Directorate and in accordance with the Right Staffing Programme.

The proposal was agreed and steps will be taken to move towards this model.

The Right Staffing programme Board has agreed a suite of metrics that will indicate delivery of intended benefits. Terms of reference and have been agreed for the following task and finish groups who will deliver the agreed objectives for each workstream. Each sub-group will be chaired by a Director. The workstreams are:

- Recruitment and Retention (chaired by Deputy Director of HR and OD)
- Training, development and leadership (chaired by Director of N&G)
- Temporary Staffing Services Workstream (chaired by Deputy Director of HR and OD)
- Staffing establishment workstream (chaired by COO)
- New roles and development of consultant workforce (Co-chaired by Medical Director and Director of Therapies)

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

There are a number of areas that have had high levels of clinical activity necessitating increased observation and engagement levels with patients in addition to sickness and vacancies. This has resulted in difficulties in some wards meeting their planned staffing levels particularly with regard to registered nursing staff fill rates on days. In some ward areas this has resulted in high levels of agency and bank HCA's. This issue has been highlighted as a concern by the CQC in recent inspection reports for other Mental Health Trusts and may pose a risk as to our ratings however the actions set out in section 3.9 aim to mitigate these risks going forward.

4.2 Financial/Value for Money:

It has been identified that there is little spare capacity in nursing establishments as they have been planned for maximum efficiency – it is therefore implied that the workforce deployment needs closer scrutiny to ensure those efficiencies do not constitute risks. This work is being progressed and will be a feature of this financial year's Right Staffing work stream referred to above.

4.3 Legal and Constitutional (including the NHS Constitution):

The Care Quality Commission and NHS England have set regulatory and contractual requirements that the Trust ensures adequate and appropriate staffing levels and skill mix to deliver safe and effective care. Inadequate staffing can result in non-compliance action and contractual breach.

The March 2013 NHS England and CQC directives set out specific requirements that will be checked through inspection and contractual monitoring as they are also included in standard commissioning contracts. The Trust has complied with these directives to date. The 2016 NQB guidance has also been taken into account in the Trust approach

4.4 Equality and Diversity:

Ensuring that patients have equal access to services means staffing levels should be appropriate to demand and clinical requirements.

4.5 **Other implications:**

From the data presented it is essential that a consistent reporting framework is maintained in particular the assigning of severity ratings.

5. RISKS:

5.1 Safe staffing and the risks regarding the Trusts ability to meet planned staffing levels on a daily basis have been escalated to the Trust Risk Register. Risks are managed and mitigated through operational services and the work being undertaken as highlighted within the Right Staffing work streams.

6. CONCLUSIONS:

6.1 The Trust continues to comply with the requirements of NHS England and the CQC in relation to the Hard Truths commitments and continues to develop the data collation and analysis to monitor the impact of nurse staffing on patient safety, clinical effectiveness and experience.

6.2 Comparative analysis of complaints and incidents, particularly focussing on the areas where staff fell below the planned levels has been undertaken for the period. Short term risks are being mitigated through the use of temporary staff and/or reviewing skill mix on a daily basis. There were 2 Serious Incidents (SI) that occurred within inpatient areas during the month of April. One SI related to Rowan Ward who was cited for having agency usage in excess of 4%. The other incident related to Overdale who has not been cited in this report. From those incidents that were reviewed at Directors Panel in April, there was 1 case (2018-3650) following a fall which resulted in a fractured neck of femur. The case highlighted agency workers and their competency. There was 1 complaint raised in relation to Cherry Tree which highlighted concerns with regards to staff attitude, this complaint is currently being investigated.

6.3 The report sets out the work that continues in localities and through the Right Staffing programme to address shortfalls where planned establishments are not being met and to address capacity and capability in line with severity scores.

7. RECOMMENDATIONS:

7.1 That the Board of Directors notes the exception report and the issues raised for further investigation and development. In addition CHPPD needs to be discussed and a decision made as to how best to present this data that would be meaningful in future reports.

Emma Haimes
Head of Quality Data and Patient Experience
May 2018

Appendix 1

TOTALS OF THE HOURS OF PLANNED NURSE STAFFING COMPARED TO ACTUAL TRUSTWIDE ACROSS 30 DAYS IN April

WARD	Locality	Speciality	Bed Numbers	DAY		NIGHT	
				FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (REGISTERED)	FILL RATE BETWEEN PLANNED AND ACTUAL (UN-REGISTERED)
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	85.8%	112.4%	83.0%	98.5%
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	75.7%	136.2%	90.0%	108.3%
Bedale Ward	Teesside	Adults	10	102.7%	139.1%	85.3%	221.3%
Bilsdale Ward	Teesside	Adults	14	101.4%	125.0%	113.6%	108.5%
Birch Ward	Durham & Darlington	Adults	15	68.6%	133.9%	93.3%	173.3%
Bransdale Ward	Teesside	Adults	14	125.0%	108.8%	100.3%	106.9%
Cedar Ward	Durham & Darlington	Adults	10	118.9%	82.6%	103.5%	82.8%
Cedar Ward (NY)	North Yorkshire	Adults	14	118.2%	139.1%	104.1%	137.3%
Ebor Ward	York and Selby	Adults	12	93.9%	114.2%	107.2%	103.6%
Elm Ward	Durham & Darlington	Adults	20	92.8%	112.0%	86.7%	126.8%
Farnham Ward	Durham & Darlington	Adults	20	107.0%	116.2%	93.3%	103.3%
Kirkdale Ward	Teesside	Adults	16	85.5%	106.7%	100.5%	100.0%
Lustrum Vale	Teesside	Adults	20	99.6%	111.9%	106.7%	101.7%
Maple Ward	Durham & Darlington	Adults	20	81.2%	110.3%	103.3%	108.8%
Minster Ward	York and Selby	Adults	12	92.4%	120.8%	102.0%	110.5%
Overdale Ward	Teesside	Adults	18	109.6%	109.0%	100.0%	103.5%
Primrose Lodge	Durham & Darlington	Adults	15	98.3%	117.0%	100.0%	100.0%
Stockdale Ward	Teesside	Adults	18	117.8%	98.6%	117.8%	108.8%

The Orchards (NY)	North Yorkshire	Adults	10	85.7%	133.3%	82.9%	130.0%
Tunstall Ward	Durham & Darlington	Adults	20	104.7%	97.8%	100.0%	100.0%
Ward 15 Friarage	North Yorkshire	Adults	12	89.7%	121.3%	106.7%	100.0%
Willow Ward	Durham & Darlington	Adults	15	87.4%	173.1%	107.1%	100.4%
Baysdale	Teesside	CYPS	6	108.1%	110.4%	114.9%	100.0%
Holly Unit	Durham & Darlington	CYPS	4	148.9%	155.8%	127.9%	182.2%
Newberry Centre	Teesside	CYPS	14	106.0%	157.9%	142.3%	202.0%
Talbot Direct Care	Durham & Darlington	CYPS	1	54.0%	0.0%	100.1%	0.0%
The Evergreen Centre	Teesside	CYPS	16	81.9%	109.0%	123.6%	121.1%
Westwood Centre	Teesside	CYPS	12	93.5%	164.9%	109.1%	203.3%
Clover/Ivy	Forensics	Forensics LD	12	102.6%	114.2%	161.5%	211.6%
FLD Eagle ASD	Forensics	Forensics LD	0	100.1%	90.0%	100.0%	100.0%
Harrier/Hawk	Forensics	Forensics LD	10	110.3%	124.8%	113.3%	148.0%
Kestrel/Kite.	Forensics	Forensics LD	16	103.3%	113.0%	113.3%	143.3%
Langley Ward	Forensics	Forensics LD	10	87.2%	105.2%	100.0%	100.0%
Northdale Centre	Forensics	Forensics LD	12	92.1%	93.9%	126.7%	89.1%
Oakwood	Forensics	Forensics LD	8	91.8%	150.8%	100.0%	100.0%
Thistle	Forensics	Forensics LD	5	93.1%	95.9%	100.3%	101.7%
Brambling Ward	Forensics	Forensics MH	13	105.3%	97.0%	100.0%	101.7%
Jay Ward	Forensics	Forensics MH	5	99.8%	115.9%	109.6%	131.8%
Lark	Forensics	Forensics MH	17	98.8%	107.1%	103.3%	98.3%
Linnet Ward	Forensics	Forensics MH	17	99.1%	105.1%	100.0%	100.0%
Mallard Ward	Forensics	Forensics MH	14	106.8%	112.8%	132.9%	160.7%
Mandarin	Forensics	Forensics MH	16	87.3%	168.0%	125.9%	215.5%
Merlin	Forensics	Forensics MH	10	130.2%	124.6%	105.0%	172.3%
Newtondale Ward	Forensics	Forensics MH	20	122.0%	122.0%	96.5%	176.1%

Nightingale Ward	Forensics	Forensics MH	16	96.1%	90.1%	100.0%	100.7%
Sandpiper Ward	Forensics	Forensics MH	8	109.0%	98.0%	103.6%	129.4%
Swift Ward	Forensics	Forensics MH	10	97.1%	95.1%	99.6%	103.7%
Aysgarth	Teesside	LD	6	91.9%	99.9%	99.9%	100.4%
Bankfields Court Flats	Teesside	LD	6	126.7%	69.8%	114.2%	100.0%
Bankfields Court Unit 2	Teesside	LD	5	105.1%	108.7%	93.3%	123.4%
Bankfields Court Unit 3	Teesside	LD	6	100.8%	104.1%	100.0%	98.3%
Bankfields Court Unit 4	Teesside	LD	6	101.8%	86.7%	150.0%	93.3%
Bek-Ramsey Ward	Durham & Darlington	LD	11	149.2%	110.1%	100.4%	104.4%
Oak Rise	York and Selby	LD	8	112.7%	96.7%	103.2%	101.0%
The Lodge	Teesside	LD	1	76.3%	76.7%	84.5%	76.7%
Acomb Garth	York and Selby	MHSOP	14	104.8%	239.8%	96.7%	398.1%
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	94.1%	137.4%	100.0%	144.1%
Cherry Tree House	York and Selby	MHSOP	18	113.0%	118.6%	96.7%	188.6%
Hamsterley Ward	Durham & Darlington	MHSOP	15	94.8%	146.9%	100.0%	149.6%
Meadowfields	York and Selby	MHSOP	14	97.1%	110.8%	101.4%	163.5%
Oak Ward	Durham & Darlington	MHSOP	12	84.4%	103.7%	100.0%	98.3%
Roseberry Wards	Durham & Darlington	MHSOP	15	99.7%	100.0%	103.6%	100.0%
Rowan Lea	North Yorkshire	MHSOP	20	85.9%	120.0%	100.2%	116.7%
Rowan Ward	North Yorkshire	MHSOP	6	95.5%	124.3%	103.8%	143.3%
Springwood Community Unit	North Yorkshire	MHSOP	14	90.1%	116.3%	103.3%	165.0%
Ward 14	North Yorkshire	MHSOP	10	72.6%	108.8%	100.0%	100.0%
Westerdale North	Teesside	MHSOP	18	109.5%	133.4%	116.7%	132.8%
Westerdale South	Teesside	MHSOP	14	98.8%	299.6%	88.5%	437.2%
Harland Rehab Ward	Durham & Darlington	Rehab	1	126.6%	83.4%	98.7%	101.6%
Kiltonview	Teesside	Day Unit	0	98.3%	92.6%		

The Orchard	Teesside	Day Unit	0	**93.1%**	**103.0%**		
Thornaby Road	Teesside	Day Unit	5	**97.6%**	**114.2%**		**101.8%**

APPENDIX 2

Scored Fill Rate compared to Quality Indicators - April 2018				Agency Usage Vs Actual Hours			Bank Usage Vs Actual Hours			Totals for Quality Indicators					Incidents of Restraint			
Known As	Locality	Speciality	Bed Numbers	Total Actual Hours	Total Agency Hours	% Against actual Hours	Total Actual Hours	Total Bank Hours	% Against actual Hours	SUI	L4 Incidents	L3 Incidents	Complaints	PALS	Incidents	PRO used	Other	Restraint Total
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	2429.8	220.00	9.1%	2429.8	222	9.1%									
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2762.8	66.00	2.4%	2762.8	288	10.4%					1	10		13	
Bedale Ward	Teesside	Adults	10	4818.5	287.50	6.0%	4818.5	711	14.8%					1	13	2	27	
Bilsdale Ward	Teesside	Adults	14	2831.7	0.00	0.0%	2831.7	34.5	1.2%									
Birch Ward	Durham & Darlington	Adults	15	3723.3	324.00	8.7%	3723.3	1114.33	29.9%						2		2	
Bransdale Ward	Teesside	Adults	14	2770.0	0.00	0.0%	2770.0	191.5	6.9%				1		2		3	
Cedar Ward	Durham & Darlington	Adults	10	4784.5	84.00	1.8%	4784.5	1099	23.0%			1	2	1	33		64	
Cedar Ward (NY)	North Yorkshire	Adults	14	3814.5	1694.25	44.4%	3814.5	195	5.1%			1	1		8		17	
Ebor Ward	York and Selby	Adults	12	2807.0	111.00	4.0%	2807.0	340	12.1%						1		1	
Elm Ward	Durham & Darlington	Adults	20	3143.8	191.33	6.1%	3143.8	692.34	22.0%					1	2		2	
Farnham Ward	Durham & Darlington	Adults	20	2679.0	24.00	0.9%	2679.0	240	9.0%						1		1	
Kirkdale Ward	Teesside	Adults	16	3048.5	0.00	0.0%	3048.5	488.25	16.0%						1		1	
Lustrum Vale	Teesside	Adults	20	2903.3	34.50	1.2%	2903.3	269.5	9.3%									
Maple Ward	Durham & Darlington	Adults	20	2623.0	120.00	4.6%	2623.0	506	19.3%			1			1		1	
Minster Ward	York and Selby	Adults	12	2839.3	183.50	6.5%	2839.3	206	7.3%				1		11		12	
Overdale Ward	Teesside	Adults	18	2743.5	34.50	1.3%	2743.5	46	1.7%	1	1							
Primrose Lodge	Durham & Darlington	Adults	15	2772.0	0.00	0.0%	2772.0	354.5	12.8%									
Stockdale Ward	Teesside	Adults	18	2946.5	11.50	0.4%	2946.5	69	2.3%					1	2		2	
The Orchards (NY)	North Yorkshire	Adults	10	2183.0	0.00	0.0%	2183.0	149	6.8%									

Tunstall Ward	Durham & Darlington	Adults	20	2671.5	0.00	0.0%	2671.5	60	2.2%										
Ward 15 Friarage	North Yorkshire	Adults	12	2600.8	118.25	4.5%	2600.8	641.25	24.7%										
Willow Ward	Durham & Darlington	Adults	15	2936.4	12.00	0.4%	2936.4	391.5	13.3%						3		5		
Baysdale	Teesside	CYPS	6	2420.8	0.00	0.0%	2420.8	305.81	12.6%										
Holly Unit	Durham & Darlington	CYPS	4	1434.8	0.00	0.0%	1434.8	164.09	11.4%										
Newberry Centre	Teesside	CYPS	14	5307.6	212.67	4.0%	5307.6	538.23	10.1%					2	77	1	98		
Talbot Direct Care	Durham & Darlington	CYPS	1	611.9	0.00	0.0%	611.9	0	0.0%						1		1		
The Evergreen Centre	Teesside	CYPS	16	4971.5	92.00	1.9%	4971.5	284.75	5.7%						90	4	145		
Westwood Centre	Teesside	CYPS	12	5811.7	0.00	0.0%	5811.7	103.5	1.8%						13		23		
Clover/Ivy	Forensics	Forensics LD	12	4924.8	33.75	0.7%	4924.8	2217.02	45.0%					2	38	2	81		
FLD Eagle ASD	Forensics	Forensics LD	1	2639.0	191.25	7.2%	2639.0	116.75	4.4%										
Harrier/Hawk	Forensics	Forensics LD	10	4601.8	0.00	0.0%	4601.8	1026	22.3%					1	6		9		
Kestrel/Kite.	Forensics	Forensics LD	16	4329.0	0.00	0.0%	4329.0	1074.5	24.8%					1	1		2		
Langley Ward	Forensics	Forensics LD	10	2114.3	0.00	0.0%	2114.3	376	17.8%										
Northdale Centre	Forensics	Forensics LD	12	4287.3	0.00	0.0%	4287.3	755.5	17.6%					1	3		6		
Oakwood	Forensics	Forensics LD	8	1917.2	0.00	0.0%	1917.2	285.75	14.9%										
Thistle	Forensics	Forensics LD	5	2906.2	0.00	0.0%	2906.2	180.17	6.2%						8		12		
Brambling Ward	Forensics	Forensics MH	13	2818.5	0.00	0.0%	2818.5	275	9.8%						2		5		
Jay Ward	Forensics	Forensics MH	5	3196.7	0.00	0.0%	3196.7	588.5	18.4%						5		14		
Lark	Forensics	Forensics MH	17	2817.3	0.00	0.0%	2817.3	283	10.0%										
Linnet Ward	Forensics	Forensics MH	17	2838.6	0.00	0.0%	2838.6	137.5	4.8%										
Mallard Ward	Forensics	Forensics MH	14	3812.7	0.00	0.0%	3812.7	1271.48	33.3%					5					
Mandarin	Forensics	Forensics MH	16	4214.5	0.00	0.0%	4214.5	1815.4	43.1%					1	9		14		
Merlin	Forensics	Forensics MH	10	4469.0	0.00	0.0%	4469.0	922.75	20.6%						3		4		
Newtondale Ward	Forensics	Forensics MH	20	4738.3	0.00	0.0%	4738.3	1496.08	31.6%										
Nightingale Ward	Forensics	Forensics MH	16	2706.8	0.00	0.0%	2706.8	300	11.1%										
Sandpiper Ward	Forensics	Forensics MH	8	3983.0	0.00	0.0%	3983.0	613.5	15.4%						68	1	149		

Swift Ward	Forensics	Forensics MH	10	3024.5	0.00	0.0%	3024.5	122.25	4.0%						2		2	
Aysgarth	Teesside	LD	6	2234.2	0.00	0.0%	2234.2	282.5	12.6%									
Bankfields Court Flats	Teesside	LD	6	1950.4	0.00	0.0%	1950.4	72	3.7%									
Bankfields Court Unit 2	Teesside	LD	5	2454.5	0.00	0.0%	2454.5	444.66	18.1%									
Bankfields Court Unit 3	Teesside	LD	6	2433.4	0.00	0.0%	2433.4	163.67	6.7%						20		31	
Bankfields Court Unit 4	Teesside	LD	6	2063.8	0.00	0.0%	2063.8	72	3.5%									
Bek-Ramsey Ward	Durham & Darlington	LD	11	4064.8	108.00	2.7%	4064.8	359.33	8.8%						20	5	34	
Harland Rehab Ward	Durham & Darlington	LD	1	2143.0	36.00	1.7%	2143.0	288	13.4%						1	1	0	
Oak Rise	York and Selby	LD	8	3654.8	247.00	6.8%	3654.8	500.19	13.7%									
The Lodge	Teesside	LD	1	1464.5	0.00	0.0%	1464.5	0	0.0%									
Acomb Garth	York and Selby	MHSOP	14	6632.8	3811.50	57.5%	6632.8	543.5	8.2%						14		21	
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	3693.4	283.50	7.7%	3693.4	340	9.2%						3		6	
Cherry Tree House	York and Selby	MHSOP	18	3707.5	857.50	23.1%	3707.5	491	13.2%				1	1	2		3	
Hamsterley Ward	Durham & Darlington	MHSOP	15	3652.0	94.37	2.6%	3652.0	1053.84	28.9%						3		2	
Meadowfields	York and Selby	MHSOP	14	3447.3	631.50	18.3%	3447.3	390.75	11.3%						1		2	
Oak Ward	Durham & Darlington	MHSOP	12	2563.4	0.00	0.0%	2563.4	239.24	9.3%						1		2	
Roseberry Wards	Durham & Darlington	MHSOP	15	2633.5	0.00	0.0%	2633.5	313.33	11.9%					1				
Rowan Lea	North Yorkshire	MHSOP	20	3882.3	406.17	10.5%	3882.3	473.08	12.2%					1	4		5	
Rowan Ward	North Yorkshire	MHSOP	6	3136.3	635.50	20.3%	3136.3	341	10.9%	1					3		4	
Springwood Community Unit	North Yorkshire	MHSOP	14	3469.8	370.75	10.7%	3469.8	468.75	13.5%						15		24	
Ward 14	North Yorkshire	MHSOP	10	2436.1	15.75	0.6%	2436.1	78.75	3.2%									
Westerdale North	Teesside	MHSOP	18	3599.7	478.00	13.3%	3599.7	117.67	3.3%									
Westerdale South	Teesside	MHSOP	14	8170.0	1591.00	19.5%	8170.0	2808	34.4%						42		43	
Kiltonview	Teesside	LD	0	2037.5	0.00	0.0%	2037.5	194	9.5%									
The Orchard	Teesside	LD	0	1069.7	0.00	0.0%	1069.7	71.5	6.7%									
Thornaby Road	Teesside	LD	5	1774.3	0.00	0.0%	1774.3	78.83	4.4%									

Severity Scoring by Total Score

APPENDIX 3

WARD	Locality	Speciality	Bed Numbers	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	Serious Incident	L4 Incidents	L3 Incidents	Complaints	Control & Restraint	TOTAL SCORE (Apr)
Westerdale South	Teesside	MHSOP	14	2	2	1	1	2	0	0	0	0	2	**10**
Cedar Ward	Durham & Darlington	Adults	10	4	0	0	1	1	0	0	1	2	1	**10**
The Lodge	Teesside	LD	1	8	0	1	0	0	0	0	0	0	0	**9**
Bedale Ward	Teesside	Adults	10	2	2	1	1	1	0	0	0	0	1	**8**
Birch Ward	Durham & Darlington	Adults	15	2	2	0	1	2	0	0	0	0	0	**7**
The Evergreen Centre	Teesside	CYPS	16	2	2	0	1	0	0	0	0	0	2	**7**
Mandarin	Forensics	Forensics MH	16	2	3	0	0	2	0	0	0	0	0	**7**
Clover/Ivy	Forensics	Forensics LD	12	0	2	1	1	2	0	0	0	0	1	**7**
Cedar Ward (NY)	North Yorkshire	Adults	14	0	2	1	1	0	0	0	1	1	0	**6**
Newberry Centre	Teesside	CYPS	14	0	3	0	1	0	0	0	0	0	2	**6**
The Orchards (NY)	North Yorkshire	Adults	10	4	2	0	0	0	0	0	0	0	0	**6**
Talbot Direct Care	Durham & Darlington	CYPS	1	6	0	0	0	0	0	0	0	0	0	**6**
Willow Ward	Durham & Darlington	Adults	15	2	1	1	1	1	0	0	0	0	0	**6**
Holly Unit	Durham & Darlington	CYPS	4	0	4	0	0	1	0	0	0	0	0	**5**
Harland Rehab Ward	Durham & Darlington	Rehab	1	2	1	0	1	1	0	0	0	0	0	**5**
Hamsterley Ward	Durham & Darlington	MHSOP	15	0	2	0	1	2	0	0	0	0	0	**5**
Sandpiper Ward	Forensics	Forensics MH	8	0	1	1	0	1	0	0	0	0	2	**5**
Minster Ward	York and Selby	Adults	12	0	1	1	1	0	0	0	0	1	1	**5**
Elm Ward	Durham & Darlington	Adults	20	2	1	0	1	1	0	0	0	0	0	**5**
Maple Ward	Durham & Darlington	Adults	20	2	0	0	1	1	0	0	1	0	0	**5**
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2	1	1	1	0	0	0	0	0	0	**5**
Merlin	Forensics	Forensics MH	10	0	3	1	0	1	0	0	0	0	0	**5**
Newtondale Ward	Forensics	Forensics MH	20	0	3	0	0	2	0	0	0	0	0	**5**
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	4	0	0	1	0	0	0	0	0	0	**5**
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	0	2	1	1	0	0	0	0	0	0	**4**
Westerdale North	Teesside	MHSOP	18	0	2	1	1	0	0	0	0	0	0	**4**
Meadowfields	York and Selby	MHSOP	14	0	1	1	1	1	0	0	0	0	0	**4**

Rowan Ward	North Yorkshire	MHSOP	6	0	2	0	1	0	1	0	0	0	0	**4**
Rowan Lea	North Yorkshire	MHSOP	20	2	0	0	1	1	0	0	0	0	0	**4**
Mallard Ward	Forensics	Forensics MH	14	0	2	0	0	2	0	0	0	0	0	**4**
Ward 15 Friarage	North Yorkshire	Adults	12	2	1	0	1	0	0	0	0	0	0	**4**
Springwood Community Unit	North Yorkshire	MHSOP	14	0	1	0	1	1	0	0	0	0	1	**4**
Northdale Centre	Forensics	Forensics LD	12	2	1	0	0	1	0	0	0	0	0	**4**
Kirkdale Ward	Teesside	Adults	16	2	0	1	0	1	0	0	0	0	0	**4**
Acomb Garth	York and Selby	MHSOP	14	0	2	0	1	0	0	0	0	0	1	**4**
Cherry Tree House	York and Selby	MHSOP	18	0	1	0	1	1	0	0	0	1	0	**4**
Bankfields Court Unit 4	Teesside	LD	6	2	1	0	0	0	0	0	0	0	0	**3**
Westwood Centre	Teesside	CYPS	12	0	2	0	0	0	0	0	0	0	1	**3**
Jay Ward	Forensics	Forensics MH	5	0	1	1	0	1	0	0	0	0	0	**3**
Oakwood	Forensics	Forensics LD	8	0	1	1	0	1	0	0	0	0	0	**3**
Harrier/Hawk	Forensics	Forensics LD	10	0	2	0	0	1	0	0	0	0	0	**3**
Langley Ward	Forensics	Forensics LD	10	2	0	0	0	1	0	0	0	0	0	**3**
Overdale Ward	Teesside	Adults	18	0	0	0	1	0	1	1	0	0	0	**3**
Bankfields Court Flats	Teesside	LD	6	2	1	0	0	0	0	0	0	0	0	**3**
Ward 14	North Yorkshire	MHSOP	10	2	0	0	1	0	0	0	0	0	0	**3**
Bek-Ramsey Ward	Durham & Darlington	LD	11	0	1	0	1	0	0	0	0	0	1	**3**
Bilsdale Ward	Teesside	Adults	14	0	1	1	0	0	0	0	0	0	0	**2**
Stockdale Ward	Teesside	Adults	18	0	0	1	1	0	0	0	0	0	0	**2**
Kestrel/Kite.	Forensics	Forensics LD	16	0	1	1	0	0	0	0	0	0	0	**2**
Ebor Ward	York and Selby	Adults	12	0	0	0	1	1	0	0	0	0	0	**2**
Nightingale Ward	Forensics	Forensics MH	16	0	0	1	0	1	0	0	0	0	0	**2**
Bransdale Ward	Teesside	Adults	14	0	1	0	0	0	0	0	0	1	0	**2**
Bankfields Court Unit 2	Teesside	LD	5	0	1	0	0	1	0	0	0	0	0	**2**
Oak Ward	Durham & Darlington	MHSOP	12	2	0	0	0	0	0	0	0	0	0	**2**
Oak Rise	York and Selby	LD	8	0	0	0	1	1	0	0	0	0	0	**2**
Roseberry Wards	Durham & Darlington	MHSOP	15	0	0	1	0	1	0	0	0	0	0	**2**
Aysgarth	Teesside	LD	6	0	0	1	0	1	0	0	0	0	0	**2**
Baysdale	Teesside	CYPS	6	0	0	1	0	1	0	0	0	0	0	**2**
FLD Eagle ASD	Forensics	Forensics LD	1	0	0	1	1	0	0	0	0	0	0	**2**
Primrose Lodge	Durham & Darlington	Adults	15	0	0	0	0	1	0	0	0	0	0	**1**
Linnet Ward	Forensics	Forensics MH	17	0	0	1	0	0	0	0	0	0	0	**1**
Farnham Ward	Durham & Darlington	Adults	20	0	0	0	1	0	0	0	0	0	0	**1**

Lark	Forensics	Forensics MH	17	0	0	1	0	0	0	0	0	0	0	**1**
Bankfields Court Unit 3	Teesside	LD	6	0	0	0	0	0	0	0	0	0	1	**1**
Lustrum Vale	Teesside	Adults	20	0	0	0	1	0	0	0	0	0	0	**1**
Thornaby Road	Teesside	Day Unit	5	0	0	1	0	0	0	0	0	0	0	**1**
Tunstall Ward	Durham & Darlington	Adults	20	0	0	0	0	0	0	0	0	0	0	**0**
Eagle/Osprey	Forensics	Forensics LD	0	0	0	0	0	0	0	0	0	0	0	**0**
Thistle	Forensics	Forensics LD	5	0	0	0	0	0	0	0	0	0	0	**0**
Swift Ward	Forensics	Forensics MH	10	0	0	0	0	0	0	0	0	0	0	**0**
Brambling Ward	Forensics	Forensics MH	13	0	0	0	0	0	0	0	0	0	0	**0**
Kiltonview	Teesside	Day Unit	0	0	0	0	0	0	0	0	0	0	0	**0**
The Orchard	Teesside	Day Unit	0	0	0	0	0	0	0	0	0	0	0	**0**

Severity Scoring by Speciality

APPENDIX 4

WARD	Locality	Speciality	Bed Numbers	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	Serious Incident	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	Control & Restraint	TOTAL SCORE Apr
Cedar Ward	Durham & Darlington	Adults	10	4	0	0	1	1	0	0	1	2	1	**10**
Bedale Ward	Teesside	Adults	10	2	2	1	1	1	0	0	0	0	1	**8**
Birch Ward	Durham & Darlington	Adults	15	2	2	0	1	2	0	0	0	0	0	**7**
Cedar Ward (NY)	North Yorkshire	Adults	14	0	2	1	1	0	0	0	1	1	0	**6**
The Orchards (NY)	North Yorkshire	Adults	10	4	2	0	0	0	0	0	0	0	0	**6**
Willow Ward	Durham & Darlington	Adults	15	2	1	1	1	1	0	0	0	0	0	**6**
Minster Ward	York and Selby	Adults	12	0	1	1	1	0	0	0	0	1	1	**5**
Elm Ward	Durham & Darlington	Adults	20	2	1	0	1	1	0	0	0	0	0	**5**
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	4	0	0	1	0	0	0	0	0	0	**5**
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2	1	1	1	0	0	0	0	0	0	**5**
Maple Ward	Durham & Darlington	Adults	20	2	0	0	1	1	0	0	1	0	0	**5**
Kirkdale Ward	Teesside	Adults	16	2	0	1	0	1	0	0	0	0	0	**4**
Ward 15 Friarage	North Yorkshire	Adults	12	2	1	0	1	0	0	0	0	0	0	**4**
Overdale Ward	Teesside	Adults	18	0	0	0	1	0	1	1	0	0	0	**3**
Bilsdale Ward	Teesside	Adults	14	0	1	1	0	0	0	0	0	0	0	**2**
Stockdale Ward	Teesside	Adults	18	0	0	1	1	0	0	0	0	0	0	**2**
Bransdale Ward	Teesside	Adults	14	0	1	0	0	0	0	0	0	1	0	**2**
Ebor Ward	York and Selby	Adults	12	0	0	0	1	1	0	0	0	0	0	**2**
Farnham Ward	Durham & Darlington	Adults	20	0	0	0	1	0	0	0	0	0	0	**1**
Lustrum Vale	Teesside	Adults	20	0	0	0	1	0	0	0	0	0	0	**1**
Primrose Lodge	Durham & Darlington	Adults	15	0	0	0	0	1	0	0	0	0	0	**1**
Tunstall Ward	Durham & Darlington	Adults	20	0	0	0	0	0	0	0	0	0	0	**0**
The Evergreen Centre	Teesside	CYPS	16	2	2	0	1	0	0	0	0	0	2	**7**
Newberry Centre	Teesside	CYPS	14	0	3	0	1	0	0	0	0	0	2	**6**
Talbot Direct Care	Durham & Darlington	CYPS	1	6	0	0	0	0	0	0	0	0	0	**6**
Holly Unit	Durham & Darlington	CYPS	4	0	4	0	0	1	0	0	0	0	0	**5**
Westwood Centre	Teesside	CYPS	12	0	2	0	0	0	0	0	0	0	1	**3**

Baysdale	Teesside	CYPS	6	0	0	1	0	1	0	0	0	0	0	**2**
Clover/Ivy	Forensics	Forensics LD	12	0	2	1	1	2	0	0	0	0	1	**7**
Northdale Centre	Forensics	Forensics LD	12	2	1	0	0	1	0	0	0	0	0	**4**
Harrier/Hawk	Forensics	Forensics LD	10	0	2	0	0	1	0	0	0	0	0	**3**
Langley Ward	Forensics	Forensics LD	10	2	0	0	0	1	0	0	0	0	0	**3**
Oakwood	Forensics	Forensics LD	8	0	1	1	0	1	0	0	0	0	0	**3**
Kestrel/Kite.	Forensics	Forensics LD	16	0	1	1	0	0	0	0	0	0	0	**2**
FLD Eagle ASD	Forensics	Forensics LD	1	0	0	1	1	0	0	0	0	0	0	**2**
Eagle/Osprey	Forensics	Forensics LD	0	0	0	0	0	0	0	0	0	0	0	**0**
Thistle	Forensics	Forensics LD	5	0	0	0	0	0	0	0	0	0	0	**0**
Mandarin	Forensics	Forensics MH	16	2	3	0	0	2	0	0	0	0	0	**7**
Sandpiper Ward	Forensics	Forensics MH	8	0	1	1	0	1	0	0	0	0	2	**5**
Merlin	Forensics	Forensics MH	10	0	3	1	0	1	0	0	0	0	0	**5**
Newtondale Ward	Forensics	Forensics MH	20	0	3	0	0	2	0	0	0	0	0	**5**
Mallard Ward	Forensics	Forensics MH	14	0	2	0	0	2	0	0	0	0	0	**4**
Jay Ward	Forensics	Forensics MH	5	0	1	1	0	1	0	0	0	0	0	**3**
Nightingale Ward	Forensics	Forensics MH	16	0	0	1	0	1	0	0	0	0	0	**2**
Lark	Forensics	Forensics MH	17	0	0	1	0	0	0	0	0	0	0	**1**
Linnet Ward	Forensics	Forensics MH	17	0	0	1	0	0	0	0	0	0	0	**1**
Brambling Ward	Forensics	Forensics MH	13	0	0	0	0	0	0	0	0	0	0	**0**
Swift Ward	Forensics	Forensics MH	10	0	0	0	0	0	0	0	0	0	0	**0**
The Lodge	Teesside	LD	1	8	0	1	0	0	0	0	0	0	0	**9**
Bankfields Court Unit 4	Teesside	LD	6	2	1	0	0	0	0	0	0	0	0	**3**
Bankfields Court Flats	Teesside	LD	6	2	1	0	0	0	0	0	0	0	0	**3**
Bek-Ramsey Ward	Durham & Darlington	LD	11	0	1	0	1	0	0	0	0	0	1	**3**
Aysgarth	Teesside	LD	6	0	0	1	0	1	0	0	0	0	0	**2**
Bankfields Court Unit 2	Teesside	LD	5	0	1	0	0	1	0	0	0	0	0	**2**
Oak Rise	York and Selby	LD	8	0	0	0	1	1	0	0	0	0	0	**2**
Bankfields Court Unit 3	Teesside	LD	6	0	0	0	0	0	0	0	0	0	1	**1**
Hamsterley Ward	Durham & Darlington	MHSOP	15	0	2	0	1	2	0	0	0	0	0	**5**
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	0	2	1	1	0	0	0	0	0	0	**4**
Westerdale North	Teesside	MHSOP	18	0	2	1	1	0	0	0	0	0	0	**4**
Meadowfields	York and Selby	MHSOP	14	0	1	1	1	1	0	0	0	0	0	**4**
Rowan Lea	North Yorkshire	MHSOP	20	2	0	0	1	1	0	0	0	0	0	**4**
Rowan Ward	North Yorkshire	MHSOP	6	0	2	0	1	0	1	0	0	0	0	**4**

Acomb Garth	York and Selby	MHSOP	14	0	2	0	1	0	0	0	0	0	1	**4**
Cherry Tree House	York and Selby	MHSOP	18	0	1	0	1	1	0	0	0	1	0	**4**
Springwood Community Unit	North Yorkshire	MHSOP	14	0	1	0	1	1	0	0	0	0	1	**4**
Ward 14	North Yorkshire	MHSOP	10	2	0	0	1	0	0	0	0	0	0	**3**
Oak Ward	Durham & Darlington	MHSOP	12	2	0	0	0	0	0	0	0	0	0	**2**
Roseberry Wards	Durham & Darlington	MHSOP	15	0	0	1	0	1	0	0	0	0	0	**2**
Westerdale South	Teesside	MHSOP	14	2	2	1	1	2	0	0	0	0	2	**10**
Harland Rehab Ward	Durham & Darlington	Rehab	1	2	1	0	1	1	0	0	0	0	0	**5**
Kiltonview	Teesside	Day Unit	0	0	0	0	0	0	0	0	0	0	0	**0**
The Orchard	Teesside	Day Unit	0	0	0	0	0	0	0	0	0	0	0	**0**
Thornaby Road	Teesside	Day Unit	5	0	0	1	0	0	0	0	0	0	0	**1**

Severity Scoring Year to Date Position

APPENDIX 5

WARD	Locality	Speciality	Bed Numbers	Red Fill Rate	Blue Fill Rate	Missed Breaks	Agency Usage	Bank Usage	Serious Incidents	Level 4 Incidents	Level 3 (Self-Harm) Incidents	Complaints	Control & Restraint	YTD Total Score (Apr - Apr)
Clover/Ivy	Forensics	Forensics LD	12	0	2	1	1	2	0	0	0	0	1	**89**
Cedar Ward	Durham & Darlington	Adults	10	4	0	0	1	1	0	0	1	2	1	**85**
Westerdale South	Teesside	MHSOP	14	2	2	1	1	2	0	0	0	0	2	**84**
Newberry Centre	Teesside	CYPS	14	0	3	0	1	0	0	0	0	0	2	**84**
Bedale Ward	Teesside	Adults	10	2	2	1	1	1	0	0	0	0	1	**82**
The Evergreen Centre	Teesside	CYPS	16	2	2	0	1	0	0	0	0	0	2	**79**
Springwood Community Unit	North Yorkshire	MHSOP	14	0	1	0	1	1	0	0	0	0	1	**78**
Sandpiper Ward	Forensics	Forensics MH	8	0	1	1	0	1	0	0	0	0	2	**77**
Mandarin	Forensics	Forensics MH	16	2	3	0	0	2	0	0	0	0	0	**74**
Talbot Direct Care	Durham & Darlington	CYPS	1	6	0	0	0	0	0	0	0	0	0	**72**
Northdale Centre	Forensics	Forensics LD	12	2	1	0	0	1	0	0	0	0	0	**69**
Merlin	Forensics	Forensics MH	10	0	3	1	0	1	0	0	0	0	0	**68**
Ward 15 Friarage	North Yorkshire	Adults	12	2	1	0	1	0	0	0	0	0	0	**67**
Meadowfields	York and Selby	MHSOP	14	0	1	1	1	1	0	0	0	0	0	**66**
The Lodge	Teesside	LD	1	8	0	1	0	0	0	0	0	0	0	**63**
Elm Ward	Durham & Darlington	Adults	20	2	1	0	1	1	0	0	0	0	0	**63**
Maple Ward	Durham & Darlington	Adults	20	2	0	0	1	1	0	0	1	0	0	**63**
Westwood Centre	Teesside	CYPS	12	0	2	0	0	0	0	0	0	0	1	**63**
Acomb Garth	York and Selby	MHSOP	14	0	2	0	1	0	0	0	0	0	1	**62**
Birch Ward	Durham & Darlington	Adults	15	2	2	0	1	2	0	0	0	0	0	**61**
Hamsterley Ward	Durham & Darlington	MHSOP	15	0	2	0	1	2	0	0	0	0	0	**61**
Bransdale Ward	Teesside	Adults	14	0	1	0	0	0	0	0	0	1	0	**60**
Cherry Tree House	York and Selby	MHSOP	18	0	1	0	1	1	0	0	0	1	0	**58**
Ayckbourn Unit Danby Ward	North Yorkshire	Adults	11	4	0	0	1	0	0	0	0	0	0	**57**
Eagle/Osprey	Forensics	Forensics LD	0	0	0	0	0	0	0	0	0	0	0	**57**
Kestrel/Kite.	Forensics	Forensics LD	16	0	1	1	0	0	0	0	0	0	0	**55**
Holly Unit	Durham & Darlington	CYPS	4	0	4	0	0	1	0	0	0	0	0	**54**

Lustrum Vale	Teesside	Adults	20	0	0	0	1	0	0	0	0	0	0	**54**
Rowan Ward	North Yorkshire	MHSOP	6	0	2	0	1	0	1	0	0	0	0	**53**
Ebor Ward	York and Selby	Adults	12	0	0	0	1	1	0	0	0	0	0	**53**
Cedar Ward (NY)	North Yorkshire	Adults	14	0	2	1	1	0	0	0	1	1	0	**52**
Oak Rise	York and Selby	LD	8	0	0	0	1	1	0	0	0	0	0	**52**
The Orchards (NY)	North Yorkshire	Adults	10	4	2	0	0	0	0	0	0	0	0	**50**
Ayckbourn Unit Esk Ward	North Yorkshire	Adults	11	2	1	1	1	0	0	0	0	0	0	**50**
Newtondale Ward	Forensics	Forensics MH	20	0	3	0	0	2	0	0	0	0	0	**50**
Harrier/Hawk	Forensics	Forensics LD	10	0	2	0	0	1	0	0	0	0	0	**49**
Brambling Ward	Forensics	Forensics MH	13	0	0	0	0	0	0	0	0	0	0	**49**
Mallard Ward	Forensics	Forensics MH	14	0	2	0	0	2	0	0	0	0	0	**48**
Bankfields Court Flats	Teesside	LD	6	2	1	0	0	0	0	0	0	0	0	**47**
Swift Ward	Forensics	Forensics MH	10	0	0	0	0	0	0	0	0	0	0	**47**
Oakwood	Forensics	Forensics LD	8	0	1	1	0	1	0	0	0	0	0	**46**
Langley Ward	Forensics	Forensics LD	10	2	0	0	0	1	0	0	0	0	0	**45**
Overdale Ward	Teesside	Adults	18	0	0	0	1	0	1	1	0	0	0	**44**
Bilsdale Ward	Teesside	Adults	14	0	1	1	0	0	0	0	0	0	0	**44**
Kirkdale Ward	Teesside	Adults	16	2	0	1	0	1	0	0	0	0	0	**43**
Stockdale Ward	Teesside	Adults	18	0	0	1	1	0	0	0	0	0	0	**43**
Nightingale Ward	Forensics	Forensics MH	16	0	0	1	0	1	0	0	0	0	0	**43**
Lark	Forensics	Forensics MH	17	0	0	1	0	0	0	0	0	0	0	**43**
Bankfields Court Unit 4	Teesside	LD	6	2	1	0	0	0	0	0	0	0	0	**42**
Primrose Lodge	Durham & Darlington	Adults	15	0	0	0	0	1	0	0	0	0	0	**41**
Willow Ward	Durham & Darlington	Adults	15	2	1	1	1	1	0	0	0	0	0	**39**
Minster Ward	York and Selby	Adults	12	0	1	1	1	0	0	0	0	1	1	**38**
Jay Ward	Forensics	Forensics MH	5	0	1	1	0	1	0	0	0	0	0	**38**
Linnet Ward	Forensics	Forensics MH	17	0	0	1	0	0	0	0	0	0	0	**37**
Thistle	Forensics	Forensics LD	5	0	0	0	0	0	0	0	0	0	0	**36**
Bek-Ramsey Ward	Durham & Darlington	LD	11	0	1	0	1	0	0	0	0	0	1	**33**
Westerdale North	Teesside	MHSOP	18	0	2	1	1	0	0	0	0	0	0	**29**
Rowan Lea	North Yorkshire	MHSOP	20	2	0	0	1	1	0	0	0	0	0	**29**
Bankfields Court Unit 2	Teesside	LD	5	0	1	0	0	1	0	0	0	0	0	**29**
Bankfields Court Unit 3	Teesside	LD	6	0	0	0	0	0	0	0	0	0	1	**28**
Ward 14	North Yorkshire	MHSOP	10	2	0	0	1	0	0	0	0	0	0	**27**
Aysgarth	Teesside	LD	6	0	0	1	0	1	0	0	0	0	0	**27**

Farnham Ward	Durham & Darlington	Adults	20	0	0	0	1	0	0	0	0	0	0	**25**
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	0	2	1	1	0	0	0	0	0	0	**24**
Tunstall Ward	Durham & Darlington	Adults	20	0	0	0	0	0	0	0	0	0	0	**23**
Roseberry Wards	Durham & Darlington	MHSOP	15	0	0	1	0	1	0	0	0	0	0	**20**
Oak Ward	Durham & Darlington	MHSOP	12	2	0	0	0	0	0	0	0	0	0	**17**
The Orchard	Teesside	Day Unit	0	0	0	0	0	0	0	0	0	0	0	**16**
Baysdale	Teesside	CYPS	6	0	0	1	0	1	0	0	0	0	0	**13**
Kiltonview	Teesside	Day Unit	0	0	0	0	0	0	0	0	0	0	0	**13**
Harland Rehab Ward	Durham & Darlington	Rehab	1	2	1	0	1	1	0	0	0	0	0	**12**
FLD Eagle ASD	Forensics	Forensics LD	1	0	0	1	1	0	0	0	0	0	0	**2**
Thornaby Road	Teesside	Day Unit	5	0	0	1	0	0	0	0	0	0	0	**2**

Care Hours per Patient Day – April

Appendix 6

CARE HOURS PER PATIENT DAY TRUSTWIDE ACROSS 30 DAYS IN April							
				CARE HOURS PER PATIENT DAY (CHPPD)			
WARD	Locality	Speciality	Bed Numbers	Cumulative Count over the month of patients at 23:59 each day	Registered Nurses	Care Staff	Overall
Danby Ward	North Yorkshire	Adults	11	301	3.2	4.8	8.1
Esk Ward	North Yorkshire	Adults	11	303	3.5	5.6	9.1
Bedale Ward	Teesside	Adults	10	215	8.0	14.4	22.4
Bilsdale Ward	Teesside	Adults	14	574	2.1	2.8	4.9
Birch Ward	Durham & Darlington	Adults	15	363	2.9	7.4	10.3
Bransdale Ward	Teesside	Adults	14	385	3.6	3.6	7.2
Cedar Ward	Durham & Darlington	Adults	10	248	8.5	10.8	19.3
Cedar Ward (NY)	North Yorkshire	Adults	14	418	2.9	6.3	9.1
Ebor Ward	York and Selby	Adults	12	353	3.6	4.4	8.0
Elm Ward	Durham & Darlington	Adults	20	498	2.2	4.1	6.3
Farnham Ward	Durham & Darlington	Adults	20	602	2.1	2.4	4.5
Kirkdale Ward	Teesside	Adults	16	439	2.4	4.6	6.9
Lustrum Vale	Teesside	Adults	20	539	2.7	2.7	5.4
Maple Ward	Durham & Darlington	Adults	20	544	2.0	2.8	4.8
Minster Ward	York and Selby	Adults	12	321	3.8	5.0	8.8
Overdale Ward	Teesside	Adults	18	411	3.1	3.6	6.7
Primrose Lodge	Durham & Darlington	Adults	15	379	3.2	4.1	7.3
Stockdale Ward	Teesside	Adults	18	540	2.5	2.9	5.5
The Orchards (NY)	North Yorkshire	Adults	10	235	5.3	4.0	9.3
Tunstall Ward	Durham & Darlington	Adults	20	532	2.3	2.7	5.0

Ward 15 Friarage	North Yorkshire	Adults	12	362	3.1	4.1	7.2
Willow Ward	Durham & Darlington	Adults	15	352	3.1	5.2	8.3
Baysdale	Teesside	CYPS	6	119	7.0	13.3	20.3
Holly Unit	Durham & Darlington	CYPS	4	55	9.6	16.4	26.1
Newberry Centre	Teesside	CYPS	14	214	10.1	14.7	24.8
Talbot Direct Care	Durham & Darlington	CYPS	1	30	20.4	0.0	20.4
Evergreen Centre	Teesside	CYPS	16	439	5.1	6.2	11.3
Westwood Centre	Teesside	CYPS	12	343	6.3	10.6	16.9
Clover/Ivy	Forensics	Forensics LD	12	298	4.7	11.9	16.5
FLD Eagle ASD	Forensics	Forensics LD	1	30	45.2	42.7	88.0
Harrier/Hawk	Forensics	Forensics LD	10	300	4.4	11.0	15.3
Kestrel/Kite.	Forensics	Forensics LD	16	480	2.5	6.5	9.0
Langley Ward	Forensics	Forensics LD	10	150	7.1	7.0	14.1
Northdale Centre	Forensics	Forensics LD	12	360	3.3	8.6	11.9
Oakwood	Forensics	Forensics LD	8	240	4.4	3.6	8.0
Thistle	Forensics	Forensics LD	5	150	7.1	12.3	19.4
Brambling Ward	Forensics	Forensics MH	13	373	3.2	4.3	7.6
Jay Ward	Forensics	Forensics MH	5	143	8.2	14.1	22.4
Lark	Forensics	Forensics MH	17	510	2.2	3.3	5.5
Linnet Ward	Forensics	Forensics MH	17	510	2.2	3.3	5.6
Mallard Ward	Forensics	Forensics MH	14	390	3.4	6.4	9.8
Mandarin	Forensics	Forensics MH	16	450	2.5	6.8	9.4
Merlin	Forensics	Forensics MH	10	283	6.3	9.5	15.8
Newtondale Ward	Forensics	Forensics MH	20	597	2.8	5.2	7.9
Nightingale Ward	Forensics	Forensics MH	16	464	2.4	3.4	5.8
Sandpiper Ward	Forensics	Forensics MH	8	240	6.6	10.0	16.6
Swift Ward	Forensics	Forensics MH	10	300	3.8	6.3	10.1
Aysgarth	Teesside	LD	6	118	6.6	12.3	18.9
Bankfields Flats	Teesside	LD	6	90	7.3	14.4	21.7
Bankfields Unit 2	Teesside	LD	5	138	6.2	11.6	17.8
Bankfields Unit 3	Teesside	LD	6	60	10.0	30.5	40.6

Bankfields Unit 4	Teesside	LD	6	120	5.2	12.0	17.2
Bek-Ramsey Ward	Durham & Darlington	LD	11	150	7.2	19.9	27.1
Oak Rise	York and Selby	LD	8	108	12.2	21.6	33.8
The Lodge	Teesside	LD	1	30	21.2	27.6	48.8
Acomb Garth	York and Selby	MHSOP	14	407	3.7	12.6	16.3
Ceddesfeld Ward	Durham & Darlington	MHSOP	15	445	2.7	5.6	8.3
Cherry Tree House	York and Selby	MHSOP	18	536	2.3	4.6	6.9
Hamsterley Ward	Durham & Darlington	MHSOP	15	435	2.6	5.8	8.4
Meadowfields	York and Selby	MHSOP	14	232	5.1	9.8	14.9
Oak Ward	Durham & Darlington	MHSOP	12	324	3.0	4.9	7.9
Roseberry Wards	Durham & Darlington	MHSOP	15	354	3.4	4.0	7.4
Rowan Lea	North Yorkshire	MHSOP	20	502	2.8	5.0	7.7
Rowan Ward	North Yorkshire	MHSOP	6	477	2.7	3.9	6.6
Springwood	North Yorkshire	MHSOP	14	174	7.4	12.6	19.9
Ward 14	North Yorkshire	MHSOP	10	262	4.0	5.3	9.3
Westerdale North	Teesside	MHSOP	18	442	3.7	4.5	8.1
Westerdale South	Teesside	MHSOP	14	365	4.9	17.5	22.4
Harland Rehab Ward	Durham & Darlington	Rehab	1	30	27.0	44.4	71.4
Thornaby Road	Teesside	Day Unit	5	150	3.1	8.7	11.8

ITEM NO. 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**22ND May 2018**
TITLE:	**2017/18 Composite Staff Action Plan**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Information and 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 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 report provides Directors with information about progress made with completing the Trust and locality and corporate directorate action plans developed in response to the 2016 staff survey results and Staff friends and Family Test results. Though most actions were completed within the target timescale a number of actions remain to be completed. This review of progress made has highlighted examples of good practice within localities and corporate directorates. In future actions taken at Trust level in response to staff survey results will be included within the Trust Workforce Strategy rather than within a separate action plan.

Recommendations:

To note the contents of the report and to comment accordingly.

MEETING OF:	**Board of Directors**
DATE:	**22ND May 2018**
TITLE:	**2017/18 Composite Staff Action Plan**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide Directors with information about progress made with implementing the Composite Trust Action Plan and locality and corporate directorate action plans (Appendix 1) that were developed in response to the 2016 annual staff survey results and Staff friends and Family Test results.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Trust action plan was agreed by Directors in May 2017 and an update about progress made with implementation was provided at the November 2017 meeting.

3. KEY ISSUES:

3.1 Progress has been made with completion of the Composite Trust Action Plan though only 65% of all actions were completed by the target date of March 2018.

3.2 Of the six outstanding actions four are in respect of the Bullying and Harassment Resolution Procedure. The procedure has been drafted and consultation undertaken however, there has been a delay in the draft procedure being considered by the Joint Consultative Committee, which meets every two months. Given the importance of this particular issue it was thought to be preferable to take a little more time to ensure that the approach taken is well founded and it is expected that the actions linked to the Bullying and Harassment Resolution Procedure will be completed by July 2018.

3.3 One action is outstanding in respect of the 'understanding the impact of presenteeism within the Trust' theme. The completion of an action to gather managers views about their interpretation of the Sickness Absence Management Procedure has been affected by a review of the procedure itself and it is now expected that this action will be completed by September.

3.4 The final outstanding action is in respect of developing a standard process for sharing key staff experience /engagement information with appropriate people and groups. An improvement event has taken place as part of this action which is expected to be completed by July.

3.5 Good progress has been made with implementation of locality and corporate directorate action plans. 85% of the one hundred and eighty actions were completed by the end of March 2018. Examples of good practice within the

localities and corporate directorates that has arisen through local actions being taken in response to survey results are provided in Appendix 1.

3.6 Given the recent development of the TEWV Workforce Strategy it has been agreed that rather than develop a separate action plan in response to the 2017 annual staff survey results a review of the actions described within the Workforce Strategy will be undertaken and should it be necessary additional actions will then be included within the strategy itself and an update reported to the Resources Committee in October 2018. Localities and corporate directorates are expected to continue to produce local action plans in response to the staff opinion survey results.

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:** The need to continue to address differences between the experiences of disabled and BAME staff compared to not disabled and White staff is an issue that continues to receive attention.

4.4 **Other implications:** None identified.

5. RISKS:

RISKS: There is a risk of survey fatigue given the number of times that Trust staff are asked to complete surveys and efforts to find alternative ways of gathering staff views are underway.

6. CONCLUSIONS:

6.1 Overall sound progress has been made with completing actions in response to the 2016 staff survey and there is evidence of the activities being developed and implemented that constitute good practice. It is however, too soon to say what the lasting impact of the actions has been. The outstanding actions within the Trust action plan are expected to be completed over the coming months and it is hoped that they will contribute to creating a better working environment throughout the Trust.

7. RECOMMENDATIONS:

7.1 To note the contents of the report and to comment accordingly.

David Levy
Director of Human Resources and Organisational Development

Background Papers:

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

APPENDIX 1

LOCAL ACTION PLANS END OF QUARTER 4 - 2018 UPDATE

Service Area	Number of actions allocated to Q1/Q2	Achieved	Yet to be achieved	Examples of Good Practice
1. Durham and Darlington	19	18	1 deferred to 2018/19	• Locality local brief design refreshed to provide a new way of communicating information. • Two locality wide events held to engage staff in assisting with the business plan.
2. Estates and Facilities Management	7	7		• The findings from the Staff Survey results were shared with DMT and action planning have already began.
3. Finance and Information	18	13	5 deferred to 2018/19	• Representatives from the directorate have undertaken Coaching training. • Introduced an 'above and beyond' section in the staff communication bulletin to recognize and acknowledge staff.
4. Forensic Services	17	17		• Compassionate Leadership Training has been rolled out along with coaching conversations to encourage staff to be more involved in decision making.
5. Human Resources/Organisational Development	21	14	7 deferred to 2018/19	• An RPIW event was facilitated in March to look at ways of identifying and sharing information on staff experience, engagement information and other intelligence. The report will be presented to EMT shortly to review the recommendations. • Research has commenced with York University and TEWV on the impact of 12 hour shifts on staff within the York and Selby Directorate.
6. Medical Directorate	5	5		• Highlighting the need to raise concerns of bullying and harassment was discussed during recent team briefs along with confirmation that any staff member returning from work should have a RTWI that discusses their general health and wellbeing and support mechanisms available.
7. North Yorkshire	10	10		• Listening events have been facilitated across the locality to support staff and gain an understanding of the possible effects the change programme initiated from the CCG will have on staff. • Adult mental health have introduced a reflection log to try and support those teams with recruitment challenges.
8. Nursing and Governance	11	8	3 deferred to 2018/19	• Group session facilitated at directorate day to provide awareness to managers on how to use the new appraisal system. • Coaching training has been provided at two directorate events.
9. Planning, Performance and Communications	19	13	5 deferred to 2018/19, 1 superseded following other work.	• Teams within the trust were encouraged to attend and present at directorate events on the work they have undertaken, including introducing change. Several teams have taken up this offer to promote their work and achievements.
10. Teesside AMH	7	7		• 'Visiting our premises' posters outlining expectations from both service users and staff have been circulated within wards and teams.
11. Teesside MHSOP	21	21		• The staff engagement team are working with teams across the directorate that have been identified via the Staff FFT as needing additional support and assistance in areas regarding their work. • Appraisal rates are now monitored weekly to ensure compliance.
12. York and Selby Directorate	25	25		• The new appraisal system has been rolled out, and those receiving an appraisal is at its highest. • Job descriptions have been revisited following feedback and have been amended with staff involvement.

Composite Trust Action Plan 2017/2018

No	Theme	Staff Survey	Staff FFT	Action Owner	Completion date	Action	Intended outcome/result	Progress update
1	Prevention of bullying and harassment	v		Nicola Rutherford	Q2	Develop a separate draft TEWV-wide anti bullying and harassment procedure, via the Policy Working Group, that will apply to all TEWV staff.	That staff will be more willing and confident to report incidences of bullying and harassment. That the experience of staff seeking to challenge bullying and harassment will be more positive and staff will feel more supported by TEWV. That managers will feel more confident about responding to allegations of bullying and harassment and supporting staff. That there will be a noticeable increase in the number of reported allegations of bullying and harassment during 2017/18 and 2018/19 followed by a reduction in the number of allegations thereafter.	Draft Bullying and Harassment reporting and resolution procedure presented to PWG 27.04.18. Awaiting comments before going to JCC. Action to be carried over.
				Nicola Rutherford	Q2	Ensure that there is appropriate consultation about the draft procedure at the relevant forums.		Draft Bullying and Harassment reporting and resolution procedure presented to PWG 27.04.18. Awaiting comments before going to JCC. Action to be carried over.
				David Levy	Q3	Secure Joint Consultative Committee and Executive Management Team support for the proposed terms of the anti bullying and harassment procedure.		Action to be carried over.
				Julie Jones	Q3	Develop and implement a communications plan to raise awareness amongst TEWV staff of the anti-bullying and harassment procedure and related actions		Action to be carried over.
				Michelle Brown	Q4	Incorporate the key issues and requirments of the anti bullying and harassment procedure within Trust leadership and management development Programmes.		Action to be carried over.
				Beverley Vardon-Odonkor	Q4	Design and deliver informal training sessions to staff on how to use and interpret the procedure.		To be arranged upon ratification of procedure, therefore action to be carried over.
2	Understanding the impact of presenteeism within the Trust	v		Paul Walker	Q2	Arrange and facilitate focus groups with registered nurses and health care assistants within the York & Selby, Durham & Darlington and Forensic Directorate to establish contributing factors which make staff feel under pressure to attend work when feeling unwell.	A reduction in staff reporting for work despite feeling unwell indicator within the Staff Survey 2018 survey.	Completed.
				Paul Walker	Q3	From the data identify themes that could be contributing to the way staff have reported in the staff survey 2016 results.		Completed
				David Levy	Q3	Explore with local higher education institutes the potential for and interest in undertaking research with TEWV into the causes of presenteeism.		TEWV and York University are collaborating over research into the impact of 12 hour shift working upon staff and services in the York and Selby locality. The research report is expected to be completed by the end of 2018. Further research activity with York University, about manager interventions/training to support staff health and wellbeing interventions, is being considered at present.
				David Levy	Q3	Share findings of the focus groups with the Executive Management Team and identify what additional support can be put in place.		Completed
				Lesley Hodge	Q3	Understand from managers their intepretation of the sickness absence management procedure, if necessary provide refresh sessions on the key messages of the procedure.		The current sickness procedure has been extended until Sept 2018 to allow time for listening events to take place across the trust, to hear from managers and staff as to how the procedure is working, what improvements can be made and any suggestions for managing absence differently. The procedure will then be updated accordingly and training sessions provided to managers on the changes.
				Michelle Brown	Q4	Include information to assist managers to recognise presenteeism and to discourage a culture of staff working when unwell within TEWV leadership and management development programmes.		Completed - restructure of appraisal process assists with this action and it is covered within the embedding values sessions.
				Sheila Jones	Q3	Pilot the introduction of short term reasonable adjustments in the identified hotspots for staff who are exhibiting symptoms of 'presenteeism'.		Action ceased due to lack of supporting information.
				Russell Smith	Q3	Work in collaboration with the Health and Wellbeing CQUIN Project Manager to further promote opportunities within the identified areas.		Completed - Staff Health & Wellbeing section reguarly updated containing information e.g. Musculo-skeletal issues/physiotherapy self-help guides, mental health support. Weekly Wellbeing Wednesday messages on a whole range of different subjects.
3	Improving staff engagement across the Trust	v	v	David Levy	Q3	Arrange and faciliate an RPIW to identify how and when to share/triangulate key staff experience/engagement information/intelligence between the Organisational Development Team and other staff support services. Agree which delegates to invite including HR staff, employee support, Union representatives, contact officers etc.	An increase in the staff engagement indicator within the Staff Survey 2018. Improved co-ordination of TEWV staff support/engagement activities. Greater assurance that key staff experience/engagement issues are being identified, acted upon and outcomes communicated and understood.	Completed
				Michelle Brown	Q4	As a result of the RPIW develop a standard process for how and when to share key staff experience/engagement information and with whom whilst maintaining the confidence of those who share the information.		Action to be carried over.
				Michelle Brown	Q3	Develop electronic guidance for managers and other staff providing information about the TEWV staff engagement resources that are available.		Completed

Durham & Darlington Local Action Plan
Lead: Jane Marron-Shepard

No	Theme	Intended outcome/result	Source of Action Staff Survey	Action	Action owner	Target date for completion	Progress update
1	Improving Staff Engagement	Staff are involved in decisions which affect their work; Staff are able to make improvements happen in their place of work; managers ask for staff opinions before making decisions that affect their work.	√	Ensure that staff at all levels are able to contribute to QIS work in their own areas;	All Heads of Service All Ward and Team Managers	Q3	Staff are actively encouraged to contribute to QIS work in their own areas and there have been numerous events across the Locality to provide opportunities for this to happen. We are also refreshing the Locality's QIS Report Out in order to allow higher numbers of staff to attend and encourage engagement with QIS work.
				Continue to use Daily Lean Management to pick up any issues or concerns quickly and take appropriate action to address.	All Heads of Service All Ward and Team Managers	Q3	DLM processes are well embedded across all services and managers are able to act quickly on any issues or concerns raised.
				Embed a robust process for supervision in order that staff have opportunities to discuss such decisions/improvements in their work area	Head of Nursing	Q3	Work is ongoing with good progress made but further improvements are required. A number of wards have introduced a supervision VCB which has been helpful and there are plans to roll-out to other areas.
				Continue to ensure that staff are involved in business planning processes	Director of Operations All Heads of Service	Q3	During 2017, we widened out opportunities for staff to engage. A number of pop-up events were held across D&D sites and there were 2 Locality-wide events held which were open to all staff to attend and be involved in the business planning process.
2	Safe Staffing	Staff have the necessary resources to do their job; there are enough staff to do the job properly.	√	Continue to monitor and report on Safe Staffing metrics for the Locality and take appropriate corrective actions;	Director of Operations Head of Nursing All Heads of Service All Modern Matrons	Q2	All staffing issues are discussed during DLM and staff deployed to ensure safe cover across all inpatient environments. Monthly safe staffing report is received and actioned.
				Complete Hurst tool across all inpatient areas and consider outcomes;	Head of Nursing	Q2	Hurst Tool completed within all in patient wards. Clinical validation within the Trust taken place.
				Explore re use of Community Nurse Bank;	Head of Nursing	Q2	Head of Nursing has an RPIW planned for w/c 6.11.17 to consider developing a pool of staff.
				Continue to embed and improve processes in community services to allow staff to spend more time in clinical care	Director of Operations Head of Nursing All Heads of Service	Q4	PPCS work is the key driver in improving caseload management and releasing time for clinical care. PPCS work continues across all services and improvements are measured and are demonstrable.
				Continue to explore new methods for recruitment and retention of staff e.g Recruitment Fairs, Retire and Return scheme; develop the Workforce Plan for the Locality	Head of Nursing	Q2	Recruitment fairs held in various venues on nursing and AHPs. Continue to promote retire and return scheme. All band 5 posts are recruited to permanently. Draft workforce plan developed.
3	Senior Management visibility	Staff know who senior managers are; communication between staff and senior managers is effective; senior managers try to involve staff in important decisions; senior managers act on staff feedback; staff are satisfied with recognition for good work.	√	Produce and cascade a Locality 'Who's Who' for senior managers;	Operational Support Manager	Q4	There have been a number of significant changes to the Senior Management Team and further changes are imminent. As a result, we have deferred this action.
				Continue to offer opportunities for staff to be involved in QIS work	All Heads of Service All Ward and Team Managers	Q3	Staff are actively encouraged to contribute to QIS work and there have been numerous events across the Locality to provide opportunities for this to happen. We are also refreshing the Locality's QIS Report Out in order to allow higher numbers of staff to attend and encourage engagement with QIS work.
				Consider new methods to communicate and refresh Local Brief;	Director of Operations Operational Support Manager	Q4	We continue to explore new and innovative ways of communicating. The Local Brief has been refreshed and plan to review again in short term to capture new ideas.
				Consider new methods for staff to feedback;	Director of Ops Operational Support Mgr	Q4	We continue to explore new methods for staff to feedback. DLM has been a key component and we encourage staff involvement in this process.
				Consider new staff recognition schemes and assess for effectiveness	Director of Ops Operational Support Mgr	Q4	Team/Individual of the Month (awarded by LMGB) continues. We continue to explore new and innovative staff recognition schemes.
4	Health and Wellbeing	The Locality takes positive action on health and well being	√	Publicise the staff well being initiatives on a regular basis e.g. mindfulness training, staff yoga, staff walks,LRH 'boot camp' etc; as necessary.	Director of Ops Operational Support Mgr	Q2	Well-being intiatives in the locality are promoted through the locality team brief.
				Remind managers re staff stress assessments.	All Heads of Service All Locality Managers	Q2	A reminder of the value of staff stress assessments was included in Aug/Sept local brief.
				Continue to monitor sickness rates to quickly identify any potential 'hot spots' and take action	Director of Operations All Heads of Service	Q2	Sickness rates are moniored as part of Daily Lean Management and reported weekly at Heads of Services report out and OMT report out.
5	Opportunities for development	Staff are supported by their manager to receive training, learning or development and this is identified in appraisals	√	Embed a robust process for supervision in order that staff have opportunities to discuss and developmental needs on a regular basis;	Head of Nursing	Q3	Work ongoing, good progress made but further improvements are required. A number of wards have introduced a supervision VCB which has been helpful and there are plans to roll-out to other areas. QuAGs provide a monthly update on progress to LMGB.
				Continue to monitor mandatory and statutory training compliance and identify any 'hot spots' and take corrective action as necessary	Director of Operations Operational Support Manager All Heads of Service	Q3	Compliance montored weekly as part of DLM and in the HoS Report Out. Training report allows us to identify areas which are struggling and provide the support needed to make improvements.

Local Action Plan - Esates and Facilities Management
Lead: Yvonne Watson

No	Theme	Intended outcome/result	Source of Action		Action	Action owner	Target date for completion	Progress update
			Staff Survey	Staff FFT				
1	Communication with immediate managers	Encourage staff to feel they are supported by their immediate manager	√	√	Discuss at Roadshows, Team Briefs and Tool Box Talks – open conversation and sharing staff survey results	Yvonne Watson, Graham Nellis, Paul Shoulder, Brian Jarvis, Keith Legg, George Watson	Q2	Completed
2	Appraisals	Review how we deliver appraisal process for staff	√	√	Open conversation with staff regarding appraisal process via Roadshows, Tool Box Talks and appraisal	Yvonne Watson, Graham Nellis, Paul Shoulder, Brian Jarvis, Keith Legg, George Watson	Q3	Completed
					Discuss 1:1 appraisal -v- group appraisal			Completed - Agreed in 1:1 appraisal
3	Understanding the impact of presenteeism within EFM	A reduction in staff reporting for work despite feeling unwell		√	Share findings from staff survey results (Your Health, Wellbeing and Safety at Work 9d, 9e, 9g)	Yvonne Watson, Graham Nellis, Paul Shoulder, Brian Jarvis, Keith Legg, George Watson	Q4	Completed
			√	√	Explore findings from above			Completed
					Share and discuss at EFM DMT to produce action plan			Completed
					Report back to staff			Completed

Finance & Information Local Action Plan
Leads: Gillian Duffy & Sarah Gray

No	Theme	Intended outcome/result	Source of Action: Staff Survey	Action	Action owner	Target date for completion	Progress update
1	Improving Staff Engagement	Staff are involved in decisions which affect their work; Staff are able to make improvements happen in their place of work; managers ask for staff opinions before making decisions that affect their work.	√	A cross-functional working group has been established that will build on the suggestions for improvement made at the department away day. The group will develop an action plan	Working group (Information)	Q2	Group has been established with cross department representation. A draft terms of reference are in the process of being finalised.
				Ensure that staff at all levels are able to contribute to QIS work	Associate Director of Finance	Q2	New associate director of information appointed 1/10/17. A number of actions have been identified on the business plan which will be monitored by the AD.
				Continue to use Daily Lean Management to pick up any issues or concerns quickly and take appropriate action to address	Associate Director of Finance Heads of Information Heads of Service Team managers and supervisors	Q2	Huddles in place across the department along with visual display boards.
				Embed a robust process for 1:1's in order that staff have opportunities to discuss such decisions/improvements in their work area	Associate Director of Finance Heads of Information Heads of Service Team managers and supervisors	Q3	**On-going - Active** All monthly 1:1s are in diaries but further work is required to standardise approach. The department Information working group (Information Staff Forum) is taking forward this action.
				Re-measure the individual engagement survey that was undertaken as part of the cultural barometer work. This will measure the degree to which staff are involved, committed and psychologically invested in their work, their job and the Trust, and help direct action to be focused on where support is needed and those areas that need improvement.	Information Risk, Policy and Records Standards Manager	Q4	**On-going & On Target** Cultural barometer lead has met with Heads and Dept. working group to discuss approach. Planning has commenced. Currently awaiting ethical approval by Teesside University
2	Opportunities for development	Staff are supported by their manager to receive training, learning or development and this is identified in appraisals	√	Continue to monitor mandatory and statutory training compliance and take corrective action as necessary	Associate Director of Finance	Q2	Monitored through Huddles, Q2 figures 89% remedial action in place.
				Embed a robust process for 1:1's in order that staff have opportunities to discuss and developmental needs on a regular basis;	Associate Director of Finance	Q3	**On-Going - Active** All monthly 1:1s are in the diaries, but further work is required to standardise approach.
				To develop individual skills matrices to identify any gaps in training, knowledge and skills. This will be used to inform a department training plan	Heads of Information Heads of Service Team managers and supervisors	Q3	**On-going - Active** This is still outstanding, but progress has been made. The recent IM&T Governance Audit (T&A and Skills Matrix) produced various recommendations which due by 30/06/18 (18/19 Q1). Plan in place to complete by that date. This is on progress. Scoping meeting planned with heads on 5/4/18
				Ensure that those who conduct appraisals have received training in the Trust process and expected values and behaviours	Heads of Information Heads of Service Team managers and supervisors	Q2	Some appraisal training is still outstanding.
				Gather feedback from staff to identify how to improve appraisals and improve the way managers provide positive feedback to staff	Associate Director of Finance	Q4	Initial coaching training has been completed (02/02/18) to identify how we could use this to assist meeting this action. Follow up workshop planned in April.
3	Harassment bullying and abuse; raising concerns	Reduction in the number of staff experiencing harassment, bullying or abuse; Staff feel secure raising concerns	√	Raise awareness within the department of the TEWV-wide anti bullying and harassment procedure and whistleblowing/raising concerns process	Heads of Information Working group	Q3	Discussions have taken place within the group and with HR to view and comment on new Trust policy. Examples of scenarios identified. This will be taken forward to be discussed at team huddles for further ideas, then a plan developed
				Raise awareness of the Equality and Diversity champions as contact officers for bullying and harassment issues.	Heads of Information Working group	Q2	Link identified and work ongoing to promote.
				Review and analysis of DATIX information to identify themes and trends of staff experiencing harassment, bullying and abuse.	Senior managers	Q4	**On-going** Further training is scheduled for Senior Managers. After this, senior managers to determine how/what needs to be analysed.. Datix training took place on 25/01/18 within SMT meeting. A standard operating procedure has been developed and it was agreed that risks (review of Datix) would be a standard agenda item for heads meeting once a month and would be discussed in term huddles.
4	Senior Management visibility	Staff know who senior managers are; communication between staff and senior managers is effective; senior managers try to involve staff in important decisions; senior managers act on staff feedback; staff are satisfied with recognition for good work.	√	Update and cascade department organisation chart;	Business Administration Team	Q1	Completed
				Embed a series of mechanisms that enable two way communication to occur across the department at all levels	Working group	Q2	Huddles and core meetings inplace, weekly communication published.
				Determine prioritised plan of who should undertake training (process owner, sponsor, QIS for leaders, Certified leaders, observation training, QIS for admin)	Heads of Information Heads of Service Team managers and supervisors	Q2	QIS trained staff identified along with those who require training. Work underway to esbalish a baseline level of knowledge across department.
				Consider new methods for staff to feedback	Working group	Q4	Ideas box in place.
				Consider new staff recognition schemes and assess for effectiveness	Associate Director of Finance Heads of Information Heads of Service Team managers and supervisors	Q4	Started to use 'above and beyond' within weekly department communications email. This topic is also scheduled for discussion at IT Working Group meeting

Forensic Services Local Action Plan
Lead: Sue Sirrell

No	Theme	Intended outcome/result	Staff Survey	Staff FFT	Action	Action owner	Target date for completion	Progress update
1	Team effectiveness and communication	To increase staff opportunity to meet to discuss team effectiveness and achieve the team objectives.	√	√	Opportunity for clinical teams/MDT to facilitate development days.	Service Development Manager	Q4	Completed
					Incorporate within the Model Ward Project: Daily Huddles			Completed
					Staff attendance at Schwartz Rounds			Completed
2	Physical violence from patients, their relatives or other members of the public	Reduce the number of staff experiencing physical violence.	√	√	Continue the implementation of Safe Wards and PBS training.	Emma Phipps	Q2	Safe Ward updates and PBS/PAT training attendance registers.
					Implementation of the Positive Approaches Training-(PAT)	Emma Phipps	Q2	
3	Involving staff in important decision making	Staff involvement in important decisions.	√	√	Implementation of daily huddles /weekly huddles for Ward Managers	Service Development Manager & Jenny Marshall	Q4	Completed
					Incorporate within the Model Ward Project		Q4	Completed
					Team Meetings and staff development days		Q4	Completed
					Coaching conversations and use of high quality questions.		Q4	Completed
					Roll out of the Compassionate Leadership training		Q4	Completed
4	Acting on staff feedback	Senior Managers to review and act upon feedback from Staff Friends and Family	√	√	Senior Managers to review FFT feedback and narrative comments.	Ward Managers & Service Development Manager	Q3	Completed
					Discuss FFT feedback with ward teams and collaboratively		Q3	Completed
					Developed action to be taken if identified.		Q3	Completed
					Review findings of the FFT within the Creating Compassionate Care Steering Group		Q3	Completed
5	Taking action to learn from errors	Reduction in the number of errors repeated.	√	√	Innovation Event to review communication and learning lessons	Service Development Manager	Q4	Completed
6	Harassment, bullying or abuse	Reduction in the number of staff experiencing harassment, bullying or abuse.	√	√	Review and analysis of DATIX information to identify themes and trends of staff experiencing harassment, bullying and abuse.	Service Development Manager & Ward Managers	Q4	Completed
					Datix analysis findings to be reported at the Creating Compassionate Care Meeting.		Q4	Completed
					Discussion of incidents within MDT/.Ward Rounds.		Q4	Completed

HR/OD Directorate Local Action Plan 2017/2018
Lead: Various

No	Theme	Intended outcome/result	Staff Survey	Staff FFT	Action	Action owner	Target date for completion	Progress update
1	Support from within the Directorate	To enable staff to feel 'safe' to raise any concerns within the team and with their manager without the fear of reprisals. For any concerns raised to be taken seriously and dedication for such issues to be resolved/alleviated.	√	√	Deliver a Social Safeness session at the next HR Directorate Away Day.	Paul Walker Abigail Holder	Q3	Completed 30.11.17
					Offer coaching to those Directorate staff that show an interest and ask what more can be done.	Paul Walker Abigail Holder	Q3	Design team meeting took place 19.1.18, 1:1 meetings to be arranged across all 8 teams.
2	Prevention of Bullying and harassment	That staff will be more willing and confident to report incidences of bullying and harassment and other areas of concern. That the experience of staff seeking to challenge bullying and harassment will be more positive and staff will feel more supported by TEWV. That managers will feel more confident about responding to allegations of bullying and harassment and supporting staff. That there will be a noticeable increase in the number of reported allegations of bullying and harassment during 2017/18 and 2018/19 followed by a reduction in the number of allegations thereafter.	√		Develop a separate draft TEWV-wide anti bullying and harassment procedure, via the Policy Working Group, that will apply to all TEWV staff.	Nicola Rutherford	Q3	Draft Bullying and Harassment reporting and resolution procedure presented to PWG 27.04.18. Awaiting comments before going to JCC. Action to be carried over.
					Ensure that there is appropriate consultation about the draft procedure at the relevant forums.	Nicola Rutherford	Q4	Action to be carried over.
					Secure Joint Consultative Committee and Executive Management Team support for the proposed terms of the anti bullying and harassment procedure.	David Levy	Q3	Action to be carried over.
					Incorporate the key issues and requirments of the anti bullying and harassment procedure within Trust leadership and management development Programmes.	Michelle Brown	Q4	Action to be carried over.
					Design and deliver informal training sessions to staff on how to use and interpret the procedure.	Beverley Vardon-Odonkor	Q4	Action to be carried over.
3	Presenteeism	Encourage flexibility and compassion amongst the HR/OD directorate to provide a more supportive working environment. The staff survey results indicated that directorate staff feel under pressure to attend work when feeling unwell, creating presenteeism. This can be more evident in a conscentious workforce.	√		Strengthen existing processes such as appraisals and supervision to include discussions on an individual's wellbeing, performance and workload pressures. Ensuring actions are put in place to help alleviate any issues raised.	Heads of Service	Q4	Completed
					Reinforce the support mechanisms in place for staff including Occupational Health, counselling services, physiotherapy and Employee Support to ensure staff are 'well' enough to be at work.		Q4	Completed
					Hold focus groups across the Directorate to gain feedback on what support staff would benefit from in relation to presenteeism and maintaining attendance at work.	Paul Walker	Q3	Completed - focus groups facilitated 21 & 22nd November 2017
					Arrange and facilitate focus groups with registered nurses and health care assistants within the Y&S, D&D and FMH/FLD Directorates to establish contributing factors which make staff feel under pressure to attend work when feeling unwell.	Paul Walker	Q2	Completed
					From the data identify themes that could be contributing to the way staff have reported in the staff survey 2016 results.	Paul Walker	Q3	Completed
					Share findings of the focus groups with the Executive Management Team and identify what additional support can be put in place.	David Levy	Q3	Completed
					Pilot the introduction of short term reasonable adjustments, if any, in the identified hotspots for staff who are exhibiting symptoms of 'presenteeism'.	Sheila Jones	Q3	Action ceased due to lack of supporting information
					Understand from managers their intepretation of the sickness absence management procedure, if necessary provide refresh sessions on the key messages of the procedure.	Lesley Hodge	Q3	The current sickness procedure has been extended until Sept 2018 to allow time for listening events to take place across the trust, to hear from managers and staff as to how the procedure is working, what improvements can be made and any suggestions for managing absence differently. The procedure will then be updated accordingly and training sessions provided to managers on the changes.
					Include information to assist managers to recognise presenteeism and to discourage a culture of staff working when unwell within TEWV leadership and management development programmes.	Michelle Brown	Q4	Completed - restructure of appraisal process assists with this action and it is covered within the embedding values sessions.
					Explore with local higher education institutes the potential for and interest in undertaking research with TEWV into the causes of presenteeism.	David Levy	Q3	TEWV and York University are collaborating over research into the impact of 12 hour shift working upon staff and services in the York and Selby locality. The research report is expected to be completed by the end of 2018. Further research activity with York University, about manager interventions/training to support staff health and wellbeing interventions, is being considered at present.
					Work in collaboration with the Health and Wellbeing CQUIN Project Manager to further promote opportunities within the identified areas.	Russell Smith	Q3	Completed - Staff Health & Wellbeing section reguarly updated containing information e.g. Musculo-skeletal issues/physiotherapy self-help guides, mental health support. Weekly Wellbeing Wednesday messages on a whole range of different subjects.
4	Improving staff engagement across the Trust	An increase in the staff engagement indicator within the Staff Survey 2018. Improved co-ordination of TEWV staff support/engagement activities. Greater assurance that key staff experience/engagement issues are being identified, acted upon and outcomes communicated and understood.		√	Arrange and faciliate an RPIW to identify how and when to share/triangulate key staff experience/engagement information/intelligence between the Organisational Development Team and other staff support services. Agree which delegates to invite including HR staff, employee support, Union representatives, contact officers etc.	David Levy	Q3	An improvement event took place March 2018. The outcomes of the event are to be shared with the Executive Management Team and other groups within TEWV over the coming months. An information sharing forum is to be established that will assist with triangulation and help to raise awareness of staff experience through regular reporting on an anonymised basis on progress being made and any emerging themes.
					As a result of the RPIW develop a standard process for how and when to share key staff experience/engagement information and with whom whilst maintaining the confidence of those who share the information.	Michelle Brown	Q4	Action to be carried over.
					Develop electronic guidance for managers and other staff providing information about the TEWV staff engagement resources that are available.	Michelle Brown	Q3	Completed

Medical Directorate Local Action Plan
Lead: Jenny Miller

No	Theme	Intended outcome/result	Source of Action		Action	Action owner	Target date for completion	Evidence (To be retained by action owner)	Progress update
			Staff Survey	Staff FFT					
1	Bullying & Harassment	To reduce the number of people who are bullied or harassed in the workplace.	√		Undertake survey to understand what people mean by bullying and harassment. Managers to speak with staff at 1:1's. Discussions to take place at Senior Management Team.	Medical Development	Q4		Discussions took place regarding Bullying & Harrassment in the workplace, staff were signposted who to speak with if they felt they were were being bullied or harrassed at work and made aware of the Freedom to Speak Up Guardian. This was also discussed at the Team Brief to make sure all staff were aware that any reports of bullying & harrassment would be tackled.
2	Presentism	To try and help staff reduce the pressure they put on themselves to come to work when ill.	√		Managers ask staff about pressure coming back to work in return to work interviews.	Medical Development Line Managers (Bryan O'Leary, Julie Khan, Elaine Corbyn, Samantha Gavaghan, Hayley Lonsdale, Val Holmes, Emma Tootle & Dawn Carter)	Q4		When staff members have returned to work they have a RTW Meeting with their line manager and their wellbeing is discussed to ensure they are feeling fit enough to return to work.
3	Feedback/Suggestions on improving work of the Medical Development Department	Staff feel it is valuable to make suggestions in the workplace.	√	√	Introduction of suggestion box. Associate Director of Medical Development to meet with staff on a 1:1 basis to discuss feedback/suggestions to help improve work of team/department.	Associate Director of Medical Development & IIP Focus Group	Q2		Suggestions are being put forward and discussed. Associate Director of Medical Development has been meeting staff informally to discuss feedback and suggestions.
4	Team Objectives	Staff are clear about Team Objectives.	√		Staff understand the objectives of the Team. Team objectives are displayed within the Medical Development Department. Associate Director of Medical Development to meet with staff on a 1:1 basis to discuss team objectives.	Medical Development	Q3		Objectives have been discussed in Team Meetings so the Team are aware of their objectives and the Objectives of Medical Development.
5	IIP Accreditation	Staff are prepared for IIP Accreditation			Staff undertake the online assessment and are prepared to take part in interviews with IIP Assessors. Evidence is gathered ahead of IIP accreditation. Invite a member of Research & Development to attend the future IIP Focus Group meetings.	IIP Focus Group	Q2		Staff were encouraged to complete the online assessment. Staff are briefed ahead of the IIP Visit in November at Team Briefs.

Nursing & Governance Local Action Plan 2017/2018
Lead: Elizabeth Moody & Rachael Surtees

Intended outcome/result	Source of Action		Action	Action owner	Target date for completion	Progress update
	Staff Survey	Staff FFT				
Improvement in score for staff agreeing that learning and development activities helped to improve their career chances. Able to provide accurate data for staff progressing in their careers in the Directorate/Trust and external to the Trust.	√	√	Managers to ensure that conversations regarding career planning are included in appraisal processes and learning and development opportunities are identified wherever possible.	Elizabeth Moody	Q4	Group exercise undertaken at Directorate event to highlight managers awareness of action using new appraisal plus documentation need consider how this applies to staff under band 5.
			Carry out an audit of a sample of appraisal documents to establish if this is happening including where shadowing secondment opportunities have been discussed.	Elizabeth Moody	Q4	Carry over to 2018/2019 peer audit team.
			Review what training directorate staff have attended over and above mandatory training.	Elizabeth Moody	Q4	Carry over to Q1 18/19 team managers to complete proforma.
			Talent management conversations to continue.	Elizabeth Moody	Q4	From April 2018 all appraisals undertaken using new appraisal plus paperwork will included this
			Identify staff turnover in the Directorate and where staff are moving to/ from.	Elizabeth Moody	Q4	Carry over to Q1 2018/2019 liaise with HR.
			Line managers to access coaching training to support teams in their own development.	Elizabeth Moody	Q4	Training sessions held at 2 directorate events, indiviual support given to teams, Nursing and Governance rep trained as think on coach and all teams submitted umbrella goals
Reduce the % of staff who report personally experiencing harassment bullying or abuse at work.	√		All managers to revisit Trust values and behaviours with their teams and document this in team meeting minutes.	Elizabeth Moody	Q3	Values and Behaviours discussed as part of the appraisal process and also revisited during supervision. Discussed as
			All staff to consider methods of communicating with each other is e-mail always the best can we have more conversations.	Elizabeth Moody	Q3	Regular meetings encourage staff to meet and discuss issues face to face. Staff are encouraged to speak by phone where possible for a more prompt, personal response.
			Information regarding the range of staff support processes that are available in the Trust to be publicised.	Elizabeth Moody	Q3	Staff made aware of support services and where to access. Support services all discussed as part of the Return To work procedure.
Reduce the number of staff working extra hours.	√		Use of Huddles and DLM to review workloads and identify pressure points in teams and increase support where appropriate.	Elizabeth Moody	Q3	Regular meetings are held ie. huddles/weekly report outs and monthly team meetings.Teams arrange special huddles for times of increased pressure.Flexi is discussed monthly as part of 1:1 to ensure work loads are managed correctly and extra work can be shared by the team also.
			All Managers to identify QIS opportunities to reduce waste and time spent on non-value added activities/processes in teams	Elizabeth Moody	Q3	All team members are encouraged to attend QIS. One team developing Trustwide survey to determine if processes we use are effective. • Annual review of standard work. • Constantly using the principles when developing and reviewing processes. • Plan to obtain feedback from key stakeholders on the service we provide. Kaizan events to manage In touch pages.

Teesside MHSOP Local Action Plan 2017
Lead: Ruth Harris

No	Theme	Intended outcome/result	Source of Action			Action	Action owner	Target date for completion	Progress update
			IIP	Staff Survey	Staff FFT				
Violence, Bullying and Harassment									
1	Violence	To improve the number of colleagues reporting most recent experience of violence	√	√		Current Daily Management Huddle will identify any staff related incidents whereby Violence and Aggression has been a factor. These incidents will trigger a datix report and evidence of Datix number will be collated from Daily Huddle report	Modern Matron	Ongoing	Incidents captured on a daily basis and reviewed. Incidents and corresponding Datix are reviewed at QUAG and action planning sub-group on monthly basis.
2	Bullying and Harassment	Increase the reporting of most recent experience of harassment, bullying or abuse	√	√		All areas will have an identifed area for staff to access Health and Wellbeing information to increase the visabilty of Employee Support services, information, posters and relevant contact information.	Ward and Team Managers	Q2	Team managers have been requested to evidence the areas they have identified for their team. A hyperlink has been provided for easy access.
						All staff information areas will display a copy of Trust Values and Behaviours and Staff Compact and signpost staff to the Grievance procedure.	Ward and Team Managers	Q2	The Trust values and compact are visable on each PC and have also been displayed in all areas.
3	Violence	To reduce the number of staff experiencing physical violence from patients, relatives or the public in last 12 months	√	√		Ensure all staff who have been employed for 12 months or more will be compliant for PAT training. Ward and Team Managers will report complaince against this target via reports to QUAG	Team/Ward Manager	Monthly ongoing	Current achievement rate is at 73%, reduced from Q1. There has been intake of new staff and high rate of sickness which can acccount for out of date training. Continues to be
						Evaluation of the impact of the Behaviour Support Plans on Organic Ward in reducing incidents relating to violence and aggression. To embed the roll out of the Fuctional Care Pathway which includes the Behaviours that Challenge CLIP	GFJ/ET/KS	Q3	Audit planned to explore % of patients who had a behaviour support plan in place when they experienced a restrictive incident. Planning meeting week commencing 23rd April.
Presenteeism									
4	Health and Wellbeing	To reduce the number of staff reporting thay they do additional unpaid hours per week, over and above contracted hours	√			To consider the phased introduction of a shorter shift system on the Organic In-Patient Wards - to evaluate the impact on efficiency and effectivness of working time.	Modern Matron/Ward manger	ongoing	Mixture of shifts available and flexible working requests are being reviewed in line with policy. There is no plan to introduce shorter shift system at this present time.
						Ensure a 100% staff in MHSOP will meet the minimum standards for clinical and managerial supervision. A randon sample of supervision record will be undertaken to establish to evaluate this.	Modern Matron	Q2	Supervision is monitored against trust policy on a monthly basis, standard item on QUAG.
						100% of staff will be asked about their general wellbeing in the supervision and this will be recorded in the supervison. This will be audited.	Supervisors	Q2	Supervision template is prepopulated and during 1:1 all staff's wellbeing is considered during process.
						Evaluation of the Band 4 Community Services role and impact on service provision.	Head of Nursing/locality manager	Q3	Evaluation planned for Q1 2018-19
						To hold an RPIW that will look to reduce the current time required to input assessment and reviews on the PARIS system.	Alison Cook	Q3	This has been completed and implemented in all community teams. The RPIW has reduced recording times, decreased pressure on staff and staff feedback has been very positive - This RPIW is being presented at trust wide report out on February 26th
						Promoting the concept and Value of Mindfullness training and skills development to staff via staff information areas.	Ward manager/team lead	Q2	Mindfulness dates are updated on Intranet and made available. Leaflet displayed and made available to staff.
						Evaluation of the impact of phase one of the purposeful and productive community Service - relating to diary management, workloads and job planning.	Locality Managers/Service Managers	Q2	All CMHTs have been assessed against products and progression. Phase 2 underway.
						PIpA refresh to be undertaken and rolled out to in patient services	Modern Matron	Q4	PIpA – Roll out to Westerdale North planned to be completed by 31st May 2018. This involves 2 x training days. Westerdale South the implementation is ongoing. We have planned some training for new starters including new members of the leadership team.
5	Health and wellbeing	To decrease the percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves		√		100% of staff will be asked about their general wellbeing within managerial or clinical supervison.	Team/Ward Managers	ongoing	Supervision template is prepopulated within wellbeing question. Current organisational change process is capturing staff wellbeing in informal 1:1 sessions.
						100% of staff returning to work will have a return to work interview documented.	Team/Ward Managers	ongoing	Return to work interviews are completed. HR to audit against sickness management procedure.
						To raise awareness of stress management and resilience training across staffing groups and evaluate the % of staff who have accessed this training in 2017.	Team/Ward Managers	Q4	Staff Engagement Team are working in partnership with the Staff Experience Lead to identify teams that may benefit from some support using the results of the Staff FFT. This includes providing workshops on wellbeing, resilience and stress.
Errors & Incidents									
6	Errors and incidents	To improve upon reporting errors, near misses or incidents witnessed in the last month		√		Monitor via Modern Matrons Daily Huddle Teleconference	Modern Matron	ongoing	This process is in place and being monitored daily and monthly.
7	Errors and incidents	To promote a culture of fairness and effectiveness of procedures for reporting errors, near misses and incidents		√		Regular group supervision is to be introduced on in-patient wards to allow for discussion and peer support in regards to incidents and lessons learnt. This will also ensure debriefs are carried out at an appropriate time when an incident has occurred and are seen as safe and supportive forum for staff. Working in collaboration and with Force Reduction Model	Modern Matron	Q2	Has commenced and de-brief templates have been provided to support and assist staff.
Staff Engagement									
8	Job Satisfaction	To increase Staff satisfaction with level of responsibility and involvement	√	√	√	100% of staff will have a SMART appraisal linked to Organisation and Directorate Business goals, in addition to personal objectives.	All Managers/team leads	Q4	Appraisal rates monitored weekly. New training programme introduced in 2016 to support staff to complete meaningful appraisals.
						Review attendance over the last 12 months at Quality Improvement events to understand if this a fair representation of staffing groups within MHSOP.	Locality Managers	Q3	There is evidence of staff attending from all levels to PARIS, Admin and ICLS RPIWs in first two quarters.
9	Job Satisfaction	To increase Staff satisfaction with resourcing and support	√	√	√	Continue to use and evaluate data from thr adapted Hurst tool to evaluate staffing and workload information. Consider the potential for staff to access a workshop on "developing personal and team resilience"	Ward managers	ongoing	Staffing/roster meetings are carried out monthly to ensure forward planning. Daily discussion ensures unforeseen circumstances and clinical demand can be met.

Teesside AMH Local Action Plan 2017
Lead: Deborah Masterman

No	Theme	Intended outcome/result	Source	Action	Action owner	Target date for completion	Progress update
			Staff Survey				
1	**Health Wellbeing and safety at work**: ensure staff involved in errors are treat fairly	All those involved in errors at work feel like they have been treat fairly and that all staff are informed that that the process of incident review should be open, honest and transparent as outlined in the Incident Review policy	√	Managers to ensure Incident reporting policy is adhered to and staff members are encouraged to report incidents	Team/Ward Managers - via Assistant Locality Managers	Q2 - ongoing	Incidents are reported and are discussed during daily huddles/supervision and supercell. Locality governance reporting takes place - QUAG.
				Members of staff to discuss errors openly as part of supervision processes and adhoc support meetings and managers to treat individuals fairly with respect	Team/Ward Managers - via Assistant Locality Managers	Ongoing action	Completed
2	**Health Wellbeing and safety at work:** staff experiencing harrassment, bullying or abuse from patients/service users their relatives or members of the public	Reduce the occurrence of harrassment, bullying or abuse from patients/service users their realtives or members of the public	√	Staff members to ensure expectations of conduct from patients/service users and relatives or members of the public are discussed with patients and their carers when there is an issue	Team/Ward Managers - via Assistant Locality Managers	Ongoing action	"Visiting our premises" posters are visible in all consultation rooms and reception areas. "What we expect from you and what you expect from us – leaflet handed out to new clients – this is currently being developed by Stockton ADT team – to be signed off at QUAG All occurrences of incidents of this nature are brought to Supercell for discussion and escalation if necessary
				Occurences of incidents of this nature to be raised within management structures to enable mitigation actions to be taken			
				Where appropriate seek support from Trust Security Lead or outside agencies e.g. Police			
3	**Health Wellbeing and safety at work:** staff experiencing discrimination from patients/service users their relatives or members of the public	Reduce the occurrence of discrimination from patients/service users their relatives or members of the public	√	Staff members to ensure expectations of conduct from patients/service users and relatives or members of the public are clear	Team/Ward Managers - via Assistant Locality Managers	Ongoing action	Completed
				Occurences of incidents of this nature to be raised within management structures to enable mitigation actions to be taken			
				Where appropriate seek support from Trust Security Lead or outside agencies e.g. Police			
4	**Health Wellbeing and safety at work**: staff treated fairly in terms of career progression	Ensure all members of staff have, where required, discussions within managerial supervision and their Personal Development aspirations regarding their career progression	√	Managers to ensure career progression aspirations are discussed as part of supervision and to have talent management conversations where applicable	Team/Ward Managers - via Assistant Locality Managers	Discussions with staff members by end September and ongoing action	IIC reports detailing completed supervision and appraisals The localities use the Trust's Talent Management approach to identify staff with potential to grow into leadership roles.
				Ensure training is considered as part of an individuals' career progression where appropriate			
				Recruitment and selection processes utilised for all appointments to ensure fair selection of an individual	Appointing Officers	Ongoing	Values based recruitment framework used New appointing officers are trained in recruitment and selection best practice Service Users/Carers are involved in an increasing number of recruitment processes

York & Selby Local Action Plan 2017
Lead: Carol Redmond

No	Theme	Intended outcome/result	Source of Action			Action	Action owner	Target date for completion	Progress update
			IIP	Staff Survey	Staff FFT				
Overarching York and Selby Locality									
1	Staff feel they have adequate equipment to do their work	Staff feel they have the right equipment to do their job and feel confident in using it		√	√	Survey to identify what equipment people feel they need to do their job better and also identify any training needs to use the equipment to maximum effect.	Assistant Locality Manager MHSOP	Q2	Completed
						Training programme to be developed to train staff on use of all equipment as identified from the aforementioned survey		Q3	Completed
2	Communication between staff and senior management is effective and staff know who the senior managers are	Staff to be more familiar with the management team and therefore more readily able to approach them		√	√	Devise/update locality management chart with staff photos, to include TM/CD/Assistant locality managers/modern matrons/service managers/HoS/DOO	HoS	Q3	Completed
						Develop an organisational chart of all corporate staff supporting Y&S locality	HoS	Q3	Completed
						Develop a monthly newsletter, sharing positive stories as well as key messages from LMGB and QUAGS.Each Speciality to have a link person to update on a monthly basis. Newsletter to be circulated 2 weeks after LMGB	Assistant Locality Manager/ Locality Support Manager	Q2	Ongoing distribution of newsletters. Completed
Learning Disability Services									
3	Staff feel Trust response to errors is not fair and there is no feedback	Staff to feel confident that any reported errors are dealt with fairly and transparently and they will receive a response	√	√	√	Reflective practice sessions to include review of incidents ad errors	Team Managers	Q3	Ongoing run by Consultant Psychologist. Completed
		To see increase in staff response that errors are treated fairly				Staff meetings to include review of datix reports with opportunity for learning	Team Managers	Q3	Completed
4	Staff experience physical violence from service users	Improved responses in staff FFT				Ensure all staff are up to date with PAT 2 training	Team Managers	Q2	Now at 91% - only outstanding staff are on LTS
		Less incidents reported				Ensure all staff have received harm minimisation training	Team Managers	Q3	This is at 96%
						Ensure PBS pathway is used in inpatient setting	Consultant Psychologist	Q3	Ongoing work with PBS champion and Consultant Psychologist. Completed
						Identify PBS champion on ward.	Team Managers	Q2	Completed
						Introduce regular incident reviews via team meetings	Team Managers	Q3	Completed
Mental Health Services for Older People									
5	Communication between senior management and staff as effective	Senior managers are more visible to staff and communication is more effective.		√	√	All members of the locality senior management team (Head of Service, Locality Manager, Modern Matron and Assistant Locality Manager) will carry out a Gemba visit to each teams/wards at least 8 times per year. The feedback will be shared live following the visit with the team/ward and discussed in the report out.	HoS	Q4	Gemba walks are continuing according to a planned schedules across both Inpatient and Community Services.
6	Organisation definitely takes positive action on health and well being	All staff have an increased awareness of the health and well being support that is available				A one page guide to all health and well being support that is available is developed and circulated to all staff and a copy displayed in each ward and team office.	Assistant Locality Manager	Q2	Poster has been developed and circulated for display in all MHSOP wards and teams.
Adult Mental Health Services									
7	Senior Managers to be more visible on the Gemba across all teams and wards.	Improve related responses in the 2017 Staff Survey results and Staff FFT results.		√	√	Diary Management schedule of team/ward visits from Hos and Locality Managers.	HoS and Locality Managers supported by Admin	Q4	Completed
		Improved related feedback in the next IiP accreditation.				Senior Management attendance at Huddles/report outs and/or team meetings to discuss work demands and engage in coaching conversation opportunities.			Completed
						Leadership Teams presence on Gemba offering coaching conversations for improvement	Leadership Teams	Q4	Completed
8	To reduce the numbers of staff suffering from work related stress	Improve related responses in the 2017 Staff Survey results and Staff FFT results.		√	√	Human Resource representative to monitor any trends reported to HR and feedback to Senior Leadership Team	HR Manager	Q4	Completed
9	Support managers and staff to deal with high pressure/work-load demands placed on them	Improve related responses in the 2017 Staff Survey results and Staff FFT results.				Development of the B7 management and leadership passport pilot.	Debi Whalen – OD	Q3	Completed
						Improve use if IIC	Mick Batters	Q4	Completed-ongoing
						Review of Clinical /Management Supervision across teams and wards.	Locality Psychology Lead/Head of Nursing	Q3	Clinical supervision audit undertaken locality.
						Increase uptake of reflective supervision	Locality Psychology Lead/Head of Nursing	Q4	Completed
						Continue to roll out new appraisal process with reflective learning	Managers	Q4	Completed
Child and Adolescent Mental Health Services									
10	Staff feel they are able to manage their competing demands and have enough capacity in the service to deliver high quality services	Improved related feedback in the next IiP accreditation		√	√	Roll out of job plans, supported by caseload management supervision to understand C&D issues	Team Managers and HoS	Q3	Some changes have been made to staff's original job planning based on their experiences and level of satisfaction. Job plans have been adapted in accordance to staff preferences.
		Capacity and demand work to be better understood, with clear expectation from commissioners on realistic delivery model					Team Managers	Q4	Completed

Communication, Planning & Performance Directorate Local Action Plan 2017
Lead: Julie Jones

No	Theme	Intended outcome/result	Source of Action: Staff FFT	Action	Action owner	Target date for completion	Progress update
1	Staff Survey: Reduce pressures on staff to work excessive unpaid hours by improving focus / tasking on core work (i.e. to improve understanding across organisation of each team's focus and what we should not be asked to assist with)	Develop specificationn for Planning and Business Development team	√	P&BD specification tested against expecations of EMT, Chief Exec, COO, Directors of Operations	Chris Lanigan	Q3	This work has been delayed. An initial specification was produced, based on the previous team prospectus, but prior to taking this to OMT & EMT further work needs to be done by team to capture different use of P&BD resource in different localities and the reasons. This work is taking place in April and May 2018.
		Test specification for Planning and Business Development team					Carry over 2018/2019
		Approval received for P&BD team specification		Director of PP&C approves team specification	Chris Lanigan	Q4	Carry over 2018/2019
		Dissemination of P&BD team specification		New specification distributed to all EMT members and Heads of Service. Other activities as per Comms Plan	Chris Lanigan	Q4	Carry over 2018/2019
		Develop specificationn for Corporate Performance team role		CPT team specification developed	Sarah Theobald	Q3	Drafted - Carry over 2018/2019
		Share the specifications with EMT and obtain agreement on them		Specs discussed with EMT and EMT signed up to them	Sharon Pickering		Unable to progress due to delays in the Planning team element of this work. Carry over 2018/2019
2	Staff Survey: Feel my role makes a difference to patients and the services	Brief a joint meeting of the Planning and Comms teams on the outcomes and outputs of the pre-engagemetn Kaizen event and emphasise the role of both teams in supporting co-produiction of service-users in solution generation and the postiive impacts this has on recovery.	√	P&BD / Comms joint meeting on outputs of engagement Kaizen held	Julie Jones / Chris Lanigan	Q3	Completed
		Encourage the "committees" who develop Team Development Day agendas to put in items that increase understanding of front line services and our role in supporting these		At least one "front-line" related item in each Team Development Day			Examples of front-line services who have presented at PP&C Directorate events include: -A weight of your mind (including service user perspective; - Recovery/ppper support -CAMHS crisis and intensive home treatment team -Autism strategy prison mental health teams' role
		Review the use of protected time to support engagement with and learning of clinical services: • Individual to consider and raise in quarterly supervision • Manager to prompt in q'ly supervision meeting for consideration		1:1 paperwork to be reviewed and updated	Kassie Greenwood	Q2	Completed
		Review the induction process to include awareness of the clinical services		Induction checklist and file reviewed and refreshed	Kassie Greenwood	Q2	Completed
		Improve feedback from services to understand better how the work of the performance lead has made a difference		Action plan to be produced to capture identified improvements	Penny Pinder	Q2	Completed
		Improve the process to set team away day agenda to strengthen focus on patient / carer / clinical services		Recommendations from review to be agreed by SMT	Kassie Greenwood	Q2	Completed
3	Pressure to work additional hours	Review huddle process to improve effectiveness	√	Currently within CPT business plan		Q2	Completed
		Consider the appropriateness of challenges to commissioners in relation to narrative / detail / feedback required		Process agreed with HOCP in relation to agreeing deadlines for non routine information requests from commisisoners	Allison Bowery	Q2	Completed
		Review QIS timescales and improve management of extra workload		Currently within CPT business plan - To monitor the Quality improvement work within the team	Allison Bowery/Ashleigh Lyons/Victoria Reed	Q1	Completed
		Review home working arrangements to support staff wellbeing		Guidance relating to home working in CPT be produced	Allison Bowery/Ashleigh Lyons/Victoria Reed	Q2	This has been superceded by departmental guidance
		Review processes to ensure we capture issues that may cause staff to feel pressure to work when ill		Pressures to routinely discussed in 1:1's, daily huddles and return to work interviews	Allison Bowery/Ashleigh Lyons/Victoria Reed	Q1	Completed
4	Staff Survey: Feel my role makes a difference to patients and the services	Produce standard work for process for taking on work to support services (to ensure that we're taking on work that adds value) to include mechanisms for escalation	√	standard work in place	Angie Binns	Q3	This will now form part of 2018/19 business priority.
5	Staff Survey: Feel my role makes a difference to patients and the services	Develop proposal for revised raising concerns process (to promote more appropriate use of the mechanism) and submit to EMT		Proposal submitted to EMT for consideration	Julie Jones	Q3	Further discussion planned with chief exec in Q1. Carry over 2018/19

North Yorkshire Local Action Plan 2017
Leads: Belinda Goode MHSOP, Carla Pawson & Bridget Lentell LD, Liz Herring AMH

No	Theme	Intended outcome/result	Source of Action		Action	Action owner	Target date for completion	Progress update
			Staff Survey	Staff FFT				
1	Prevention of bullying and harassment	Encourage more staff to report harassment, bullying or abuse when it happens	√		To raise the issue within Team meetings and ensure staff are aware of support mechanisms within the trust as and when required.	LD Team managers	Q1	June 2017, on-going agenda item. No incidents reported to date.
					To discuss in management supervision sessions	LD Team managers	Q1	
2	Physical Violence	Reduce the number of staff experiencing physical violence from patients, relatives or the public		√	Staff aware of reporting mechanisms (Datix) and then ties into answer above re staff been informed of staff support mechanisms as required.	LD Team managers	Q1	Staff FFT results have declined, action plan developed to support staff.
		Increase the proportion of staff who report errors, near misses or incidents that they witness		√	Ensure that staff are aware of the reporting mechanism and are advised of importance regarding capturing near miss and error to enable learning across the wider trust.	LD Team managers	Q2	
3	Work related stress	Continue to reduce the numbers of staff suffering from work related stress	√	√	To complete individual stress assessments as required if staff are reporting increased stress and to consider support mechanisms in trust and within teams.	LD Team managers	ongoing	
					To consider team building exercises - linked with OD team as required	HoS/ Service manager/ Team managers	ongoing	AMH - OD days have been held with Harroigate & Ryedale teams with action plans arising form the days. Team manager resilience days taken place along with additional master coach support.
4	Work load pressures	Support managers and staff to deal with high pressure/work-load demands placed on them	√		For staff to be supported in developing improved skills in relation to time/ case management/ for teams to consider service demand and ensure any increased demand is reported via QUAG/ Business meetings so it can be escalated as required and if necessary to consider developing business cases	All staff	Q4	AMH - issue log reflecting teams with recruitment challenges. 'Stop the Clock' days being encouraged to support staff manage workload and Paris activity. requirements. Organisational development supporting Harrogate and Ryedale teams. Resilience workshops planned for all staff within AMH.
					Consider need for some externally facilitated sessions regarding time/ diary management	HoS/ Service Manager	Q3	Listening sessions havce been held for SWR with North Yorkshire County Council staff. Locality leads have held time out sessions with their managers to support them through change within service.
5	Senior management visability	Ensure that members of the senior management team continue to be visible in the workplace/around the Trust	√		For HoS and Service Manager to have a regular attendance at team bases and attend team meetings to allow opportunity for teams to ask questions in an open forum.	HoS/ Service Manager	Q1-Q4	AMH - additional monthly listening events have been held in each locality each month. With the support of the director of operations and head of service Harrogate is being supported with some time out to think about the way the system operates to understand the pressures and a future change programme initiated by the CCG and the organisation.
					For Team leadership team to be visible and supportive in relation to teams and meeting the demands placed upon them – to lead from the front and encourage a 'can do positive attitude' to any forthcoming challenges.	Whole/ LD team manager team	Q1-Q4	

ITEM NO 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday, 22 May 2018**
TITLE:	**Report of the Mental Health Legislation Committee**
REPORT OF:	**Richard Simpson, Non-Executive Director**
REPORT FOR:	**Assurance/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:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 4, 2017-18.

- **Key areas for consideration:**
- Report on Discharges from Detention, use of Section 136, Section 15 – medical scrutiny element.
- Review of the scheme of delegation in relation to assurance to the Committee
- Seclusion activity report
- CQC MHA specific inspections summary report
- Schedule of audit reports and approval and monitoring of Code of Practice required policies.
- Report on MCA and DoLS update and activity
- Annual Committee performance assessment results 2017/18
- Partnership Working
- Response to Department of Health re: Mental Health Act Review
- Patient case study

Recommendations:

The Board of Directors is asked to:

i) Receive and note the assurance report, following the MHLC meeting held on 19 April 2018 and to note the approved minutes of the MHLC meeting held on 26 February 2018. (Annex 1)

ii) Confirm the Scheme of Delegation in respect of the MHA 1983.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 22 May 2018**
TITLE:	**Report of the Mental Health Legislation Committee**

1. INTRODUCTION & PURPOSE:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for Quarter 4, 2017-18; through consideration of the work of the Mental Health Legislation Committee at its meeting held on 19 April 2018.

2. BACKGROUND INFORMATION AND CONTEXT:

The Mental Health Legislation Committee has been established as a formal Committee of the Board of Directors under the Constitution.

The Terms of Reference of the MHLC require the minutes of its meetings to be formally presented to the Board.

3. KEY ISSUES:

The confirmed minutes of the Mental Health Legislation Committee held on 26 February 2018 are attached as Annex 1.

The MHLC also met on 19 April 2018. The key issues considered at this meeting were as follows:

COMPLIANCE WITH MHA PROCESSES

3.1 Discharges Report

The Committee considered the Discharges report.

- In Quarter 4 there were 156 Associate Hospital Managers reviews held which resulted in two patients being discharged from the MHA. One patient was discharged from section three, where the panel did not feel the patient was likely to be dangerous and one from a CTO.

- The total number of Mental Health Tribunals held in Quarter 4 was 117, of the MHTs held, seven resulted in discharge, four from section, one on section three, one conditional discharge and one discharge from a Community Treatment Order (CTO).

The Committee was assured that there were no trends identified in relation to RC or team where a MHT discharges contrary to the clinical view of the team and that patients were being safeguarded appropriately, which can be seen by patients exercising their rights and the number of tribunals held.

3.2 Section 136 Report

The Committee considered data and trends around s136.

- There were 180 uses of s136 across the Trust compared to 153 in the previous quarter. There have been increases for York (34 to 48) and Durham (16 to 34).
- Of those, 46 people were formally detained and 24 accepted informal admissions (compared to 16 in the last quarter).

  The Committee requested some further consideration for the reasons for the increase of Section 136 use at the Operational Group meeting for York and North Yorkshire at its next meeting to be held in May 2018 and to ensure that there will be appropriate Trust operational representation attending this group.

- There were three people taken to a police place of safety, one of which was due to the fact that both Scarborough and York PoS was full.

  The Committee requested further clarification on the escalation processes relating to Section136 arrangements and that information be included in future reports on individuals waiting more than 12 hours to gain more understanding around the issues, which could be around issues such as bed availability and/or waiting for a Doctor.

- There were eight individuals under the age of 18 years of age held under section 136, all aged 16, one lasting for just over 20 hours due to being too unwell to be assessed as they had taken an overdose. The Committee received assurance that this time period included treatment at an Acute Hospital.

3.3 **Section 15 MHA 1983 – Medical Scrutiny Element**

The Committee considered for the first time a report on Section 15 MHA 1983.

- The report will provide information on Section 15 of the Mental Health Act and assurance that the Trust is compliant with the requirements of the Act. One of the main purposes of providing this report to the Committee will be to provide assurance with regard to the medical scrutiny element of Section 15 MHA.

- The Committee agreed that this information will report to the MHL Committee on an annual basis and a presentation will be given at the Senior Medical Staff Committee around the process to escalate by exception for a senior clinician to overrule medical scrutiny.

3.4 **Mental Health Legislation Committee - Scheme of Delegation**

The Committee reviewed the Scheme of Delegation in respect of the MHA 1983, in accordance with its terms of reference.

The Committee agreed that the following areas will be reported to the Committee in future to provide further levels of assurance.

Section 5(2)	Receipt of documents – in respect of holding powers - Staff authorising inpatient detention for up to 72 hours.
Section 5(4)	Record of hospital inpatient – power to detain an inpatient for a maximum of six hours. (Form H2)

Section 23 (2)(a)	Receipt of nearest relative order for discharge – nearest relative must give 72 hours' notice of their intention to discharge.
Section 18	Patients absent without leave.
Section 132	Information to patients – duty of hospital managers to give information to detained patients.

It was acknowledged by members of the Committee that these areas will provide improved scrutiny and assurance, by answering the high quality question, "How does the Trust demonstrate compliance with MHA processes?"

The Board is asked to confirm the Scheme of Delegation in respect of the MHA 1983. (Attached as Annex 2)

COMPLIANCE WITH KEY CODE OF PRACTICE REQUIREMENTS

3.5 Seclusion Report

The Committee discussed the seclusion report.

- In Q4 there were 83 episodes of seclusion with multiple episodes for 15 patients. Of the 83 episodes, 39 were less than 24 hour, of which 24 were under 12 hours.

- An exception has been reported regarding a patient in their bedroom due to the lack of a seclusion room; efforts were made to move the patient to PICU however this was refused by staff as the patient was not detained under section 2 or section 3 (the patient was sectioned under Section 5(2)). The seclusion lasted just over 3 hours.

- An exception was reported where staff used "flexible seclusion" for a time for a patient who had been in seclusion for some weeks. The plan was that if the patient demonstrated settled behaviour for a 24 hour period they would be allowed out of seclusion but with the option to return them if needed. The patient came out of the seclusion and commenced "flexible seclusion" on 6 April 2018. No returns to seclusion recorded. Seclusion ended on 09 April 2018.

3.6 CQC MHA Visits Feedback Summary Report

The Committee considered the CQC MHA Visits Feedback report**.**

- There were eleven visits to the Trust in Quarter 4 with 28 issues raised in the inspection feedback summaries. The review of the themes raised following visits continues to raise similar issues as in previous inspections and these are included in monthly reports to QuAGs and quarterly reports presented to LMGBs.

- The top five key issues identified during inspection are:

    1. Issues with Capacity assessments/consent (raised 6 times)
    2. Issues with Care plans (raised 6 times)
    3. Issues with Section 17 leave forms (raised 3 times)
    4. Issues with MHA section forms (raised 3 times)
    5. Issues with Patient's rights (raised 3 times)

- The Medical Director agreed to disseminate a bulletin for the medical workforce to include the key messages and a thematic review in preparation for the CQC visits.

3.7 **Schedule of Audit Reports to MHLC**

The Committee considered a risk based internal audit on compliance with the Mental Health Act and Code of Practice.

The key matters to note are:

- This audit looks at the overall arrangements and assurance mechanisms that the Trust has in place to ensure compliance with the MH Act.
- The audit links to risk ref. 369 of the Integrated Assurance Framework and Risk Register: "we could be subject to regulatory action and suffer reputational damage if it fails to comply with national targets and standards".
- The audit concluded that: Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. A high level of compliance with the control framework was found to be taking place.

The Committee agreed that to provide assurance on the effectiveness of controls around any relevant audits that a report will go to the MHL Committee when required. An audit around seclusion will be the next audit report to go to the Committee.

3.8 Code of Practice Policies

The Committee agreed that following any review of MH Act and Code of Practice policies that a report will be submitted to the MHL Committee.

EFFECTIVE IMPLEMENTATION OF THE MCA AND DOLS

3.9 Mental Capacity Act and DoLS Report

The Committee noted the quarterly update report on the key issues with regards to the effective implementation of the Mental Capacity Act within the Trust and the use of DoLS.

The key matters discussed were:

- There have been 20 MCA champions successfully trained who will be assessed against national capabilities with set competencies to achieve prior to receiving their 'champion status'.
- Following the introduction of MCA mandatory training in April 2018, the updated MCA1/2 forms were being uploaded onto Paris and would be linked with e-learning and available on In touch. DoLS was also now being recorded in Paris.
- In terms of DoLS activity, in Q4 there were 70 currently active, the majority of which were in LD respite services with 16 new requests.

KEY GOVERNANCE INFORMATION

4.0 Annual Committee Performance Results

The Committee discussed the annual performance results for 2017/18.

Overall there has been a decline in score for 8 of the 20 questions and an improvement of 8, which members felt was a balanced view.

The Committee has undergone an overall review in the last year, including a re-look at the agenda, reports provided and the levels of assurance and exceptions.

A revised agenda was proposed (at the MHLC meeting of 19 April 2018) and agreed by the Committee which is framed around high quality questions, in line with CQC key lines of enquiry. Members welcomed the more robust levels of assurance going forward.

Following the review of the scheme of delegation and the inclusion of further reporting to provide assurance around the MHA in the next year, members acknowledged that the MHL Committee has made significant improvements over the last six months.

PARTNERSHIP WORKING

4.1 Partnership Working Report

The Committee considered Partnership Working with regard to the MH Act 1983 and the Mental Capacity Act 2005.

The key points to note are:

- There are arrangements in place across the TEWV footprint to enable partnership working.
- The Locality Mental Health Legislation Operational Group will meet quarterly and feed into the MHLC.
- The Committee agreed that exception reports will be provided to MHLC when necessary.

HOW THE EXPERIENCES AND VIEWS OF DETAINED PATIENTS FORM PART OF THE COMMITTEES CONSIDERATIONS

4.2 Response to the Department of Health re: MHA Review Report

The Committee noted the evidence submitted by the Trust following a commissioned review in October 2017 by the Prime Minister of the Mental Health Act.

- The Trust facilitated two focus groups involving service users and carers to help culminate the response and would remain engaged with the review until its conclusion.

4.3 Case Study

The Committee noted a case study in relation to a person who had been subject to long term seclusion within a PICU.

4.4 The Committee discussed the importance of considering how the views and experiences of detained patients form part of the Committee's considerations. Going forward it was felt important to include any key or thematic feedback from MHA inspections.

5. IMPLICATIONS:

5.1 Compliance with the CQC Fundamental Standards:

CQC MHA visit reports do not indicate any significant issues with regard to compliance with the Fundamental Standards in terms of the MHA and MCA.

5.2 Financial/Value for Money:

There are no implications.

5.3 Legal and Constitutional (including the NHS Constitution):

Non-compliance with the CQC regulatory framework for the Mental Health Act and Mental Capacity Act and DoLS and/or non-compliance with the MHA or MCA itself would have serious consequences for the organisation and place the organisation at risk of breach of the conditions of the Independent Regulators or potential litigation.

5.4 Equality and Diversity:

There are no implications.

6. CONCLUSIONS:

The MHL Committee receives reports and evidence for assurance on all elements of the Mental Health Act administration and implementation, demonstrating compliance with CQC regulatory requirements. This assurance is externally supported by the feedback from the CQC Mental Health Act inspections.

The MHL Committee is currently undergoing a review of reporting mechanisms and it is anticipated that the re-structured agenda framed around high quality questions will provide a higher level of assurance.

6. RECOMMENDATIONS:

The Board of Directors is asked to:

(i) *Receive and note this report including the confirmed minutes of the meeting of the MHLC held on 26 February 2018.*
(ii) Confirm the Scheme of Delegation in respect of the MHA 1983

Richard Simpson
Chairman of the Committee

Background Papers:
Annex 1 – Confirmed minutes of the 26 February 2018 MHL Committee Meeting

Annex 2 - The Scheme of Delegation in respect of the MHA 1983

Annex 1

MINUTES OF THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 26 FEBRUARY 2018 IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30AM.

Present:
Mr R Simpson, Non-Executive Director, Chairman of the Committee
Dr N Land, Medical Director
Mrs E Moody, Director of Nursing & Governance

In Attendance:
Mrs D Oliver, Deputy Trust Secretary, (Corporate)
Miss M Wilkinson, Head of Mental Health Legislation
Mrs R Downs, Mental Health Legislation Advisor (MCA Lead)
Mrs J Ramsey, Mental Health Team Manager
Mr C Allison, Public Governor

Apologies: Apologies for absence were received from Ms S Talbot-Landon, Governor and Mr P Murphy, Non-Executive Director Mrs J Illingworth, Director of Quality Governance, Mrs L Bessant, Chairman of the Trust, Mr D Brown, Acting Chief Operating Officer, Dr A Khouja, Medical Director Designate and Mrs S Richardson, Non-Executive Director

18/01 MINUTES OF LAST MEETING

Agreed – *That the minutes of the last meeting held on 19 October 2017 be approved as a correct record and signed by the Chairman.*

Mr Simpson, on behalf of the Committee welcomed Mrs Jacqueline Ramsey, Mental Health Legislation Team Manager and Mr Cliff Allison as the second Governor representative to MHLC.

18/02 ACTION LOG

The Committee noted the actions and following updates:

17/33 Benchmarking data on seclusion:
It was noted that information had been sought on benchmarking however it would be difficult to make comparisons with other Trusts of similar size, providing complex care in adolescents and forensic services.

The Committee agreed that this would be followed up with NTW and reported back to the April 2018 MHLC meeting.

17/33 Consideration to be given to a future governor developmental day around anonymous case study in seclusion.
This had been added to the list of matters for consideration by the Governors by Mrs K Ord for future Governor Developmental days.

Completed

17/34 Formal feedback as part of CQC report to show progress on repeated themes raised in MHA inspections.
It was noted that there would be some further information around the regular issues in the CQC report with a timeline to show progress made.
This item was deferred to the 19 April 2018 MHLC meeting.

17/38 Escalate to Director level the implications for TEWV and the potential for unlawful detentions with a view to working with Beachcroft Solicitors to resolve issues. Mrs Moody highlighted that the Local Authorities had both been written to formally by Beachcroft and any subsequent responses would be addressed and any actions completed.

Completed

18/03 SECLUSION REPORT

The Committee considered and noted the Seclusion Report.

The following was highlighted from the report.

(1) In Q3 there were 82 episodes of seclusion with multiple episodes for 19 patients. Of the 82 episodes, 33 (40%) were less than 24 hours and of those, 15 of which were under 12 hours.

Assurance was provided that robust reporting mechanisms are in place for the escalation of prolonged periods of seclusion and there will be further work undertaken around reporting on IIC.

The Committee requested that future reporting around seclusion should include data with annual comparisons.

Action: Mrs J Ramsey

18/04 MHA DISCHARGES FROM DETENTION REPORT

The Committee considered and noted the MHA Discharges from Detention Report.

The following was highlighted from the report:

(1) In Quarter 3 there were 145 Associate Hospital Managers reviews held which resulted in no patients being discharged from the MHA.

(2) The total number of Mental Health Tribunals held in Quarter 3 had been 138, of the MHTs held 7 had resulted in discharge as follows, one discharged from section two, four discharged from section three (one deferred), there was one conditional discharge and one discharged from a Community Treatment Order (CTO).

There had been no trends identified in relation to RC or team where a MHT discharged.

18/05 SECTION 136 REPORT

The Committee received and noted the Section 136 report.

The following was highlighted from the report:

(1) There had been 153 uses of s136 across the Trust compared to 188 in the previous quarter. Significant decreases had been noted in Cleveland and Durham force areas and a slight increase in North Yorkshire.

(2) Of those, 42 people (44 in the last quarter) were formally detained and 16 had accepted
informal admissions (compared to 37 in the last quarter).

(3) Those taken into police custody had reduced to zero in December 2017 for all three Police areas. The changes to s136 which came into effect in December 2017 raised the criteria for the use of the police station as a place of safety.

(4) There were four individuals under the age of 18 held under section 136 one aged 15 and three aged 17, one accepted informal admission, two were formally detained and the other had been returned to the community with follow up for their current service.

(5) No s136 detention exceeded the 72 hour maximum time limit pre 11 December 2018 and none had exceeded the 24 hour maximum time limit post 11 December 2018.

(6) There had been one under 17 year old held under section 136 for just over 18 hours who had been taken to the Acute Trust emergency department due to an increased heart rate. It had been disappointing that a Section 12 Doctor was unavailable for assessment of this person until the next afternoon.

Members expressed their concerns over the delays with the assessment of the under 18 year old.

Miss Wilkinson advised that there has been reluctance for Doctors to undertake assessments without an AMHP present. The other contributory factor was the inability to identify a CAMHS bed for this individual who had eventually been transferred to Children and Young People's services three days later following initial admission to an adult ward.

Agreed: that further investigation should take place to understand the processes that were followed around this care and the Committee would be informed at its meeting to be held on 19 April 2018.

Action: Miss M Wilkinson

Following discussion it was noted that the Trust faced a serious issue with the lack of CAMHS beds for under 16 year olds both locally and nationally and there had been an instance of an under 16 year old being placed on an adult ward.

Mrs Moody advised that it would be worthwhile communicating to Directors on call information around the processes for placing under 16 year olds when there were no CAMHS beds available.

Action: Mrs E Moody

18/06 MENTAL CAPACITY ACT AND DOLS REPORT

The Committee received and noted the Mental Capacity Act and DoLS Update Report.

Arising from the report it was noted that:

(1) Further improvements had been made with recording DoLS through the Mental Health Act module in Paris, however were still some problems with interpretation and application of DoLS where the eligibility criteria was not being used properly by the Local Authorities.

Assurance was provided to the Committee that discussions had taken place with colleagues in York and North Yorkshire to improve understanding around this.

(2) In terms of DoLS activity, in Q3 there had been 16 applications made for Standard Authorisations and 13 had been granted. The remaining three were withdrawn as they had been made subject to MHA whilst awaiting DoLS assessment.
(3) There were currently 50 active DoLS cases across the Trust, most of whom were in LD respite services.

18/07 CARE QUALITY COMMISSION (MHA) VISIT FEEDBACK SUMMARY REPORT

The Committee noted the Care Quality Commission MHA visit feedback report.

The following was highlighted from the report:

(1) There had been six visits to the Trust in Quarter 3 with 30 issues raised in the inspection feedback summaries.
(2) The review of the themes raised following visits continued to raise similar issues as in previous inspections.

On this matter the Committee was assured that the Quality Compliance Group would be focusing closely on the issues raised at its next meeting.

(3) The CQC had picked up on the recording of formal capacity assessments which were not on an MCA 1 form, which on some occasions could not be found.

18/08 CASE STUDY

The Committee received and noted a case study in relation to a person who had been subject to long term seclusion within a PICU.

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18/09 POLICIES AND PROCEDURES

The Committee received and considered the following policies and procedures which had been circulated for the originally planned MHLC meeting on 18 January 2018.

- Section 135 (2) Procedure.
- Deprivation of Liberty Safeguards (DoLS) Procedure
- Deprivation of Liberty Policy
- Advance Decisions and Statements Policy.

Due to the cancellation of the 18 January 2018 meeting, members had reviewed the policies and procedures, with the opportunity for comments to be submitted to the MHL team.

There were no queries or comments on the policies and procedures.

The Committee approved the policies and procedures set out above, which would be taken to EMT for formal ratification.

18/10 CODE OF PRACTICE – SCHEME OF DELEGATION

The Committee noted that a further meeting would take place to discuss the scheme of delegation and which areas of risk and assurance would need to be taken into account, based on feedback from CQC inspections.

Action: Mrs E Moody/Miss M Wilkinson

18/11 REVIEW OF MHLC ACTIVITY AND PERFORMANCE

The Committee noted that further discussions would take place around which areas of activity and performance should be focused on for reporting, taking into account discussions around the Code of Practice and Scheme of Delegation.

Action: Mrs E Moody/Miss M Wilkinson

18/12 MOCK UP AGENDA

The Committee noted that a further meeting would take place to set out a draft agenda for the MHLC Committee to consider at its meeting to be held on 19 April 2018.

The Chairman noted that the transition work for the Committee would be a positive step forward for the overall improvement and effectiveness of the MHL Committee.

18/13 REVIEW OF ANY ISSUES THAT MIGHT IMPACT ON THE TRUST'S STRATEGIC RISKS

There were no issues raised that might impact on the Trust's strategic risks.

The Committee discussed the implications around the difficulties of sourcing a first doctor by AMHPS for assessments and the inability to find a doctor until after hours.

Dr Land noted that there was reduced medical capacity in smaller areas such as Scarborough and Harrogate and with clinical responsibilities capacity was an issue.

It was agreed that this matter should be discussed further at Director of Operations and then LMGBs.

Action: Mrs E Moody

18/14 ANY OTHER BUSINESS

The Committee considered the following matters:

(1) Department of Health Review of Mental Health Act

The Committee noted that the Trust had submitted a response to the Department of Health regarding a review of the Mental Health Act.

Miss Wilkinson highlighted the following:

(1) Two feedback sessions had been held with Service Users and Carers in response to the Department of Health request for services to facilitate this nationally.
(2) That the Trust response had been given to NHS Providers to be included with their response at their request.
(3) A preliminary report would be published sometime in the spring with a more in depth report in November 2018.

Following discussion it was noted that:

(1) Some of the issues being looked at within the review were around conveying, the use of ambulances, community treatment orders and nearest relatives and it was not necessarily about changing the MHA legislation.

The Chairman requested that a report including details on the review and response be brought to the 19 April 2018 MHLC meeting.

Action: Miss M Wilkinson

(2) Unlawful Detention

The Committee noted that there had been an unlawful detention of a young lady who had initially been transferred in from out of the area.

Miss Wilkinson drew attention to the following:

(1) The renewal of detention for the young lady had been missed following a complex transfer into TEWV.
(2) The appropriate steps to rectify the issue and regain lawful detention were taken and Duty of Candour had been complied with.
(3) The individual had been offered support to seek legal assistance if they wished.

Assurance was provided to the Committee that a review of all transfers had taken place with no further issues noted and lessons had been learned.

(3) Retirement of the Medical Director

The Chairman, on behalf of the Committee expressed thanks and appreciation to Dr Nick Land, Medical Director for all his advice and support on the Mental Health Legislation Committee and wished him well in his retirement.

The meeting concluded at 11.45pm

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Annex 2

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

SCHEME OF DELEGATION IN RESPECT OF MENTAL HEALTH ACT 1983 AS AMENDED BY THE MENTAL HEALTH ACT 2007 as per Code of Practice at 37.9

1. Functions which are to be delegated to TEWV Hospital Managers Panel

Function	Statutory Reference (1)	Code of Practice Reference	Authorised Person/s
Review of patient's detention following renewal	Section 20(3)	Chapter 38	Hospital Managers Panel
Review of patient's Community Treatment Order (CTO) following extension	Section 20A(5)	Chapter 38	Hospital Managers Panel
Review and discharge of unrestricted patients and patients subject to Community Treatment Order	Section 23	Chapter 38	Hospital Managers Panel

Sections referred to are in the Mental Health Act 1983 as amended by the Mental Health Act 2007*. Regulations are in The Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008.

* Unless otherwise stated.

2. Functions which are to be delegated to officers of TEWV and TEWV MHL Officers

Function	Statutory Reference/s(1)	Code of Practice Reference	Authorised Officer/s
Admission and detention of patients – authority to detain patients in hospital (acting on applications that appear to be duly made)	Section 6(2), (part 2 MHA) 40(1)(b),40(3)(b),45B(1)(b) (Part 3 MHA)	Chapter 37	Staff of TEWV NHS Foundation Trust
Receipt of admission documents - receipt of applications and supporting recommendations (for sections 2,3 & 4) within the specified period	Section 11 Regulation 3(2)	Chapter 35	Staff of TEWV NHS Foundation Trust (exceptionally MHL Officer)
Record of detention in hospital (for sections 2,3,4) (Form H3 part1)	Regulation 4(4)	Chapter 35	Staff of TEWV NHS Foundation Trust (exceptionally MHL Officer)
Record of hospital in patient – power to detain an in-patient for a maximum of six hours (Form H2)	Section 5(4) Regulation 4(1)(h)	Chapter 18	TEWV Nurse of the prescribed class - (Regulation 2(1) of the Mental Health

			(Nurses) (England) Order 2008 (SI 2008/1207)
Receipt of documents in respect of holding powers • Receipt of report on hospital in patient (section 5(2)) authorising detention for up to 72 hours • Receipt of record for the purposes of section 5(4)	Section 5(2) Regulation 4(1)(g)	Chapter 18 Chapter 18	Staff of TEWV NHS Foundation Trust (exceptionally MHL Officer)
Receipt of Nearest Relative Order for Discharge -Nearest Relative must give 72 hours' notice of their intention to discharge	Section 23 (2)(a)		Staff of TEWV NHS Foundation Trust (exceptionally MHL Officer)
Receipt of report barring discharge by the Nearest Relative made by RC (Form M2) – within the 72 hours above, the RC may bar the discharge of the Nearest Relative	Section 25(1)		Staff of TEWV NHS Foundation Trust (exceptionally MHL Officer)

Transfer of patients - authority for transfer of patient from one hospital to another under different managers & record of transfer (Form H4) - authority to transfer from hospital to guardianship & record of transfer (Form G6) - transfer from guardianship to hospital (record of admission to hospital) (Form G8 part 2) - transfer and assignment of responsibility for CTO patients	Section 19 Regulation 7(2)(a) & 7(3) Section 19 Regulation 7(4) Section 19 Regulation 8(2) Section 17F Regulation 9 & regulation 17	Chapter 37.16-37.27, Chapter 37.28-37.29 37.30-37.31	Staff of TEWV NHS Foundation Trust or MHL Officer Staff of TEWV NHS Foundation Trust or MHL Officer
Return of patients absent without leave – where a detained patient has left the hospital without authorised leave they may be returned	Section 18	Chapter 28	Staff of TEWV NHS Foundation Trust or any person authorised in writing by the Managers
Record of date of reception of a patient in England (admittance to hospital/CTO) (Form M1)	Regulation 15(2) & 16(2)		Staff of TEWV NHS Foundation Trust or MHL Officer
Information to patients - duty of managers of hospitals to give information to detained patients	Section 132	Chapter 4 & chapter 37	Staff of TEWV NHS Foundation Trust
Correspondence of patients - authority for hospital managers to inspect, open and withhold postal packets	Section 134(1)(a) & 131(4)	Chapter 37	Staff of TEWV NHS Foundation Trust

3. Functions which are to be delegated to MHL officers ONLY

Function	Statutory Reference/s(1)	Code of Practice Reference	Authorised Officer/s
Scrutiny of admission documents - applications & medical recommendations) for accuracy and completeness and to check that they do not contain any failure to comply with the procedural requirements of the Act in respect of applications for detention.	Section 15	Chapter 35	MHL Officer or their deputy
Rectification of admission documents – consent to have amended applications or supporting medical recommendations found to be in any way incorrect or defective - authority to reject a medical recommendation considered to be insufficient to detain	Section 15 Regulation 4(3)(a) Section 15 Regulation 4(3)(b)	Chapter 35	MHL Officer Medical Scrutiniser in conjunction with MHL Officer
Record of patients detention in hospital after recall – record made on behalf of the managers recording the date and time of the patients detention in hospital following recall (form CTO4)	Regulation 6 (3)(d)	Chapter 29.69	MHL Officer
Record of the receipt of a report for the purposes of section	Section 21B(2)(b)		MHL Officer

21B(2) (authority for detention, guardianship or community treatment after absence without leave for more than 28 days (Form H6)	Regulation 14(1)(b)		
Information to patients - duty of managers of hospitals to give information to nearest relative - provision of information to nearest relatives - duty of managers of hospitals to inform nearest relatives of discharge	Section 132 Section 132A Regulation 26 Section 133	Chapter 4	MHL Officer MHL Officer MHL Officer
Correspondence of patients – - record keeping in relation to withholding post - informing patients that post has been withheld	Section 134(5) Section 134(6)	Chapter 37	MHL Officer MHL Officer
Referral to Tribunal – duty of managers of hospitals to refer cases of detained and CTO patients to the tribunal in certain circumstances - authority to ask the Secretary of State for Health to refer cases to the Tribunal	Section 68	Chapter 37	MHL Officer MHL Officer

Board of Directors
Version 2 – Post Audit Committee

Tees, Esk and Wear Valleys NHS Foundation Trust

Annual report and accounts 2017/18

Tees, Esk and Wear Valleys NHS Foundation Trust

Annual report and accounts 2017/18

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

Contents

Foreword by the Chairman and Chief Executive

Foreword by the Chairman and Chief Executive

Reviewing the past
In 2018 the NHS celebrates its 70th anniversary and it's an opportunity for us to recognise the tremendous work our staff do every day to support the people who use our services.

It's been a busy and, at times, difficult year but time and time again our staff have risen to the challenges and have gone that extra mile. Although we haven't met all our targets we've achieved a great deal (despite significant pressure on our services) and we're very proud of the positive difference our staff have made.

Our staff are our most important asset and it's important that we support them. In December 2017 we achieved gold accreditation from the internationally recognised **Investors in People**. This is a significant achievement as the Gold Standard is only expected to be awarded to the top 2% of organisations that are assessed.

Over the last twelve months we've continued to work with service users, their carers, staff, partner organisations and commissioners to modernise existing services, to develop new and innovative ways of working and to take on responsibility for (and to transform) new services. Our aim is always to make the most of our resources to minimise the impact that mental illness or learning disability has on a person's life.

The way that some mental health and learning disability services are commissioned is changing. An example of this is the introduction of the **new care models for tertiary mental health services**, which are being piloted across the country and which see provider trusts taking over responsibility for the commissioning budget. Last year we started to see a real positive impact from the work we're doing as part of the pilot in **children and young people's services**– fewer young people are being admitted to hospital and, if admission is necessary, we're providing beds nearer to home for more young people. In June our joint application with Northumberland, Tyne and Wear NHS Foundation Trust to be part of wave two, with **adult secure services**, was successful. We hope to build on the work we've done to date in wave 1 to improve adult secure services across our patch.

In February we took over responsibility for **mental health and learning disability services in Pocklington**, which had previously been provided by Humber NHS Foundation Trust on behalf of the Trust and we would like to welcome staff to the Trust.

Work has also started with partners in both Yorkshire and Humber and the North East and North Cumbria region to deliver a new **forensic child and adolescent mental health (FCAMH) service.** This is a new service commissioned by NHS England and is part of the children and young people's mental health transformation programme, aiming to establish FCAMH services across England.

Our staff are passionate about promoting recovery and wellbeing and this means supporting service users to achieve the goals they've set themselves. People tell us that wherever possible they want to receive the care and support they need at home and strengthening our community services is one of our priorities.

Following extensive engagement with local people, including a formal public consultation, NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (CCG) gave the go ahead for us to transform **mental health services for adults and older people in Hambleton and Richmondshire**. We're now developing plans to strengthen our community mental health services for adults and older people, so that more people can be supported at home, and for moving inpatient care from the Friarage Hospital in Northallerton to more modern inpatient environments. In the future those people who cannot be supported at home will be admitted to their nearest mental health hospital (either Roseberry Park in Middlesbrough or West Park Hospital in Darlington). A small number of people with severe dementia will be admitted to Auckland Park Hospital in Bishop Auckland, the nearest specialist hospital.

In July 2017 the planned development of the new mental health hospital for **Harrogate** was put on hold to undertake a thorough review of options for **developing mental health service for adults and older people** in the area. The decision was made by the Trust and NHS Harrogate and Rural District Clinical Commissioning Group (CCG) as a result of significant financial pressures across the local NHS. We appreciate this was disappointing news for many people. However, it's important that we make best use of our resources and this pause gives us the opportunity to think about how we could do things differently (and hopefully better). We've involved local people in these discussions and this work is continuing into 2018/19.

One of the major setbacks of 2017/18 was finding out that significant work is required to fix a number of construction defects at **Roseberry Park** in Middlesbrough, including problems with the hospital's fire safety system. We took immediate action to mitigate the risks and to address the safety of service users, staff and visitors whilst they're in Roseberry Park. However, these are not long term solutions and since then we've been working with the PFI provider, fire safety and other construction experts to try to establish what is needed to resolve the problems and the most effective way of doing so. This work continues and we remain committed to doing all we can to make sure all works are completed as efficiently as possible with the least disruption to service users, their families and staff.

Our work to improve the environment for services users and staff continues and last year we were granted planning permission for our **new hospital in York**. The 72 bed hospital will be located off Haxby Road in the city. It will provide two adult, single sex wards and two older people's wards.

In October 2017 we also opened our largest **mental health community hub in York.** Huntington House opened following an extensive renovation programme and is the base for around 250 staff from nine clinical teams. It was specifically designed to improve access and to help teams work more closely together.

You can read more about our key developments and improvements in the performance report and in the quality report.

Looking to the future
There is no doubt that next year will be challenging for TEWV although, thanks to the hard work of our staff, we start the year in a good position.

Our key priorities for the coming year are

- A continuing focus on promoting Recovery;
- A continuing focus on improving the quality of our services;
- A continuing focus on ensuring that our services are purposeful and productive;
- A focus on supporting the whole health and social care system to work in a more integrated; effective and efficient way in each local health economy that we contribute to.

We will continue to play our part in the changing landscape of commissioning. We will build on the great work we've done with the new care models in children and young people's services and hope to replicate this in adult secure services by reducing lengths of stay and developing a new step down facility in the community.

We will also work with our clinical commissioning groups to develop accountable care partnerships. The ultimate aim is to improve the quality of care for people with learning disability and mental ill health by improving the way services are commissioned.

It's important that we make the best of the existing and new technology available to us and over the coming years we'll be working with clinicians to improve our patient record system, PARIS. We want to minimise the time staff spend inputting to patient records and maximise the time they're able to spend with patients. We also want to improve the links between our systems and those in GP surgeries and hospitals and, in the future, want to be able to give patients online access to their own records.

It's important that we listen to people – service users, carers and staff. However, it's more important that we act on what people tell us and we recognise that there is more we can do to use the feedback we receive to improve.

Over the coming year we aim to make better use of the feedback we receive from service users and carers to improve people's outcomes and experience of our services. We will also build on the work we've done to date to involve people with lived experience in developing our services.

Our board of directors has also become increasingly concerned about the feedback we've received from black and minority ethnic staff as well as those with a disability. Statistics shows us that they have a less positive experience of working at TEWV than other staff and this is something we need to address in 2018/19.

These are challenging times for the NHS. However, with the continued support of our service users, carers, staff, governors, partner organisations and commissioners we will continue to do all we can to provide the best possible care for the people who need our services.

Lesley Bessant
Chairman
22 May 2018

Colin Martin
Chief Executive
22 May 2018

This annual report, including the annual accounts, has been prepared under a direction issued by Monitor under the National Health Service Act 2006.

The performance report

The performance report

Overview of performance

Purpose

The purpose of the performance report is to provide an overview of the Foundation Trust, our purpose, our strategic direction, including our vision, mission and strategic goals, the key risks to achieving them and information on how we have performed during the year.

Statement from the Chief Executive

Overall our performance for the year was good, despite the pressures and challenges facing the organisation. We met our financial requirements and continued to improve against a number of key performance targets. We met our mandatory and statutory training targets and our appraisal levels were the highest they have been for three years. We have seen an increase in our IAPT recovery rates and the number of people admitted out of area has decreased significantly

TEWV at a glance

Tees, Esk and Wear Valleys NHS Trust was created in April 2006, following the merger of County Durham and Darlington Priority Services NHS Trust and Tees and North East Yorkshire NHS Trust. In July 2008 we achieved foundation trust status under the NHS Act 2006. In June 2011 we gained responsibility for services in Harrogate, Hambleton and Richmondshire and in October 2015 we took over the contract for mental health and learning disability services in the Vale of York.

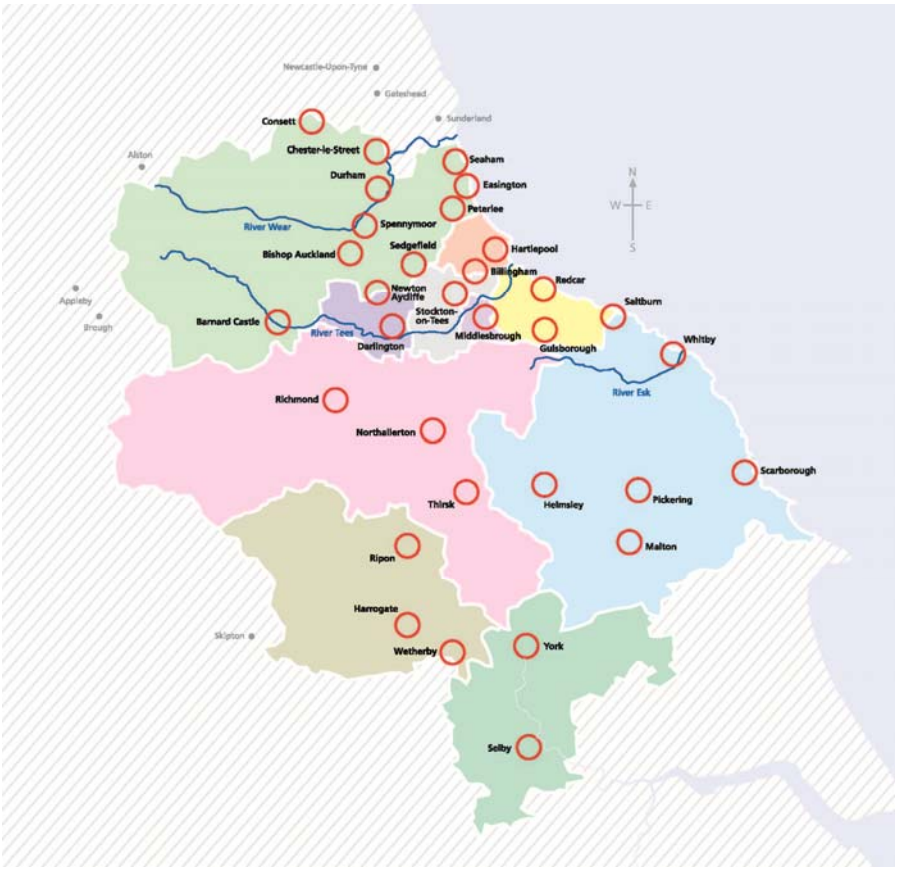
As a foundation trust we are accountable to local people through our Council of Governors and are regulated by NHS Improvement, the health sector regulator and by the Care Quality Commission.

We provide a range of inpatient and community mental health and learning disability services for approximately two million people of all ages living in

- County Durham and Darlington
- The four Teesside boroughs of
    - Hartlepool
    - Stockton-on-Tees
    - Middlesbrough
    - Redcar and Cleveland
- North Yorkshire
    - Scarborough, Whitby, Ryedale
    - Hambleton and Richmondshire
    - Selby and Harrogate
- The city of York
- The Pocklington area of East Yorkshire
- The Wetherby area of West Yorkshire

Our children and young people's wards, our adult inpatient eating disorder services and our adult secure (forensic) wards serve the whole of the North East and North Cumbria. We also provide mental health care within prisons located ni North East England, Cumbria and Lancashire.

The area we serve



The TEWV approach

Our mission

To minimise the impact that mental illness or a learning disability has on people's lives.

Our vision

To be a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations.

We will achieve our vision and mission through progressing towards our five strategic goals (see below).

Our values

Commitment to quality
We demonstrate excellence in all of our activities to improve outcomes and experiences for users of our services, their carers and families and staff.

Respect
We listen to and consider everyone's views and contributions, maintaining respect at all times and treating others as we would expect to be treated ourselves.

Involvement
We engage with staff, users of our services, their carers and families, Governors, members, GPs and partner organisations so that they can contribute to decision making.

Wellbeing
We promote and support the wellbeing of users of our services, their carers, families and staff.

Teamwork
Team work is vital for us to meet the needs and exceed the expectations of people who use our services. This not only relates to teams within Tees, Esk and Wear Valleys NHS Foundation Trust, but also the way we work with GPs and partner organisations.

Our goals

We have five strategic goals

Strategic Goal 1:
To provide excellent services, working with the individual users of our services and their families to promote recovery and well being

Strategic Goal 2
To continuously improve the quality and value of our work.

Strategic Goal 3
To recruit, develop and retain a skilled, compassionate and motivated workforce.

Strategic Goal 4
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve

Strategic Goal 5
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

The Trust has a number of strategies that set out our high level approach to achieving our strategic goals. There are Trust strategies covering recovery, quality, workforce, leadership development, equalities, finance, digital transformation and data quality. Some of these are being implemented through Trust-wide programmes, linked to our business plan priorities (e.g. recovery and digital Transformation). Others are being driven forward by Trust-wide steering groups who ensure the strategies influence new policies and processes that change the way our core work is delivered.

Our business model focusses on delivering our mission and vision. The Trust assesses opportunities to bid for new business against a range of criteria to ensure that we do not divert resources from our core purpose unnecessarily. The Trust has set up two subsidiary companies where market failure outside our core business was introducing significant clinical or financial risk to our core work. In 2014 we set up Positive Individual Proactive Support Limited (PIPS) in 2014 to address a gap in market provision for social care for individual service users with highly complex health and social care needs. We have also recently created a second subsidiary, TEWV Estates and Facilities Management Ltd to mitigate the risks caused by the winding up of Carillion.

Our services
We provide a wide range of community mental health and learning disability services for people of all ages. Our services' role is to provide therapeutic and pharmacological treatments and other support to keep patients safe and to help them to achieve the recovery goals that they set for themselves.

The Trust's services are organised primarily on a locality-basis, covering

- Durham and Darlington
- Tees
- North Yorkshire
- York and Selby

There is a fifth directorate covering forensic services.

Clinical leadership is aligned through the clinical directors across four specialities which cut across the whole Trust area:

- adult mental health services
- mental health services for older people
- children and young people's services (including child and adolescent mental health services and children's learning disability services although we do not provide child learning disability services in Harrogate, Hambleton and Richmondshire)
- adult learning disability services

Key issues and risks which could impact on the achievement of the strategic direction

Like all organisations, we are affected by, and must manage, risks and uncertainties that can impact on our ability to deliver our strategic direction.

The annual governance statement describes the systems and processes through which risks are identified, managed and mitigated. This can be found in the Accountability Report.

We consider that, at present, the key issues and risks which could impact on the achievement of our Strategic Direction are as follows:

Potential changes to service models and the provider landscape
In its "Five Year Forward View", published in October 2014, NHS England set out its vision for the future of the NHS. This has been built upon in further guidance/publications including Future in Mind, the Mental Health Five Year Forward View, the Transforming Care for People with a Learning Disability guidance and guidance on the development of Sustainable Transformation Plans (STP)/ Integrated Care Systems

These documents highlight the importance of the following:
- The need to have parity of esteem for mental health and to develop new services which support the wider health and social care economy
- The importance of prompt access to services
- The greater integration of services and how this can be achieved through new models of care
- A reduction in the over reliance on inpatient services with more people being supported in the community

From our perspective the vision created via these documents has both significant risks and uncertainties as well as opportunities.

The need to ensure parity of esteem nationally is welcome, as is the additional resource that has been identified to support the delivery of the Mental Health 5 Year Forward View and Future in Mind. However there are two risks associated with this. The first being that, whilst CCGs may allocate resources to mental health that meet the national Mental Health Investment Standard, this is not used to deliver the requirements within the guidance. This could result in key new services not being available at the anticipated levels. The second is a risk that the workforce required to implement the ambitions within the various pieces of guidance is not available or that

it leads to a reduction in the workforce in 'core' services as staff are attracted to 'new cutting edge services'.

The drive to improve access to services, both community and inpatient, is also welcome and indeed the Trust has prioritised access to services for a significant number of years. However there are risks that the national targets set do not reflect the starting points of services, that the national construction of the targets is not in line with local service models and the national targets are not achievable due to a shortage in staff with appropriate skills. This could result in the Trust not meeting the governance requirements of NHS Improvement's Single Oversight Framework.

The drive for integration of services and the development of larger planning footprints via the STPs/Integrated Care Systems has gathered pace. Whilst planning on larger footprints is essential for some services, such as inpatient and more specialist services eg perinatal services, for the vast majority of services delivered by mental health providers it is often more appropriate to plan and deliver on much smaller footprints. Furthermore the STP/Integrated Care System boundaries are not aligned to those of the Trust meaning that we are part of 4 different Integrated Care Systems. This complexity creates a number of risks for the organisation including the ability to deliver service models across the Trust geography whilst ensuring these link to the wider STP/ICS's plans and the ability to interface at appropriately senior levels with the STP/ICS's development.

The integration of services also creates risks that mental health and learning disability services might suffer due to the focus being prioritised on other health services. However, it may also provide opportunity to ensure that people's mental health is considered alongside their physical health problems, particularly in terms of people with long term conditions which often have a psychological impact.

Whilst the Trust is supportive of the need to ensure that there is not an over reliance on the use of inpatient beds there is a risk that the number of beds are reduced prior to appropriate alternatives being available in the community. This continues to be a significant risk in terms of our learning disability services where in order to discharge patients often significant care packages are required in the community. In addition there is a risk that the remaining beds become financially unsustainable.

In response to the above risks and uncertainties:

- The Board continues to keep abreast of changes to the wider environment and the implications of the key external environmental drivers such as the Five Year Forward View, the Mental Health 5 Year Forward View and the Learning Disability Transforming Care agenda and has taken them into consideration in developing its Annual Operational/Business Plan
- The Trust continues to actively engage with the development of the 4 STP/ICS's within which it operates taking a proactive role in the Mental Health and Learning Disability Programmes within these.
- In conjunction with CCGs and Local Authorities the Trust is developing two Accountable Care Partnership (ACP) approaches to the commissioning and delivery of Mental Health and Learning Disability Services in County Durham and Tees Valley and in North Yorkshire. The County Durham and Tees Valley ACP has been operating for over a year and initially focused on Learning Disabilities, however it has been agreed to widen this to include Mental

Health. In North Yorkshire the work is in an early stage of development however it has been agreed it will cover Mental Health and Learning Disability services.

- In partnership with Northumberland Tyne and Wear NHS Foundation Trust and NHS England the Trust has developed a North East and Cumbria Specialised Services Partnership Board which incorporates two New Care Models for the Trust covering Children and Young Peoples Tier 4 services (inpatient beds) and Adult Secure Services. Within these NCMs the Trust has taken on responsibility for the management of the specialised services budget with a view to reducing the need for inpatient beds, providing more support in the community and preventing the need for people to be admitted to beds out of area.
- The Trust continues to engage with commissioners on the development of services outlined in the policy documents
- The Trust has active engagement in the North East and Yorkshire and Humber Transforming Care Boards and continues to work with commissioners on the development of a robust learning disability community model that will allow more individuals to be cared for in the community whilst also ensuring that the required number of inpatients beds can be provided in a financially sustainable way
- The Trust continues to work with commissioners to ensure that they meet the national mental health investment standard and has agreed a ring fence approach, linked to the ACPs, to the total mental health and learning disability commissioning budget with a number of CCGs.

The Financial Challenge

The successful delivery and development of the services we provide depends on us maintaining our strong financial performance.

In its Spending Review and 2016 Budget the Government announced a number of measures which could impact on our financial well-being:

- Whilst funding for NHS services has been ring-fenced, this is not the case for our partners e.g. local authorities. The savings they are required to make will create financial pressures for us going forward.
- The Government announced that by 2020 additional funding of £10 billion more a year, in real terms, would be provided to the NHS compared to 2014-15.
- More recently in the autumn 2017 budget a further additional £3 bn of revenue funding was allocated to support under pressure NHS finances.
- NHS Improvement quarter3 forecast for NHS Providers is expected to be around £900m deficit mainly as a result of the financial performance of Acute Trusts. This position may deteriorate further in quarter4 and includes the £1.8bn Sustainability and Transformation funding. The planned deficit for 2017/18 was £496m.
- The autumn budget also announced an additional £3.5bn of national capital funding to support longer term system transformation schemes, and which are part of local health sustainability and transformation plans (STPs).

- There continues to be risks that the new funding provided will be focussed on reducing the deficit of the Acute sector at the expense of Mental Health and Learning Disability services.
- Training monies have been excluded from the NHS ring-fence; compounding the impact of recent reductions in training funding.

To seek to mitigate these risks we will:

- Continue to improve the productivity of our services using our well established quality improvement system.
- Continue to work with partners to seek to develop ways of providing services which meet the needs of each organisation whilst maintaining service quality.
- Continue to assess and monitor the impact of proposals for efficiency savings to ensure that they do not impact, adversely, on the quality of our services.

With regard to training:

- Develop a revised approach to how our Training Needs Analysis is compiled and monitor its effectiveness to ensure that we obtain maximum value for money from our investment in training activities.
- Pay constant attention to how we secure vocational training at the lowest cost whilst ensuring that we provide access to good quality training for non-registered staff.
- Develop a Trust approach to making the most of opportunities afforded by the introduction of the apprenticeship levy.

In addition we recognise that there are risks to our income levels during the transition from block contracts to alternative payment mechanisms.

Our excellent reference costs and the significant investment we have made in developing our clinical information systems over recent years mean that we are in a relatively strong position to respond to this change.

Recruitment and Retention of Staff

The Trust has found it harder to recruit to a range of healthcare professional posts in recent years albeit with some degree of variation. Our ability to access the right number and quality of clinical staff has been identified as being a key workforce risk for the Trust.

We also believe that the level of risk concerning the maintenance of appropriate future workforce supply could increase given the age profile of clinical staff, which is expected to result in an increase in the number of retirements on age grounds over the next two years. Age retirement is the single biggest reason for staff leaving the Trust, at one in five of all leavers.

Progress has been made during the last year to improve the ability of the Trust to recruit healthcare professional staff and recruitment fill rates are increasing. We recognise however, that there does need to be a greater focus upon improving our ability to retain staff. Though the Trust's staff retention rate compares well to those of its peer organisations it is believed that there is scope for further improvement and

relying upon efforts to increase the number of new recruits only will not be enough given NHS-wide staff shortages.

In response to concerns about clinical staff recruitment and retention, the Trust:

- Has reviewed and updated its recruitment and retention action plan
- Has identified and implemented revised and innovative recruitment processes and incentives
- Has invested in a new recruitment information tracking system to improve understanding of performance and related decision making
- Is embedding efforts to have earlier and more effective engagement with student nurses within the Trust's boundaries and elsewhere
- Has implemented and is evaluating measures to help improve the Trust's supply of temporary staffing
- Is developing new roles and career paths within the Trust and participating in the piloting of nationally developed nursing associate and physician assistant roles
- Is reviewing how staff health and wellbeing activities can assist efforts to improve staff retention
- Is reviewing Trust communications as part of efforts to increase engagement with staff

The impact of Brexit upon the NHS workforce is not yet clear and the Board will be keeping this issue under close scrutiny, particularly in terms of its possible effect on our ability to recruit and retain staff.

Demography and Demand risks

Demographic change, and changes in demand are risks for the Trust because:

- The block payment nature of our contracts means that our income does not automatically rise as activity increases
- Changes in the pattern of demand might result in the current pattern and location of resources (such as staff or beds) becoming misaligned with need.

The Trust includes predicted changes in referrals among the information used in developing the Trust's business plan. We have, therefore, factored in the likely increase in the number of Under 18s and over 65s in the coming years, alongside a static 18-65 population into our plans.

However, referral patterns can also change due to changes in GP practice, economic shocks and changes in public attitudes to mental health (i.e. decline of stigma). Sudden increases in referrals can lead to pressures on community staff and to increased waiting times. Waiting time data is carefully monitored, but the Trust recognises that we need to improve the visibility and timeliness of data on referrals to assist the Trust as a whole to move resources to where they are most needed. We are therefore currently developing new processes and reports for referrals to enable a more effective response to meet localised pressures.

We also maintain positive relationships with our commissioners so that increases in referrals can be considered during contract negotiations.

Roseberry Park Hospital

Roseberry Park Hospital in Middlesbrough is one of the Trust's major inpatient and operational hubs and serves mainly the populations of Teesside and also provides specialist forensic services.

It was purpose built, using the government's Private Finance Initiative, and opened in 2010.

Since the building was handed over to the Trust there have been a number of construction details and problems with the facilities management services on site.

The Trust has used the contractual framework available to try to seek resolution to these issues; however, there are still a large number of defects to be dealt with.

In addition to the wide range of issues identified, the PFI partners informed the Trust in June 2016 that there were a number of defects with the fire safety systems in the hospital. The Trust worked with Cleveland Fire Brigade and immediately implemented a number of measures that mean that services can still be provided from the site. However, these measures are not long term solutions and a range of rectification works will be required to address these critical issues.

The Trust has been working with a range of technical experts to highlight solutions – including the installation of a mist suppression system. A block (5) has been evacuated and patients have been transferred to Hartlepool to allow the team to undertake a range of intrusive surveys. This will inform the scope, cost and timescales associated with fixing the hospital. This information will be subject to a business case in May 2018.

This work continues and we remain committed to doing all we can to make sure all works are completed as efficiently as possible with the least disruption to service users, their families and staff.

Regulatory requirements

We fully support the NHS providing high quality healthcare. It is what both we expect of ourselves as well as what patients and carers expect from us. Nevertheless there is a risk that we might not achieve the standards set by the Care Quality Commission in all services all of the time.

To address this risk we have strengthened our governance arrangements and undertake regular self-assessments to ensure that, when shortcomings are identified, they are dealt with.

Going Concern

Through the financial statements and financial performance indicators the Trust can demonstrate a strong underlying financial position.

The 2018-19 annual plan provides for a surplus of £8.6m (2.5% of turnover) and reflects a significant level of non-recurrent expenditure. The directors view is that the

Trust is a going concern and can make the disclosure as recommended by the accounting standards board that:

“After making enquiries the directors have a reasonable expectation that the Tees, Esk and Wear Valleys NHS Foundation Trust 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”.

Colin Martin
Chief Executive **22 May 2018**

Performance analysis

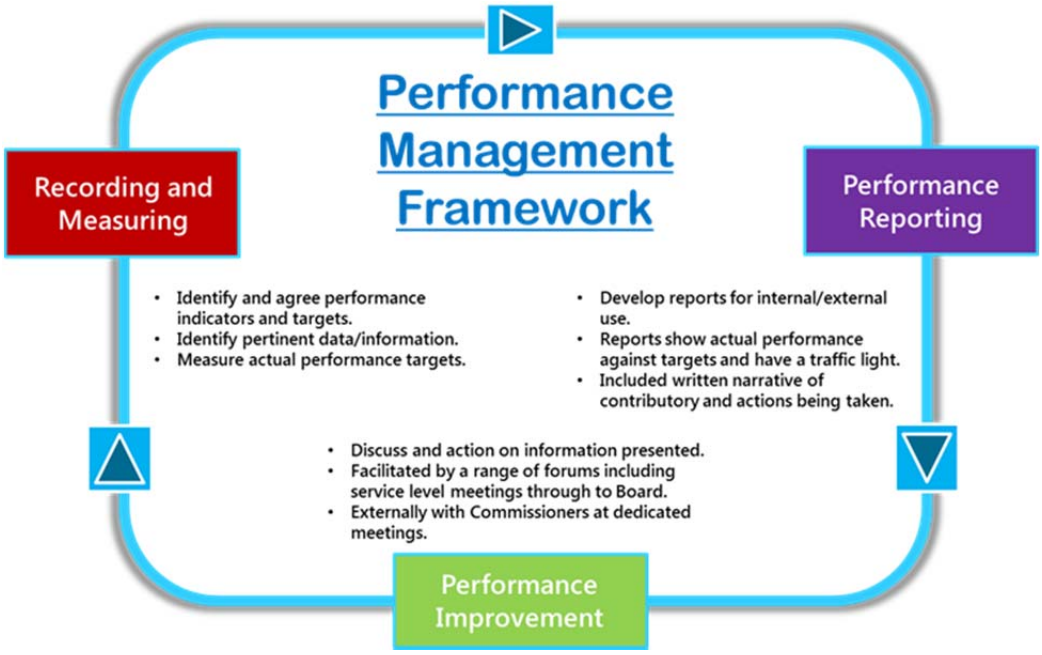
How we measure our performance

Each year the Board of Directors sets a number of stretching targets (key performance indicators) for the Trust to work towards as part of its commitment to year-on-year improvement. This is undertaken as part of the annual business planning framework where members of the Board, Executive Management Team, Senior Operational and Clinical Directors and Heads of Nursing discuss the key performance indicators for the following year.

The key performance indicators are reported within a "dashboard" which provides a high level overview of operational delivery throughout the financial year. This report is produced monthly specifically for our Board of Directors to give it assurance that the Trust is continuing to deliver operationally. We also make it available to our service users, wider public and commissioners and it is presented and discussed with our Council of Governors once a quarter. It should be noted that in setting the targets within this dashboard the Board of Directors is deliberately aspirational and stretching in recognition of our vision to provide excellent services that exceed people's expectations.

The Board of Directors discusses the "Trust dashboard" each month in terms of areas of good practice but also areas where improvement is needed. If there are any areas where the Trust is significantly underperforming the Board of Directors may request further analysis and/or an action plan if it feels this is necessary. If the Board of Directors' identify any trends which could impact on the Trust and operational delivery then this would be escalated within the risk management processes.

It is important to note that we use a number of other performance dashboards widely throughout the organisation, and the "Trust Dashboard" is an example of one of these. We believe that whilst a performance dashboard is critical in monitoring performance, it is only one part of an overarching performance management framework that supports performance and service improvement. Other examples where we use performance dashboards include the "strategic direction performance report" where we measure progress against the strategic goals we have set and our "commissioner reports" where measure progress against the key performance indicators agreed in the contract. Therefore we use performance dashboards to manage and continuously improve our performance and service delivery as part of our integrated performance management framework which is a key control for managing risk and form a continuous cycle of performance improvement, as shown in the diagram below.



Given the importance that the Trust attaches to performance dashboards, it has invested significantly in a trust-wide Integrated Information Centre (IIC). The IIC is a data warehouse which integrates data from a wide range of source systems e.g. patient information, finance, workforce and incidents. It is used to produce performance information for both internal and external use in the form of static monthly assurance reports and interactive reports which are updated daily via electronic feeds from the source systems allowing interrogation of the most up to date performance 24/7.

There are a number of benefits to having this tool which include:

- The availability of 'real time data' for use by the clinical services for clinical and business purposes. Staff are able to access the IIC at any time of day and can interact with the information it contains.
- The availability of information from different source systems in one integrated system.
- The ability to drill down to the lowest level of data available (according to access rights). This means that managers can drill down from service level reports into individual patient or staff information.
- The ability of the IIC to send prompts to staff that an area of performance is about to breach built-in standards.
- It allows our approach on performance management to move from a "reactive" to a more "proactive" one, both in the way we manage performance data in our team and in the way we engage with clinical services.

How we performed

Key developments during 2017/18

During 2017/18 the Trust has implemented its business plan and quality account priorities. These priorities were identified during 16/17 as the initiatives required by

changes in the environment that the Trust operates in, and to ensure that we move towards our strategic goals (which in turn underpin our mission and vision)

Some of these priorities are Trust-wide, long-term initiatives, being delivered through programme management arrangements. These programmes are delivering changes that are vital for long term financial, quality and access expectations to be met.

For example, our recovery programme focused on developing experts by experience to take paid and voluntary roles in staff training and service delivery. It started to train staff in trauma-informed care, and commenced work with a pilot team on designing a recovery-oriented team accreditation system. It also progressed our physical and online recovery colleges. The benefits from this work will accrue in the long term, as cultural change among staff and service users promotes resilience, and as we are able to identify processes that do not add value to patients and eliminate or reduce these.

Our purposeful and productive community services (PPCS) programme is intended to bring about short-medium term gains in quality and efficiency. In 17/18 a number of products were produced which will help teams to improve their efficiency and effectiveness – these included coaching training, electronic diary management, daily huddles (to keep track of team progress and to allocate work), an online caseload management tool and a review of admin roles. This is already starting to feed through into quality improvements and financial savings, but further progress will be made as a result of the work started in winter 2017/18 by 12 pilot teams. These teams are going to try out different ways of working, and in particular test out ways of reducing time spent entering data into computers and using ICT to cut the time spent travelling to meetings.

The Trust's right staffing programme delivered changes that sought to reduce the risk of insufficient clinical staffing being available on inpatient wards. The Trust improved the usage of electronic rostering and its escalation processes. An attempt to improve the way in which the trust rosters agency staff was only partially successful, and lessons are being learned about how to make this process more reliable. The Trust has also identified that improved retention and recruitment are vital to ensure we always have the right staff in the right place, at the right time with the right skills. We supported Sunderland University's successful bid to become a medical school (which will include a specialism in psychiatry) and are working with other providers to increase mental health and learning disability nursing places.

We also continued to improve our inpatient services. This included our model wards programme in forensic services and our ongoing purposeful inpatient admission process in other wards. This process helps us to reduce waits for patients, and hence speeds up discharge. This approach has been successfully implemented in our York wards within the last year, helping to reduce out-of-locality placements for York and Selby patients. We also delivered a number of service changes which are helping to reduce admissions, such as adult learning disability crisis teams in Durham, Darlington and Teesside. However, perhaps the most significant example in the past year has been the work enabled by our participation in a children and young people's new care models pilot. Through this we have moved resources away from expensive out-of-area inpatient beds and into crisis and intensive home treatment

teams. These have helped to reduce admissions and the length of stay for children who have been admitted.

The Trust has also made good progress in addressing substandard inpatient estate within the localities covered by the recent expansion of the Trust. Agreement has been reached with the relevant CCG for adults and older people from Hambleton and Richmondshire to access beds at the modern West Park Hospital in Darlington, Auckland Park Hospital in Bishop Auckland and Roseberry Park Hospital in Middlesbrough. The Trust has also purchased a site at Haxby Road in York which will be the site for a new 72 bed hospital for adults and older people (which will open in 19/20). The Trust's engagement with service users and other stakeholders in York and Selby has been helpful in contributing to the choice of site and the design of the new facility. Progress is already being seen on the ground in York where the Trust's new community team base, Huntingdon House opened in Autumn 2017, and where we have delivered increases in quality and decreases in waiting times in most services. The main challenge for the Trust is now to engage with the Harrogate and Rural District CCG and the stakeholders in that locality to develop options that will allow the Trust to improve quality and ensure system-wide financial sustainability in the long term. Our engagement with stakeholders commenced in 17/18 and this will remain one of our key priorities over the medium term.

As well as the gains made by the CYP New Care Models programme mentioned above, the Trust was also successful in its application (jointly with Northumberland Tyne and Wear NHS Found Trust – NTW FT) to become an Adult Secure New Care Models pilot. This announcement came relatively late in 17/18 but by the end of the year the new systems to work with NTW FT to jointly manage beds and to bring out-of-area patients back into the North East had commenced. The Trust is also progressing Accountable Care Partnership proposals with commissioners in the North East and North Yorkshire. In 17/18 initial work in Durham, Darlington and Teesside led to reviews of over 60 adult learning disability packages / placements, with significant quality and financial gains resulting. This work will continue into 18/19 and beyond.

The Trust also delivered the quality improvement priorities set out in its Quality Account. In particular, the Trust has started to see a reduction in the number of falls causing harm to patients, following 2 years of focus on this in our quality account.

Performance against key targets

The scorecard below is the Trust's dashboard of key performance indicators for 2017/18. The Board received a monthly performance report during 2017/18 which contained performance against this range of indicators.

1.Activity	2017/18 Actual	2017/18 Target	2016/17 Actual	Change on 16/17*	Comment on 2017/18
Total number of external referrals into Trust services test	105,573	91,759	100,109	↓	
Caseload Turnover	3.94%	1.99%	2.39%	↓	
Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	87.82%	85.00%	93.03%	↑	
Number of patients with a length of stay (	57	75		N/A	16/17 KPI was

from admission) of greater than 90 days (A&T wards)					from admission to discharge
Percentage of people re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	8.87%	10.00%	7.61%	🡻	
Number of instances where a patient has had 3 or more admissions in the past year to Assessment & Treatment wards (AMH and MHSOP) Rolling 3 months	309.00	255.00	291.66	🡻	
2.Quality	2017/18 Actual	**2017/18 Target**	**2016/17 Actual**	**Change on 16/17***	**Comment on 2017/18**
Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	90.73%	90.00%	85.65%	🡹	
Percentage of clinic appointments cancelled by the Trust	8.72%	10%		N/A	KPI 16/17 was all appointments
The percentage of Out of Area placements (Post-validated)	14.08%	20.00%	23.07%	🡹	
Percentage of patients surveyed reporting their overall experience as excellent or good (month behind)	91.56%	92.45%	92.45%	🡻	
Number of unexpected deaths classed as a serious incident per 10,000 open cases – post validated	16.34	12.00	8.59	🡻	
3.Workforce	**2017/18 Actual**	**2017/18 Target**	**2016/17 Actual**	**Change on 16/17***	**Comment on 2017/18**
Actual number of workforce in month (Establishment 95%-100%)	93.83%	100%	93.74%	🡹	
Percentage of registered healthcare professional jobs that are advertised two or more times	18.32%	15.00%	17.39%	🡻	
Percentage of staff in post more than 12 months with a current appraisal	94.21%	95.00%	92.88%	🡹	Snapshot as at 31st March 18
Percentage compliance with mandatory and statutory training	90.75%	90.00%	89.18%	🡹	Snapshot as at 31st March 18
Percentage sickness absence rate (month behind)	5.18%	4.50%	5.00%	🡻	
4. Money	**2017/18 Actual**	**2017/18 Target**	**2016/17 Actual**	**Change on 16/17***	**Comment on 2017/18**
Delivery of our financial plan (I and E)	24,438,000	-10,076,000	-19,222,000	🡻	
Delivery of financial plan (I and E) Excluding impairments	-16,800,000	-10,076,000	-22,406,000	🡻	
CRES delivery	6,327,551	6,284,000	6,734,472	🡻	
Cash against plan	58,415,000	52,227,000	57,845,000	🡹	

* Arrows indicate improvement (🡹) or deterioration (🡻) on previous year, when N/A this indicates a KPI has changed and so no comparison can be made.

Notes

- **Total number of external referrals into Trust services** – The Trust has failed to achieve the annual target of 91,759 by 13,814. This is an increase on the outturn of 80,350 recorded in 2016/17.

- **Caseload Turnover** - The Trust has not achieved target in 2017/18, reporting 3.94% for the financial year against a target of 1.99%. Focused work continues in all localities to identify and address issues in this area.

- **Bed Occupancy –** The Trust has achieved the target in 2017/18, reporting 87.82% for the financial year against a target of 85.00% with all localities reporting above target. During the year, the Trust has seen pressures on bed particularly in AMH and particularly in male beds. Each locality continues to proactively monitor and address issues as they arise.

- **Length of stay greater than 90 days** - The Trust has achieved the target in 2017/18, reporting 57 against the annual target of 75. The service continually reviews patients with a long length of stay to ensure appropriate plans are in place and concerns addressed promptly.

- **Percentage of people re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) -** The Trust position for the financial year is 8.87% which has met the annual target of 10%. This is a deterioration on the annual outturn for 2016/17 which was 7.61%. The circumstances of the readmissions have been investigated and all were attributable to the severity of the symptoms and personal circumstances of the patients concerned.

- **Number of patients who have 3 or more admissions in a year (AMH & MHSOP) -** The Trust has failed to achieve the target of 255 with performance of 309. This is a deterioration on the annual outturn for 2016/17. The circumstances of the readmissions have been investigated and all were attributable to the severity of the symptoms and personal circumstances of the patients concerned.

- **Percentage of patients seen within 4 weeks following external referral -** the Trust position for the financial year is 90.73% which has achieved the annual target of 90.00%. This is an improvement on the annual outturn for 2016/17 which was 82.65% and is the best performance in the previous 3 years. Where there are areas of concern, plans are in place to address these.

- **Percentage of clinic appointments cancelled by the Trust –** The Trust has achieved the target of 10% with a performance of 8.72%. Performance in this area continues to see improvements and all localities are achieving target.

- **The percentage of Out of Area placements (Post-validated**) – This indicator measures the number of times a patient is admitted to a hospital within the Trust that is not the one we would expect them to be admitted to.

  The Trust has achieved the 20% target with an outturn of 14.08%, which is also an improvement on the annual outturn for 2016/17 of 23.07%.

- **Percentage of patients surveyed reporting their overall experience as excellent or good** – The Trust has failed to achieve the target of 92.45% with a position of 91.56%. This is also a deterioration compared to the 92.45% achieved in 2016/17. Work

continues within each locality to review performance against this indicator and identify any areas of concern

- **Number of unexpected deaths classed as a serious incident per 10,000 open cases –** The number shown is the maximum level of unexpected deaths that we would expect to see rather than a target number we are trying to achieve.

  The Trust has underperformed against this indicator with 16.34 deaths. A meeting took place during March between patient safety, corporate performance team and information team to look at how the data around the coroner's verdicts can be reported in a more meaningful and detailed way. Work is underway to ensure this is in place for 2018/19 reporting.

  In addition to this, during 2017/18 the Trust has developed new mortality processes for reviewing deaths not categorised as serious incidents – 126 of these reviews were undertaken. More detail on this can be found in the 'Learning from Deaths' section of the Quality Account.

  The Trust has robust processes in place for the investigating serious incidents following the guidance set out in the NHS England Serious Incident Framework (2015). We published our 'Learning from Deaths policy in September 2017 which details how we are continuing to improve and increase the numbers of reviews we undertake and also how we are engaging families and carers in a more proactive and inclusive way.

- **Actual number of workforce in month (establishment 95% - 100%)** - The Trust position for the financial year is 93.83% which has not met the annual target, but is a slight improvement on the 2016/17 outturn. It is expected that the establishment rate will continue to improve following the appointment of 30 newly qualified nurses and on-going recruitment.

- **Percentage of registered healthcare professional jobs that are advertised two or more times** - The Trust position for the financial year is 18.32%, which is 3.32% over the annual target and a deterioration of 0.93% compared to the 2016/17 outturn. Across the year there have been a number of posts that have been difficult to recruit to. This area will continue to be monitored closely.

- **Percentage of staff in post more than 12 months with a current appraisal** – The Trust has under-performed against the 95% target with an outturn of 94.21%. Although this is just below the target of 95% it represents a sustained improvement on the figure reported in February and throughout the year. This is an improvement on the 92.88% achieved in 2016/17. The use of operational management huddles is now embedded across the Trust which includes discussions on appraisal compliance levels; this has had a positive impact on performance levels being achieved.

- **Percentage compliance with mandatory and statutory training** – The Trust has achieved the 90% target with an outturn of 90.75% and is an improvement on the outturn of 89.18% for 16/17. The use of operational management huddles is now embedded across the Trust which includes discussions on appraisal compliance levels.

- **Percentage sickness absence rate** – The Trust has under-performed against the 4.50% target with an outturn of 5.18%. This is a deterioration in performance compared to the 2016/17 outturn position. The operational management huddles continue to drive improvements in performance. The improved frequency of the IIC refresh allows a timelier update of accurate performance information to managers.

- **Delivery of our Financial Plan (I and E) –** The comprehensive income outturn for the financial year ended 31 March 2018 was a deficit of £24,438k, which was £34,514k behind the planned £10,076k surplus.

- **Delivery of financial plan (I and E) excluding impairments -** The deficit position included £41,238k of unplanned asset impairments largely due to a review of Roseberry Park Hospital (RPH) to reflect the cost of rectification works required. Excluding these impairments the Trust's operating surplus was ahead of plan by £6,724k, which represents 1.92% of the Trust's turnover.

- **CRES Delivery (snapshot) -** Identified Cash Releasing Efficiency Savings at 31 March 2018 were £44k ahead of plan for the financial year 2017/18. The Trust has, and continues to, identify and develop schemes to ensure full delivery of recurrent CRES requirements for future years.

- **Cash against plan -** Total cash at 31 March 2018 was £58,415k and was £6,188k ahead of plan largely due to funding from the Sustainability and Transformation Fund in 2016/17 not being confirmed when the plan was submitted together with working capital variations.

Environmental Management : Reducing our carbon footprint

The Trust has a five year 2015-2020 Sustainable Development Management Plan (SDMP) which supports the NHS Sustainable Development Unit's view that a sustainable healthcare system must do more than focus on carbon – it must also consider how to minimise the impact of other negative environmental impacts, such as waste or water, and also to maximise opportunities to support the local economy and community.

The Trust has developed a realistic action plan linked to the new Sustainable Development Unit's national assessment tool. It is an online self-assessment tool to help the Trust understand our sustainable development work, measure progress and help make plans for the future. It uses four cross cutting themes 'Governance & Policy', 'Core responsibilities', 'Procurement and Supply chain' and 'Working with Staff, Patients & Communities' –made up of ten modules, this new approach allows the Trust to demonstrate progress in a way that mirrors our own individual journey.

Looking ahead, the Trust proposes in the near future to be able to enter into partnership with a multi-national business solutions provider to install three combined heat and power units at three specific Trust sites. These in turn could help the Trust achieve its obligation in meeting our carbon reduction target of 34% by 2020.

In the annual Government energy certification exercise rating of our buildings (A to G with D being typical) of the 28 qualifying properties surveyed, 11 of the buildings were rated C and above with only 4 properties failing to achieve the typical.

Using assisted funding provided by The Workplace Charging Scheme, the Trust has increased the availability of electric vehicle charging points strategically across the Trust. Current locations now offering EV charging to staff and visiting members of the public include Lanchester Road Hospital, Parkside MHRC, Cross Lane Hospital, Flatts Lane Centre, West Park Hospital and Huntington House in York.

Whilst the Trust has embarked on many successful recycling initiatives, further improvements can be achieved by segregating and recycling our general waste and following a recent service improvement event at West Lane Hospital on “Waste Recycling”, significant improvements have been made in relation to the onsite recycling of domestic waste and following on from this pilot, we will be rolling this model out across the whole of the Trust during the course of 2018/19.

Emergency Planning and Business Continuity

All Trusts have a duty to prepare for emergencies, maintain plans for preventing emergencies and for reducing or controlling the effects and returning to business as usual as soon as possible.

In order to give assurance that it has addressed this duty, the Trust has developed a comprehensive management framework which addresses NHS England's Core Standards for Emergency Preparedness, Resilience and Response.

An annual report is taken to Audit Committee and the Board of Directors to provide evidence of the annual self-assessment process covering the core standards prior to the submission to Local Health Resilience Partnerships.

In the 2017 submission the Trust achieved full compliance with all the core standard categories.

Responding to the external environment

TEWV serves patients across a large geographical area that includes:

- a number of industrial and / or coastal towns with high deprivation levels
- areas of former coal mining and iron ore mining which combine semi-rurality with high deprivation levels
- sparsely populated, isolated rural areas
- relatively affluent agricultural areas
- pockets of urban and suburban affluence
- the largest concentration of armed forces personnel in the UK (Catterick Garrison).

Challenges for TEWV as a provider include how to:

- balance the different needs and priorities of commissioners while providing a consistent level of quality across the Trust
- manage resources so that we can deliver effectively in urban and rural areas with different financial pressures
- manage the changing demand for our services
- respond to new national policy and guidance
- make best use of new medical and information technology which opens up additional ways of delivering services.

Human rights

The Trust has worked with the British Institute of Human Rights to develop a human rights training package for use by TEWV early intervention in psychosis services staff that can also be accessed by staff in other NHS trusts. The training is part of efforts to empower staff to better understand and use human rights in their day to day work to improve decision making and assist with adopting a more person-centred approach to engaging with service users and carers. Evaluation of the training project has identified that 86% of practitioners believe that they now have enough or a good understanding of how to use a human rights approach in practice compared to pre-training feedback that 71% of practitioners had little or no understanding of how to use a human rights approach in practice. Training on human rights is now being

rolled out to the positive approaches training team who are to embed this approach in training given to all clinical staff on how to manage behaviour that challenges.

Modern Slavery Act statement

Tees, Esk and Wear Valleys NHS Foundation Trust provides mental health and learning disability services to a population of 2m across Durham, Teesside and North Yorkshire.

All Trust staff, in clinical or non- clinical roles, have a responsibility to consider issues regarding modern slavery, and incorporate their understanding of these issues into their day to day practice. Front line NHS staff are well placed to be able to identify and report any concerns they may have about people who use our services and modern slavery is part of the safeguarding agenda for children and adults.

The Trust is fully aware of its responsibilities towards patients, employees and the local community and, as such, we have a strict set of ethical values that we use as guidance with regard to our commercial activities. We therefore expect that all suppliers to the Trust adhere to the same ethical principles.

In compliance with the consolidation of offences relating to trafficking and slavery with the Modern Slavery Act 2015, the Trust is currently reviewing its supply chains with a view to confirming that such actions are not taking place.

We will be:

- Reviewing our supply chain and identifying general potential areas of risk including:
  - Provision of food
  - Construction
  - Cleaning
  - Clothing (work wear)
- Contacting the suppliers within these supply chains and asking them to confirm that they are compliant with the Act.
- Contacting our key suppliers and requesting confirmation from them that they too are compliant with the Act.
- Introducing a 'Supplier Code of Conduct' and asking all existing and new suppliers to confirm their compliance

Advice and training about slavery and human trafficking is available to staff through the Safeguarding Team.

Further information on Modern Day Slavery can be found by visiting: https://modernslavery.co.uk/

Anti-bribery policy

The Trust has anti-fraud, bribery and corruption policy and procedure (more detail in the staffing report).

The accountability report

The accountability report

In the Accountability Report we provide information on our governance arrangements, staffing and the remuneration of Directors and senior managers in order to demonstrate how we comply with best practice and key rules and requirements.

Colin Martin
Chief Executive **22nd May 2018**

The Directors' Report

The Chairman, Deputy Chairman, Chief Executive and other Board Members as at 31st March 2018

Lesley Bessant, Chairman of the Trust
Lesley had a long and successful career in local government until her retirement from Gateshead Council in 2005. Since then she has held a number of non-executive roles including pro chancellor on the board of governors for Northumbria University and chair of Northumbria Probation Service Board.
Qualifications: BA Economics
Principal Skills & Expertise: Strategic leadership, strategic planning, performance management, corporate governance and risk management
Term of office: 1 April 2017 to 31 March 2020*
Date of Initial appointment: 1 April 2014
(Note: The Chairman has no other material commitments and this position did not change during the year)

Dr. Hugh Griffiths Non-Executive Director, Deputy Chairman of the Trust and Chairman of the Quality Assurance Committee
Hugh was a consultant psychiatrist from 1988 and for eight years was an NHS trust medical director. In 2000 he also became medical director of the Northern Centre for Mental Health. He was director of policy and knowledge management for the NHS Clinical Governance Support Team in 2003/2004 and from then until 2010 was deputy national clinical director for Mental Health (England) at the Department of Health. Thereafter he was the National Clinical Director for Mental Health (England), leading the development of the Government's mental health strategy 'No Health Without Mental Health'. He retired in March 2013.
Qualifications: MB BS, FRCPsych
Principal Skills & Expertise: Service improvement, policy development, clinical leadership and management
Term of office: 1 April 2018 to 31 March 2021*
Date of Initial appointment: 1st April 2015 (prior to his appointment Hugh served as an Associate Non-Executive Director of the Trust (non-voting) between 1st September 2014 and 31st March 2015).

David Jennings Non-Executive Director and Chairman of the Audit Committee
David is a qualified accountant and worked for the Audit Commission for 26 years, including as acting head of operations. He set up his own business in 2011 and led the creation of a shared service between Redcar and Cleveland and Middlesbrough Councils' internal audit functions. He also acted as a consultant to a consortium of eight

national accountancy firms seeking entry to the post-Audit Commission market. . He is currently the Programme and Project Assurance Manager of Redcar and Cleveland Borough Council, having been their Financial Services Manager and deputy Section 151 officer until November 2017.
Qualifications: Chartered Institute of Public Finance and Accountancy (CIPFA)
Principal Skills & Expertise: Expertise primarily in areas associated with finance, performance, and governance and skills in governance, auditing, business planning, the public sector, local government, performance improvement, shared services, business process improvement, performance management, change management, strategy, accounting, management and leadership.
Term of Office: 1 September 2017 to 31 August 2020*
Date of Initial appointment: 1st September 2014

Marcus Hawthorn, Non-Executive Director, Chairman of the Resources Committee and Senior Independent Director
Marcus is a former Colonel in the British Army with extensive command and operations experience. His 30 years' service culminated in a number of senior programme and change management roles in the Ministry of Defence and the Home Office. Since then he was most recently the head of group risk and compliance at Age UK and he is now northern area manager for the Royal British Legion.
Qualifications: BEng(Hons) Chemical Engineering, MSc Design of Information Systems, Postgraduate Diploma in Law. Also, past Fellow of the Chartered Management Institute.
Principal Skills & Expertise: Risk, compliance and audit management, program management, operations, resilience and business continuity, systems development, change management, stakeholder engagement and partnership working, influence and strategic communications, human resource management, public and third sector focus and logistics.
Term of office: 1 September 2016 to 31 August 2019*
Date of Initial appointment: 1 September 2013

Paul Murphy, Non-Executive Director
Paul has had a broad range of experiences at a senior level in public and private (not-for-profit) sectors, as well as central and local government, including spells as a ministerial private secretary and an assistant director at City of York Council. He is now a freelance consultant, with an interest in particular in mental health, wellbeing, and in services for children and young people.
Qualifications: BA (Hons) English & Related Literature
Principal skills and expertise: Strategic planning, operational management, change management, human resources, communications, education, and articulating the service user voice.
Term of office: 1 September 2016 to 31 August 2019
Date of Initial appointment: 1 September 2016

Richard Simpson, Non-Executive Director and Chairman of the Mental Health Legislation Committee
Richard runs his own business delivering coaching, training and public relations consultancy. He has previous experience as a non-executive director in the NHS and is the Chair of The Millin Charity, an enterprise charity based in the West End of Newcastle, and a Trustee of Tyneside and Northumberland Mind
Qualifications: BA (Hons) Sociology and Social Anthropology; Advanced Diploma in Leadership and Development Coaching.
Principal Skills & Expertise: Communications, marketing, stakeholder engagement, crisis management, executive coaching, training, organisational development.

Term of office: 1 September 2016 to 31 August 2019*
Date of Initial appointment: 1 September 2013

Shirley Richardson, Non-Executive Director
Shirley was the Board Nurse Director at Gateshead Health NHS Foundation Trust for 17 years prior to her retirement in 2010.

She is a registered nurse and has leadership experience in acute, elderly, mental health, learning disability and paediatrics, across both hospital and community.

Since 2011 she has been chairman of Carers Together Foundation, a charity providing information, advice and support to carers in Middlesbrough, Redcar and East Cleveland.
Principal skills and experience: Transformational leadership, strategic planning, coaching and mentoring, service redesign, performance improvement, quality and safety systems, governance and risk management, research and development.
Qualifications: MBA, RN, Diploma of Chartered Institute of Marketing
Term of office: 1 September 2016 to 31 August 2019
Date of Initial appointment: 1 September 2016

*(Note: * indicates that the individual has been reappointed as a Board member of the Foundation Trust.)*

Colin Martin, Chief Executive
Colin has worked in local government and the NHS for over 30 years and was previously the director of finance for Tees and North East Yorkshire NHS Trust.
He is a Director of North East Transformation System Ltd, a joint venture between the Trust and Gateshead Health NHS Foundation Trust.
Qualifications: Qualified accountant, FCCA.
Principal Skills & Expertise: Programme and project management, systems development, PFI finance, information analysis, performance management and service development
Appointed: 1 May 2016 (prior to his appointment Mr. Martin was the Trust's Director of Finance and Information)

Brent Kilmurray, Deputy Chief Executive and Chief Operating Officer
Brent has been an NHS executive director since 2005, having previously worked at City Hospitals Sunderland, NHS South of Tyne and Wear and South Tyneside NHS Foundation Trust. Prior to that he worked in local government.
Qualifications: BA (Hons), MA
Principal Skills & Expertise: Operational service leadership, performance management, strategy development, service change, risk management, programme and project management.
Appointed: February 2013
(Note: Brent has stepped back from his role as the Chief Operating Officer to focus on the rectification of defects at Roseberry Park)

Drew Kendall, Interim Director of Finance and Information
Drew has extensive financial experience having worked in NHS Acute and Mental Health services for over 27 years and was previously Associate Director of Finance with the Trust since 2009. He is a member of the National HFMA (Healthcare Financial Management Faculty) Mental Health Faculty and HFMA Policy group. Drew is also a Board member of the AuditOne NHS Audit consortium.
Qualifications: Qualified accountant, FCCA

Principal Skills & Expertise: Financial management and costing, programme and project management, foundation trust regime and application process, information and systems development.
Appointed: (Interim) June 2016

Dr Ahmad Khouja, Medical Director
Ahmad is a practicing consultant psychiatrist in Forensic Learning Disabilities. He was appointed Medical Director in March 2018; prior to this he was the Deputy Medical Director and Senior Clinical Director for the Forensic Service. He has a research degree in Molecular Medicine from Oxford University. He was a former Training Programme Director for Higher Trainees in the Psychiatry of Learning Disability. He is a Certified Leader for the Trust's Quality Improvement System. He has led on recovery and harm minimisation for the Trust.
Qualifications: MRCPsych, MBChB, BA(Hons) DPhil (Oxon)
Principal Skills & Expertise: Psychiatric practice, clinical leadership, patient safety, clinical effectiveness, programme and project management, service improvement, medical education, research and development
Appointed: March 2018

Elizabeth Moody, Director of Nursing and Governance
Elizabeth took up post as director of nursing and governance in July 2015. Elizabeth has over 25 years' experience in the NHS having registered as an RMN in 1991. Prior to joining the Trust she worked as a deputy director of nursing, group nurse director for inpatient services and community services, leading on the community redesign of pathways of care and service improvement. Elizabeth has also worked nationally on programmes related to patient safety, governance and assurance.
Qualifications: RMN, PGDip Professional practice
Principal Skills and Expertise: Psychiatric nursing skills, project management, service improvement, managerial and leadership skills, patient and carer experience, patient safety, quality and assurance
Appointed: August 2015

Registers of interests
Details of company directorships or other material interests in companies held by directors which might conflict with their responsibilities are included in the "Registers of Interests". This document are available for inspection on our website www.tewv.nhs.uk.

Changes to the Board of Directors during 2017/18

- Mr. Jim Tucker, Non-Executive Director, Deputy Chairman and Chairman of the Resources Committee, retired from the Board on 31th August 2017.
- Dr. Nick Land retired from his role as the Trust's Medical Director on 28th February 2018.
- Drew Kendall, stepped back from his role as the Trust's Interim Director of Finance and Information on 31st March 2018.
  (Note: Patrick McGahon commenced his role as the Director of Finance and Information on 1st April 2018.)

Compliance with accounting guidance

The Trust prepared the financial statements in accordance with the NHS Group Accounting Manual (2017-18) as directed by NHS Improvement, and fully complies with International Financial Reporting Standards accounting practices (IFRS).

The Trust's accounting policies are set out in the Annual Accounts and have been consistently applied over the comparative period.

The accounts are independently audited by Mazars LLP as external auditors in accordance with the National Health Service Act 2006 and Monitors Code of Audit Practice (as adopted by NHS Improvement). As far as the directors are aware, all relevant audit information has been fully disclosed to the auditor and that no relevant audit information has been withheld or made unavailable. Nor have any undisclosed post balance sheet events occurred.

No political or charitable donations were made by the Trust during 2017-18.

Accounting policies for pensions and other retirement benefits are set out in the accounts and details of senior managers remuneration can be found in the remuneration report.

The Trust had complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector Information guidance.

Better Payment Practice Code

The Better Payment Practice code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. Performance for the financial year 2017-18 was as follows:

	2017-18	
	Number of Invoices	**Value of invoices £000s**
NHS Creditors		
Total bills paid	1,271	19,165
Total bills paid within target	608	12,804
Percentage of bills paid within target	47.8%	66.8%
Non-NHS Creditors		
Total bills paid	54,579	84,638
Total bills paid within target	52,897	82,209
Percentage of bills paid within target	96.9%	97.1%

It is Trust policy to pay all creditors as they fall due, unless extenuating circumstances are apparent, e.g. a dispute in the amount being charged, or the service / goods provided.

NHS Improvement's well-led framework

In this section of the Annual Report we provide an overview of the arrangements in place to ensure that services are well-led having regard to NHS Improvement's (NHSI) well-led framework.

NHSI's framework is structured around eight characteristics of a well-led organisation.

- **There is Leadership Capacity and Capability to develop high quality sustainable care**

  Our overall leadership is provided by the Board of Directors comprising a Non-Executive Chairman, Executive Directors and Non-Executive Directors.

  As shown in their biographies (provided in the Accountability Report) all Board Members are highly experienced and come from a broad range of professional backgrounds and experience.

  The composition of the Board is regularly reviewed.

  Board Members are subject to an annual performance assessment based on a scheme developed by Deloitte LLP. Details of this scheme are provided as part of the disclosures on the NHS Foundation Trust Code of Governance.

  Arrangements for the regular appraisal of all leaders within the organisation are in place and monitored by the Executive Management Team.

  Leadership of the Trust's Localities (County Durham and Darlington, Tees, North Yorkshire, York and Selby and Forensic Services) is provided by a Director of Operations, Deputy Medical Director and Head of Nursing.

  The Leadership and Management Groups (LMGBs) for each Locality:
  - Provide assurance on the quality and safety of the operational clinical services to the Quality Assurance Committee.
  - Are accountable for the delivery of relevant elements of the Business Plan, contractual requirements, and compliance with CQC and other legislative and regulatory frameworks

  The Clinical Directorate Quality Assurance Groups provide assurance to their respective LMGBs through monitoring inspection reports, user feedback, performance data, audit outcomes, untoward incidents, complaints, CQC reports, etc. and oversight of governance systems, including risk management, and the appropriate delivery of action plans.

  Speciality Development Groups, chaired by the Senior Clinical Directors, are also in place focussing on:
  - The development of quality, including standards of best practice based on lessons learnt from serious incidents, patient outcome and experience data, NICE guidelines, benchmarking, new national policies and strategies etc, and the provision of "thought leadership" to promote

a positive patient focussed culture within their respective specialties (Adult Mental Health, Children and Young People, Forensic, Learning Disability, Mental Health Services for Older People)

- Leadership of the clinical audit programme and implementation of NICE guidelines

Through these arrangements there is:

(a) Continual provision of assurance on the quality of services to the Board of Directors.

(b) Consistency and the implementation of best practice across each Clinical Specialty.

These arrangements enable the Trust to achieve the benefits which come from being large and diverse whilst providing robust building blocks for our clinical governance systems.

Leaders across the organisation place a high importance on being visible and approachable.

"Gemba" walks, the personal observation of work being undertaken, is a key element of our quality improvement system.

Each month, teams of Directors visit services providing staff with opportunities to raise issues. The outcomes of these visits are reported to, and monitored by, the Executive Management Team with an annual report being provided to the Board.

Succession planning and talent management arrangements are in place to identify and develop our next generation of leaders.

- **There is a clear vision and credible strategy to deliver high quality sustainable care to people and robust plans to deliver it.**

Our Strategic Direction, comprising the vision, mission and strategic goals, is focussed on the delivery of high quality, sustainable care (see "The Performance Report").

The business plan, to deliver our Strategic Direction, is refreshed annually taking into account changes to the external and internal environment and the views of stakeholders, Governors, service users and carers, staff and partner organisations.

Through this process, strategic priorities, including the Quality Priorities (see "The Quality Report") are identified and agreed.

For 2017/18 our strategic priorities included:

- Implementing phase 2 of the recovery strategy
- Developing and delivering the Purposeful and Productive Community Services Programme
- Improving the consistency and purposefulness of inpatient care across the Trust
- Ensuring Safe Staffing in all our services

- "Making a Difference Together" focusing on supporting staff live our values
- Implementing the Transforming Care agenda in Learning Disability Services
- Improving the clinical effectiveness and patient experience at times of transition
- Developing a Trust-wide approach to delivering services to service users with Autism
- Improving the inpatient estate in York
- Delivering new models of care for Adult Mental Health and Mental Health Services for Older People in Harrogate and Hambleton and Richmondshire
- Reducing the number of preventable deaths
- Reducing occurrences of serious harm resulting from inpatient falls

Delivery of the priorities in undertaken through a programme approach. The Executive Management Team meets each month as the "Strategic Change Oversight Board" to monitor progress.

A number of strategies also support the delivery of the Strategic Direction. Of these, the Quality Strategy sets our vision and direction for the further development and improvement of the quality of care delivered by the Trust. Each of its goals is supported by high-level measures which seek to enable the Trust, through its Quality Assurance Committee, to monitor that the Quality Vision is being delivered.

- **There is a culture of high quality, sustainable care.**

The Trust promotes an organisational culture which is open, fair and promotes learning. It encourages all staff to adopt a responsive and open approach towards identifying and understanding potential risks and responding to them. This includes requirements to report unsafe acts or conditions and untoward incidents and near misses using the Trust's incident reporting process.

The Trust's Values: commitment to quality, respect, involvement, wellbeing and teamwork, were developed in consultation with service users, carers, Governors and staff.

Expected behaviours to support each of these Values have been identified.

A staff Compact has also been developed which sets out the psychological contract, "gives" and "gets", between the Trust and its staff.

All nursing and healthcare staff are expected to comply with the six enduring values and behaviours of 'compassion in practice' published by NHS England.

Our culture is supported by:

- Our Quality Improvement System which instils a philosophy of continuous improvement
- Our Recovery Programme focussing on the model of co-production with increased opportunities for individuals with lived experience to be involved in the design and delivery of services

During 2017/18 we have introduced a new policy on Conflicts of Interest in response to guidance provided by NHS England.

There are a number of ways in which staff can raise concerns about patient safety:

- Through the "Whistleblowing Policy"
- Through an online system (anonymously if required) with the Executive Management Team
- Through the Freedom to Speak Up Guardian
- Through the Guardian of Safe Working
- Through the quarterly Friends and Family Test surveys
- During Directors' visits to services

- **There are clear responsibilities and roles and systems to support good governance and management**

Clarity of roles and responsibilities within the Trust's governance arrangements is provided in:

- The Constitution including the schedule of matters reserved by the Board and Scheme of Delegation
- The schedule of responsibilities of the Chairman and Chief Executive included in the Integrated Governance Framework
- The Scheme of Delegation of functions included in the Mental Health Act Code of Practice
- The terms of reference of the Board's Committees and the Executive Management Team
- The Trust's Quality Governance arrangements which sets out the membership, roles and responsibilities of the LMGBS, QuAGs, SDGs and Thematic Quality Groups.
- The Trust's programme and project management arrangements

A number of systems are in place to support good governance including:

- The PARIS clinical record system
- The Integrated Information Centre (IIC) which is a data warehouse and supports both corporate decision making and assurance processes and management activity through the provision of "real time" performance information
- The DATIX system enabling us to manage and report on incidents, complaints and risks and which supports our serious incident processes.
- The e-rostering system which supports safe staffing in the Trust's services

- **There are clear processes in place to manage risks, issues and performance**

The key systems and processes in place for managing risks, issues and performance are aligned to our governance structure: the Board, the Board's Committees, the Executive Management Team, the LMGBs, QuAGs and wards and teams.

Daily lean management and escalation procedures, together with the clear roles and responsibilities described above, provide a ward to Board approach.

Further information on our performance management processes are provided in the performance analysis section of the Annual Report.

During 2017/18 we have:

- Strengthened our risk management processes with the development and approval of a revised Operational Risk Management Policy, additional resources being provided to support risk management and training taking into account recommendations made by the Trust's Internal Auditors
- Developed and implemented systems and processes to learn from deaths, working with nine other providers in the North of England, in accordance with the "Learning from deaths framework" published by the National Quality Board (NQB)
- Continued to refine our systems and processes and escalation arrangements in relation to safe staffing

- **Appropriate and accurate information being effectively processed, challenged and acted upon.**

  Our performance metrics, and their targets, are reviewed and refreshed each year as part of our business planning processes.

  Benchmarking and other external sources of information are used as appropriate and available e.g. from the NHS benchmarking team.

  Evidence of information being challenged and acted upon is provided in the minutes of Board and committee meetings which are available on our website.

  Our performance dashboard metrics are subject to data quality checks.

  During 2017/18:

  - We have established an internal group to review and monitor data quality
  - Agreed an annual programme of data quality reviews with our Internal Auditors

- **People who use services, the public, staff and stakeholder partners are engaged and involved to support high quality sustainable services**

  Wide ranging arrangements are in place to enable us to effectively engage with the public, staff and stakeholder partner organisations.

  Principally these include:

  - Our Council of Governors
  - Engagement with our members (see the Membership Report)
  - The work of our involvement and engagement team (details provided later in this section)

- The Recovery Programme including the involvement of experts by experience in cultural change, participation in various project and steering groups, taking part in recruitment and contributing to policy
- Formal consultation on service changes in partnership with our commissioners, for example, in 2017/18 those relating to the development of new models of care in North Yorkshire.
- The national patient survey
- The collection of patient experience data and the involvement of service users in identifying actions for improvement
- The national staff survey and quarterly "friends and family" test surveys
- Our involvement in sustainability and transformation partnerships and other joint arrangements with commissioners and other providers
- Membership and participation in local safeguarding boards
- Regular meetings with representatives of local healthwatch
- Bespoke engagement to support our business plan priorities including, in 2017/18, the TEWV values and staff compact consultation and an event to seek views on tackling the abuse of staff as part of the "Making a Difference Together" priority

The Trust's conclusion that it is well-led is based on:

- The CQC assessment undertaken in January 2017 which rated the Trust as "good" in the well led domain.
- An independent external governance review undertaken by Grant Thornton LLP during 2017. This was based on NHS Improvement's guidance in place at that time and which broadly corresponds to the "Well- led framework".

  The findings of the review were that all areas were rated as either meeting or partly meeting (with confidence in management's capacity to deliver within a reasonable timescale) the regulator's expectations for a well governed foundation trust.
- The achievement of a NHSI Single Oversight Framework rating of 1 (maximum autonomy). Further information on this matter is provided in the "Accountability Report.
- The Head of Internal Audit's Annual Opinion for 2017/18 that "From my review of your systems of internal control, I am providing good assurance that there is a sound system of internal control, designed to meet the Trust's objectives, and that controls are generally being applied consistently."
- There being no material inconsistences identified between the Annual Governance Statement, the quality report, the annual report, the annual corporate governance statement and reports arising from CQC planned and responsive reviews.

Using our Foundation Trust Status to develop services and improve patient care

Being a foundation trust is helping us:

- build on and improve positive relationships with service users, carers, staff, partners and local people and be more accountable to local people
- strengthen our internal process and systems to meet the challenges of modern health services
- develop locally based specialist services
- respond better to market opportunities

- continue to invest in capital developments such as a new hospital for York and Selby
- engage with NHS England and the CCGs to develop new models of care

Performance against key health care targets
The Trust monitors a range of key health care targets which include those set internally by the Board of Directors, those set externally as part of the mental health contracts with Commissioners and the national ones within NHS Improvement's (NHSI) Single Oversight Framework (SOF). This section will focus on the national ones within the NHSI SOF as the former two are covered already within this Annual Report (see Chapter 2 "Overview of Performance" and further below "Progress towards targets as agreed with local commissioners".

There are 9 operational metrics within the Single Oversight Framework (SOF) November 2017, which revises and replaces some of the previously defined SOF metrics. The Trust monitors progress against each of the operational metrics and provides an update to the Board of Directors within its monthly performance report, in addition to a quarterly report that monitors all SOF metrics. The Trust has achieved all targets within 2017/18; however NHSI introduced a metric for Inappropriate out of area placements (OAPs) for adult mental health services in November 2017. The process for agreeing trajectories towards eliminating OAPs was jointly led by NHS England and NHS Improvement regional teams during October to December 2017 and the Trust has agreed a trajectory with the CCGs to improve performance and reduce the 2017/18 figure by 10% each year. Representatives from the Trust have met with CCGs to develop action plans to support this delivery. It should be noted that all Trust out of area admissions reported during 2017/18 are internal, whereby the patient has remained within their home organisation, ie this Trust, but the location of the receiving unit disrupts their continuity of care.

Overview of arrangements in place to govern and improve service quality
The Trust has implemented its quality strategy, launched in 2014 , which describes the arrangements for the governance of quality across the organisation. Those arrangements include the clinical governance systems for the Trust services together with the clinical assurance systems that detail how the corporate governance teams and Trustwide assurance groups manage the relevant assurance processes. The quality strategy is being delivered through frameworks for patient safety, patient experience and clinical effectiveness together with the Trust workforce strategy. The strategy was refreshed in 2016 following consultation with service users, carers and staff and progress against the new metrics is being monitored by relevant Trust groups.

Delivery of the quality strategy is reported through a strategic scorecard with key performance indicators for each framework, reported quarterly to the Quality Assurance Committee, a sub-group of the Board of Directors.

Each clinical directorate, in the five operational localities of the Trust, has a quality assurance group (QuAG) that reviews the performance against quality indicators of their clinical teams. Those groups manage their clinical directorate quality improvement plan, monitoring quality data and the local risk register providing assurance and escalating risk where necessary to the five locality management and

governance boards (LMGB). These boards provide exception reports monthly to the Quality Assurance Committee with a regular bi-monthly assurance report on service quality. A set of standardised quality reports for the quality assurance groups, locality management and governance boards, Trustwide quality assurance groups, Quality Assurance Committee and commissioners are in place. Work will continue during 2018/19 to align the agendas with the CQC Fundamental Standards for Quality and Safety.

The corporate quality governance teams manage the operational systems to provide quality performance information for the service and Trustwide quality assurance groups, boards and committee. These include, for example, the complaints and PALS teams, patient safety team, clinical audit team, quality data team and patient and carer experience team. The regulatory compliance team implements a programme of peer and service user inspections across Trust services to monitor the quality of service delivery against the regulatory fundamental standards. All corporate teams then also monitor quality improvement action plans developed from the performance deficits and risks identified and report into the Trustwide assurance groups and the Quality Assurance Committee. Key information on the CQC activity and ratings for the Trust along with data on complaints and incidents can be found within the Quality Report section of this report. During 2016/17 a Quality Compliance Group has been established which is chaired by the Director of Quality Governance and the membership is the Heads of Service and Modern Matrons from across the organisation. The purpose of this group is to provide information and share learning from CQC and other regulatory inspections.

The Trustwide quality assurance groups track the performance against the quality strategy scorecard and other Trustwide key performance indicators related to the key elements of quality – safety, effectiveness, experience, safeguarding, infection control, physical health, equality, diversity and human rights and medicines management. These groups also develop responses to national quality and best practice directives on a Trustwide basis and report on a regular reporting schedule to the Quality Assurance Committee.

The Quality Assurance Committee provides an assurance and exception report to the Board of Directors on a monthly basis.

In addition to the implementation of the quality strategy, the Trust monitors and reports on performance against the national and local quality indicators in the commissioned contracts. Monthly quality reports are produced for all the service contracts and reviewed by commissioners with the locality operational management teams, corporate performance and quality governance teams. Each locality management team therefore has oversight of their service performance against the internal strategic quality targets and against their contractual quality indicators. More information relating to contractual performance metrics can be found in the Quality Report.

Our most recent comprehensive inspection by the Care Quality Commission was in November 2016. Whilst the inspection highlighted many areas of good practice, there were some areas that both the CQC and the Trust recognised needed to be improved. An action plan was developed following the visit to ensure that all improvements were put in place in a timely manner and this has been implemented

throughout 2017/18. A Trust wide Quality Compliance Assurance Group of senior managers has been established to ensure that the action plan is completed and that all learning from our inspections is shared across all localities and specialities. Senior staff from the Nursing and Governance directorate also have regular engagement meetings throughout the year with staff from the Care Quality Commission to discuss areas of interest and monitor the ongoing completion of Trust actions.

In July 2017, Her Majesty's Inspectorate of Prisons conducted an unannounced inspection of Holme House Prison, a category B local prison near Stockton on Tees. Following the inspection, the Care Quality Commission issued the Trust with a Requirement Notice regarding Regulation 9: Person Centred Care. This states that 'The care and treatment of service users must be appropriate, meet their needs and reflect their preferences'. In response to this the Trust has reviewed its processes (in conjunction with staff from the prison services) and put in place required improvement actions to ensure that appropriate care was consistently provided to meet the needs of these patients. This work was also monitored though the same governance routes mentioned above and discussed during engagement meetings with the Care Quality Commission.

Progress towards targets agreed with local commissioners

The Trust provides regular performance information to its commissioners as part of the contracts we hold covering activity, key performance indicators and measures of quality. The Trust's commitment to contract performance management is evidenced through monthly contract meetings, and sub groups with commissioners which are regularly attended and have full participation of senior staff, including a number of Board members. These meetings/groups focus on areas such as service quality, service development and finance.

There were two operational standards and four national quality requirements included within the 17/18 mental health contract which were:

- Number of episodes of mixed sex accommodation – sleeping
- Percentage CPA 7 day follow up (adult services)
- Duty of Candour (failure to notify)
- Data completeness - NHS Number
- Data completeness – Ethnicity Coding
- People with a first episode of psychosis begin treatment with a NICE recommended package of care within 2 weeks of referral

The majority of targets were achieved for the 17/18 financial year for the 9 core CCGs. The only target not achieved was 'People with a first episode of psychosis begin treatment with a NICE recommended package of care within 2 weeks of referral' for Darlington CCG where they achieved 40.74% against a target of 50%. Within the Darlington locality the number of referrals received in this area are small and as a result it is easy for an under performance to occur. Within this area patient DNAs are consistently a reason for failure to achieve the target. The service continues to address issues around patient engagement.

We have also continued to drive improvements in the quality of our services. Much of this has been progressed using our Quality Improvement System, and

commissioners / service users and carers have been involved in some of these developments.

During 2017/18 we:

- Delivered the actions set out in our Quality Account improvement priorities (Recovery oriented services, reducing harm from falls, CYP to Adult Transitions, Reducing Preventable Deaths and Safe Staffing
- Redesigned many of our clinical pathways and clinical link pathways (CLiPs).
- Spread the existing Purposeful Inpatient Admissions (PIPA) approach from our Adult wards to our Older People's wards. This reduces delays in assessment, treatment and discharge, encourages multi-disciplinary team working and reduces inconsistencies in approach between different localities within TEWV.
- Improved and standardised practice across our two adult Psychiatric Intensive Care Units (PICUs) leading to a more recovery oriented approach and better arrangements for transfer back to assessment and treatment wards.
- Agreed Crisis Team triage and assessment standards, and criteria for admission and home based treatment interventions by these teams.
- Brought about improvements in the psychological input to the treatment of older people in our services (by improving the processes for referral to psychology). This is reducing waiting times from initial referral to first contact, improving the standard process for formulation, and ensuring more equity in length of time in therapy.
- Observed the daily practice of community mental health teams in all specialities and piloted new ways of entering patient information into our electronic patient record to increase the proportion of time that clinicians can spend with service users.
- Reviewed our Children and Young People's Services (CYPS) care pathways to make them more Learning Disability compatible.

We have also worked to improve our quality through staff training and, communication. For example we have:

- Commenced the delivery of Trauma Informed Care (TiC) training.
- Introduced training for all new inpatient staff in relation to patient leave and time away from the ward.

New and significantly revised services

Information about our key developments during 2017/18 are outlined in the performance report. This includes changes to adult learning disability crisis teams in Durham, Darlington and Teesside and the work we've done in the children's and young people's new care models pilot to reduce admissions and lengths of stay through the use of crisis and intensive home treatment services.

In addition on 1 February 2018 TEWV took over responsibility for delivering mental health and learning disability services in the Pocklington area (these were previously provided on behalf of the Trust by Humber NHS Foundation Trust).

Service improvements following staff or patient surveys/ comments and Care Quality Commission reports
A number of service improvements have been made following inspections by the CQC such as:

- We have appointed a Care Programme Approach Lead Officer to enhance shared decision making and co-production of clinical records and promote person-centred care planning.
- We have enhanced systems in place to ensure physical observations following administration of rapid tranquilisation are monitored and recorded in line with Trust Policy
- We have provided additional Resuscitation Training courses to ensure all relevant staff can access a course when required
- Standard work has been developed to ensure that checks of emergency equipment and other relevant ward checklists are always undertaken
- We have continued to work towards a culture of 'Positive and Safe' that has led to reduction in number of times that staff has needed to use physical restraint. The Care Quality Commission has commended the Trust for demonstrating a positive and therapeutic culture which will continue to reduce the need for restrictive interventions.

Information on complaints handling
Complaints are managed following national guidance and we endeavour to respond to all of our formal complaints within 60 days. We have a complaints manager aligned to each locality area of the Trust who works with the relevant operational staff member, service user and/or carer to resolve the issue that has been raised.

Service improvements following patient feedback
We gain important feedback from patient and carer surveys, which enable us to focus improvements on specific wards and services. For instance:

- Forensic Mental Health – Patients stated that they didn't always feel safe on the ward. To try and improve this we have ensured that patients are offered support when incidents are occurring on the ward. We have a 'Safe Wards Reassurance Lead' in place and this is advertised on ward areas so patients know who that is.
- Adult Mental Health - Patients stated they would like more activities on the ward. Following on from an improvement event the ward staff team are working towards increasing activity via a menu of options and more structured approach to the day (and evening).In the interim staff are providing at least one activity every day and a new Occupational Therapist is in post which is increasing the availability of therapeutic activity sessions.
- Mental Health Services for Older People - A carer stated "I found it rather difficult speaking about my father with him present as he doesn't think he is as bad as he is and it is upsetting." We will ensure we give carers the opportunity to speak in private if this is less distressing to their loved one and is beneficial to the assessment.

Working in partnership
TEWV has several significant partnerships and alliances. These include:

- Our work with NHS England (NHSE), Northumberland, Tyne and Wear NHS Foundation Trust (NTW) and other providers to progress new care model

pilots that are testing our provider-led management of NHSE commissioning budgets. We have active projects in adult secure (forensic) and children and young people's specialist inpatient services. The CYPS work is most advance and has led to investment in crisis / intensive home treatment teams across the area served the Trust and a reduction in admissions.

- Our involvement in the development of an Accountable Care Partnership (ACP) with the CCGs across Durham, Darlington and Teesside. In its first phase this has carried out reviews into over 60 adult learning disability NHS funded placements and brought about many improvements in both the quality and value for money of these. All partners have invested existing staff resource into this initiative.
- We have a developing research and development partnership with York University and continue to work with the appropriate research councils, clinical networks and other bodies to increase the number of TEWV service users and services supporting research into mental health (including dementia), learning disabilities and the implications of an ageing workforce.
- We continue to partner with the Virginia Mason Institute and receive continuing advice and guidance on how to further improve our Quality Improvement System.
- We support the work of 4 STPs as they develop plans for mental health and learning disability services – these STPs are Durham,Tees,Hambleton, Richmondshire and Whitby; Humber, Coast and Vale; West Yorkshire; and Northumberland, Tyne & Wear and North Durham.

In addition:

- The Trust works with a number of voluntary and charitable sector organisations. In some services, such as mental health service provision in prisons, or in our Durham and Darlington talking therapies service this is in a contractual form. But we also have more informal day to day links with the third sector, and in the Vale of York we manage a grant-giving scheme for local VCS organisations (York Connects)
- The Trust also supported the Harrogate Vanguard project throughout 2017/18. This promoted new ways of providing joined-up services to older people between different NHS and voluntary sector providers in Harrogate. The project is now closing, but lessons are being learned from this work.
- The trust has worked with GP partners to trial the placement of mental health professionals directly in GP surgeries across the south of County Durham and in Catterick Garrison in Richmondshire.

Involving local people

The Trust continues to build upon its agreed framework to involve and engage service users and carers with an extensive involvement programme largely devolved to service level but supported by the Involvement and Engagement Team.

Involvement undertaken by service users and carers ranges from consultation right through to co-production with a primary focus of improving the delivery of high quality person centred services that promote recovery.

Involvement of service users and carers over the last 12 months has included:

- Coordination of over 251 requests for involvement, with an excess of 100 service users or carers registered for involvement participating on individual interview panels for staff.
- The provision of a wide portfolio of training to a range of staff, doctors in training and nurse students through the use of personal experience stories and sharing medical histories, feedback on the carer input into the course was *'Their talk was very moving, emotive and compelling'*.
- 16 service users and carers assisted staff in the inspection of 21 wards and premises under Patient Led Assessment of the Care Environment (PLACE).
- The establishment of a design task group in the Vale of York who are influencing the detail of the interior of new build hospital. Their input is so valuable and really looks at things from a non-staff and architect's perspective.
- Service User and Carer Involvement Groups across North Yorkshire continue to have a significant impact in the business planning priorities and have been heavily involved in the conversations around transformation plans and formal consultation processes in the area in relation to the provision of inpatient and community services.
- Young People are now receiving reimbursement for their time and contribution in helping us improve services. For each hour they work with us they receive a £5 high street shopping voucher.
- We have continued to increase the membership of steering groups, committees and local governance groups. Service users and carers regularly contribute to, and influence, service improvement through the use of the Trust's Quality Improvement System.
- In terms of the support provided to service users and carers. A carer who participated in the recruitment of the Medical Directors commented '*He said everything I wanted to hear as a carer, I almost cried at one point. I really felt the process was a valuable one for the candidates to go through and was grateful for the guidance beforehand. That helped me focus on the presentations and not panic about preparing questions beforehand.'*
- Participation in service improvement events utilising the Trust Quality Improvement System's methodology.
- Co-delivery of the development programmes; Leadership for Advocates and Service Users, Expert by Experience Programme for Adult Mental Health Services has continued.
- Co-delivery of training programmes at ARCH Recovery College and service users has helped to increase the portfolio of training offered on the Trust's Recovery College online.

The Chief Executive received direct feedback from a service user group in York 'H*ow grateful they were for the work the Involvement and Engagement Officer has done with them and the wider service user group in that area'*.

2017 saw two carers shortlisted for the award of Carer of the year by the Royal College of Physiatrists.

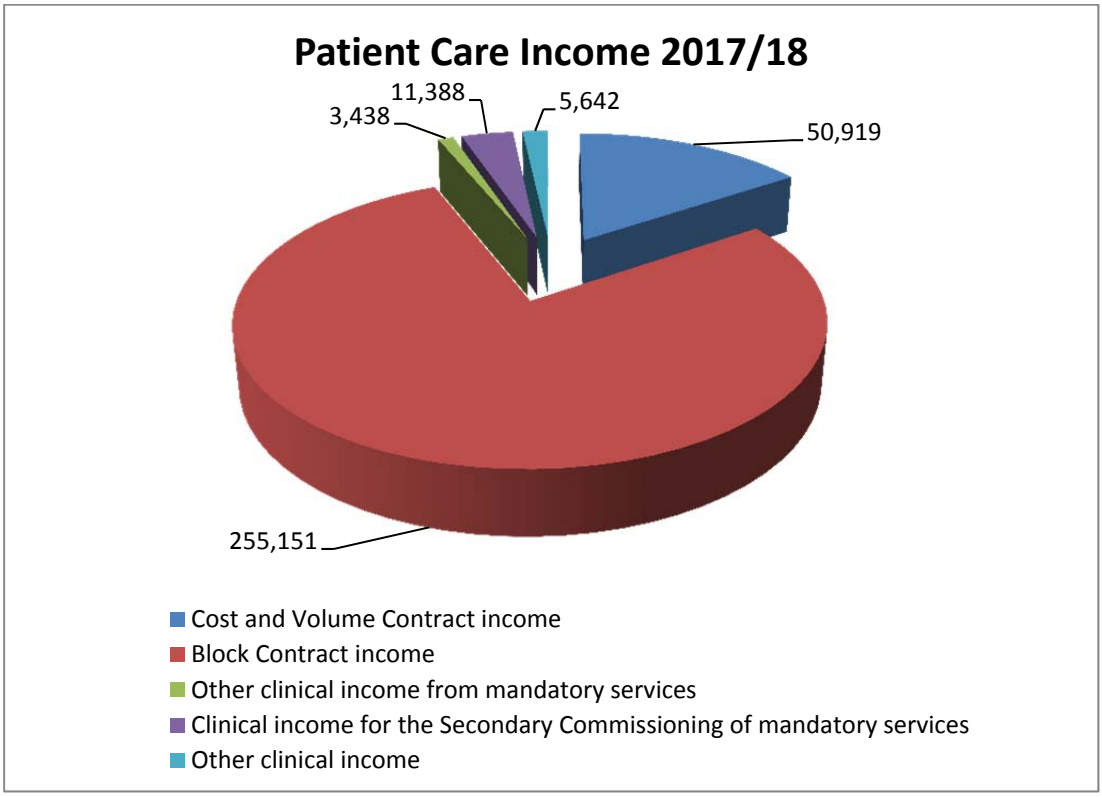
A survey of involvement members to identify satisfaction and support mechanisms was undertaken in 2017. As a result 95% reported satisfaction with their involvement, however it did highlight the need for more support and training to be available. In response the first support and training programme was launched in early 2018.

Consulting with local people
In 2017/18 we worked with NHS Hambleton and Richmondshire Clinical Commissioning Group to engage with local people about options for developing mental health services for adults and older people. This resulted in a formal public consultation on three options, which was overseen by NHS England and North Yorkshire Council's Scrutiny of Health Committee. The approved option will see community services strengthened to support more people at home and inpatient mental health services eventually moving from the Friarage Hospital in Northallerton to either Roseberry Park in Middlesbrough, West Park Hospital in Darlington and, for a small number of people with severe dementia, Auckland Park Hospital in Bishop Auckland. The decision reflects the feedback received from local people, including the consultation survey.

We also started to work with NHS Harrogate and District Clinical Commissioning Group to engage with local people about developing a vision for adult and older people's mental health services in the Harrogate area. The planned development of a new hospital for Harrogate has been put on hold while this review takes place and work will continue into 2018/19.

Fees and charges
The Trust received no income from fees and charges.

Income Generation
During 2017-18, income generated was £350.3m from a range of activities; 93.2% from direct patient care. Patient care income came from the following areas:



Statement as to disclosure to Auditors

Each of the directors, holding office on 31st March 2018, confirms that:

- as far as they are aware, there is no relevant information of which the Trust's Auditor is unaware
- that they have taken all steps they ought to have taken as a Director in order to make themselves aware of any such information and to establish that the Auditor is aware of that information.

Remuneration report

Statement from the Chairman of the Board's Nomination & Remuneration Committee

Information on the Board's Nomination and Remuneration Committee is provided in the section on Governance in the Accountability Report.

In 2014/15 the Committee agreed an Executive Management Team (EMT) Pay Framework. Details of this policy are set out below.

This Framework does not cover the remuneration of:

- The Chief Executive
- The Medical Director
- Senior Clinical Director for the Kaizen Promotion Office (KPO)
- The Director of Therapies
- Those members of the Executive Management Team employed at the time of its introduction that have chosen to remain employed under national Agenda for Change terms and conditions have the option to move under the Framework at any time.

During 2017/18 the Committee made a 1% cost of living award to those senior managers covered by the EMT Pay Framework. This award was comparable to the cost of living increase covering most NHS staff on Agenda for Change and national medical and dental terms and conditions of service.

Details of the salaries and allowances and pension benefits of senior managers in 2017/18 and payments made to past senior managers are provided in the tables in this section.

Lesley Bessant
Chairman of the Board's Nomination and Remuneration Committee

Senior Managers' Remuneration Policy

The key features of the Executive Management Team (EMT) Pay Framework and pay arrangements for those senior managers not covered by it, except for those

employed under national Agenda for Change and national medical and dental terms and conditions of service are set out in the table below:

No changes were made to the components of the EMT Pay Framework during 2017/18.

Basic Pay	The EMT Pay Framework is based on job evaluation point scores provided by Capita using an independent job evaluation system and agreed job descriptions. The pay levels are equivalent to the mid-point of the pay ranges proposed by Capita and are based upon the upper quartile market pay level for Executive Directors in Mental Health and Learning Disabilities NHS Trusts. The maximum amount which could be paid under the Framework to all members of the EMT, collectively, is £1,361,062. Through these arrangements the Trust has satisfied itself that senior managers' remuneration is reasonable. The basic pay arrangements support the short and long term strategic objectives of the Trust by enabling the Trust to recruit and retain talented individuals who undertake key leadership roles using levels of remuneration that represent value for money and which are comparable to those of other similar organisations.
Performance Related Components	In general, the EMT Pay Framework has no performance related components; however, starting salaries of less than the full amount (typically 7.5%) have been used for new post holders. The full amount becomes payable subject to the post-holder demonstrating good performance in their first year in office taking into account achievement of objectives and the outcome of their appraisals.
Recruitment and Retention Premia (RRP)	The Nomination and Remuneration Committee has the option of paying Recruitment and Retention Premia (RRP) but these should only be paid where there is clear evidence that the payments can be justified. No members of the EMT were paid a RRP during 2017/18.
Allowances	A Directors Travel Allowance of £5,444 is included within basic pay.
Provisions for the recovery of sums paid to Directors or for withholding payments of sums to senior managers	There is contractual provision for making appropriate deductions from notice period payments. Entitlement to pay progression, where applicable, is subject to confirmation from the individual's line manager that their performance over the preceding 12 months period has been rated as being good.

Remuneration above £142,500	A comparison is undertaken with NHS VSM pay-bands and with published salary bands within similar NHS organisations. The scale and complexity of TEWV which services a population of 2m people from over one hundred sites, working with nine Clinical Commissioning Groups, either upper tier local authorities and within three STPs is also a factor.
Arrangements specific to individual Senior Managers	The remuneration of the Senior Clinical Director for the Kaizen Promotion Office is in accordance with national terms and conditions for mental and dental staff

Other Policy Disclosures

- Service Contract Obligations:
  None identified

- Policy on Payment for Loss of Office:
  A contractual entitlement to three months' notice, other than in the case of summary dismissal. Where eligible an entitlement to a redundancy payment in accordance with Section 16 of the National Terms and Conditions of Service.

- Statement of consideration of employment conditions elsewhere in the Foundation Trust:
  A combination of an independent job evaluation scheme, to establish respective job weights, and independently gathered and reported information about Very Senior Manager remuneration levels in comparable trusts were used to establish the Executive Management Team Pay Framework. CAPITA undertook the job evaluation exercise and provided information about remuneration levels of equivalent posts within comparable organisations. This information has been used by the Nomination and Remuneration Committee to establish and operate the Executive Management Team Pay Framework since 2014 including consideration of updated independent remuneration reports. Individual employees directly affected by the Executive Management Team Pay Framework were consulted about the approach being taken and given the opportunity to retain their existing terms and conditions of employment should they wish to do so.

Non-Executive Director Remuneration

Basic Remuneration	The basic fees payable to the Chairman and Non-Executive Directors have been set by the Council of Governors taking into account information provided by Capita on fees payable by other Foundation Trusts. The Non-Executive Directors have not received an increase in their remuneration since 2013/14.
Additional fees paid for other duties	Additional fees are payable to the Chairman of the Audit Committee and the Senior Independent Director.
Allowances	The Chairman and Non-Executive Directors are able to claim reimbursement of expenses (e.g. travel) in line with Trust policy.

Colin Martin
Chief Executive **22rd May 2018**

Senior managers' remuneration

Name and Title	2017-18						2016-17					
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind * Rounded to the nearest £100	Pension related benefits (bands of £2500) £000	Total Remuneration (bands of £5000) £000	Expenses Paid Rounded to the nearest £100	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind * Rounded to the nearest £100	Pension related benefits (bands of £2500) £000	Total Remuneration (bands of £5000) £000	Expenses Paid Rounded to the nearest £100
Mr Martin Barkley, Chief Executive - left 28 April 2016	0	0	0	0	0	0	10-15	0	0	0	10-15	300
Mr Colin Martin, Chief Executive	170-175	0	11,300	92.5-95.0	275-280	800	155-160	0	11,800	285.0-287.5	455-460	1,100
Mr Drew Kendall, Director of Finance and Information - started 01 May 2016, left - 31 March 2018	105-110	0	2,600	0	105-110	1,300	95-100	0	2,100	167.5-170.0	265-270	1,100
Mr Brent Kilmurray, Chief Operating Officer - left 01 December 2017 and Deputy Chief Executive	120-125	0	7,900	30.0-32.5	160-165	1,300	120-125	0	0	35.0-37.5	155-160	1,700
Dr Nick Land, Medical Director - left 31 March 2018	95-100	0	6,300	0	105-110	1,800	70-75	55-60	6,200	65.0-67.5	200-205	1,800
Dr Ahmed Khouja**, Medical Director - started 01 March 2018	5-10	10-15	0	2.5-5.0	20-25	0	0	0	0	0	0	0
Mr David Levy, Director of Human Resources and Organisational Development	105-110	0	0	7.5-10.0	115-120	0	105-110	0	0	17.5-20.0	125-130	600
Mrs Elizabeth Moody, Director of Nursing and Governance	110-115	0	10,300	27.5-30.0	145-150	1,300	105-110	0	9,600	110.0-112.5	230-235	1,400
Mrs Jennifer Illingworth, Director of Quality Governance	95-100	0	4,500	30.0-32.5	130-135	1,700	95-100	0	4,000	80.0-82.5	180-185	1,400
Mrs Sharon Pickering, Director of Planning, Performance and Communications	95-100	0	9,100	25.0-27.5	130-135	1,000	95-100	0	7,300	20.0-22.5	125-130	1,600
Dr Ruth Briel***, Senior Clinical Director, Kaizen Promotion Office	65-70	15-20	0	85.0-87.5	165-170	3,500	65-70	15-20	0	25.0-27.5	110-115	3,700
Mr Patrick Scott, Director of Operations - County Durham and Darlington	105-110	0	2,000	100.0-102.5	205-210	700	95-100	0	1,700	395.0-397.5	495-500	2,600
Mr David Brown, Director of Operations – Teesside - left 01 December 2017 and Chief Operating Officer - started 01 December 2017	105-110	0	4,200	67.5-70.0	180-185	2,000	100-105	0	4,900	22.5-25.0	130-135	3,200
Mr Levi Buckley, Director of Operations – Forensic Services	95-100	0	0	117.5-120.0	210-215	700	95-100	0	0	30.0-32.5	125-130	900
Mrs Adele Coulthard, Director of Operations – North Yorkshire - left 01 September 2017 and Director of Transformation - North Yorkshire - started 01 September 2017	95-100	0	3,300	25.0-27.5	125-130	0	95-100	0	2,500	30.0-32.5	130-135	0
Mrs Elizabeth Herring, Director of Operations - North Yorkshire - started 14 November 2016, left 02 January 2017	0	0	0	0	0	0	10-15	0	600	0.0-2.5	10-15	100
Mr Phil Bellas, Trust Secretary	80-85	0	0	20.0-22.5	105-110	0	80-85	0	0	20.0-22.5	105-110	0
Mr Robert Cowell, Director of Operations - Estates and Facilities Management - left 01 March 2018 and Director of PFI Projects - started 01 March 2018	95-100	0	3,100	15.0-17.5	115-120	1,900	95-100	0	2,500	30.0-32.5	130-135	1,100
Mrs Ruth Hill, Director of Operations - York and Selby	100-105	0	1,600	25.0-27.5	125-130	600	95-100	0	1,500	50.0-52.5	145-150	1,500
Mr Paul Foxton, Director of Operations - Estates and Facilities Management - started 08 January 2018	20-25	0	0	0.0-2.5	20-25	600	0	0	0	0	0	0
Mr Tim Cate, Director of Operations – North Yorkshire - started 01 September 2017	55-60	0	1,000	0	55-60	1,000	0	0	0	0	0	0
Mr Dominic Gardner, Director of Operations – Teesside - started 01 December 2017	30-35	0	300	5.0-7.5	35-40	100	0	0	0	0	0	0
Mrs Sarah Dexter-Smith, Director of Therapies - started 16 October 2017	40-45	0	0	37.5-40.0	75-80	900	0	0	0	0	0	0
Mrs Lesley Bessant , Chairman	50-55	0	0	0	50-55	3,400	50-55	0	0	0	50-55	4,000
Mrs Barbara Matthews, Non-Executive Director - left 31 August 2016	0	0	0	0	0	0	5-10	0	0	0	5-10	1,000
Mr Jim Tucker, Non-Executive Director - left 31 August 2017	5-10	0	0	0	5-10	2,800	10-15	0	0	0	10-15	2,600
Mr Richard Simpson, Non-Executive Director	10-15	0	0	0	10-15	2,900	10-15	0	0	0	10-15	2,700
Mr Marcus Hawthorn, Non-Executive Director (Senior Independent Director)	15-20	0	0	0	15-20	100	15-20	0	0	0	15-20	0
Mr David Jennings, Non Executive Director (Head of Audit Committee from 01 November 2017)	15-20	0	0	0	15-20	1,200	10-15	0	0	0	10-15	1,100
Dr Hugh Griffiths, Non-Executive Director	10-15	0	0	0	10-15	1,800	10-15	0	0	0	10-15	2,500
Mrs Shirley Richardson, Non-Executive Director started 01 September 2016	10-15	0	0	0	10-15	1,500	5-10	0	0	0	5-10	900
Mr Paul Murphy, Non-Executive Director started 01 September 2016	10-15	0	0	0	10-15	1,900	5-10	0	0	0	5-10	1,100

Band of highest paid directors total remuneration (£000) ****	170-175
Median of total remuneration	27,635
Ratio (Director to Median)	6.2

Band of highest paid directors total remuneration (£000) ****	155-160
Median of total remuneration	27,361
Ratio (Director to Median)	5.8

The above table shows the remuneration for time worked as a senior manager only. Where this was for part year (dates shown in table) the table reflects this.
* Benefits in kind are the provision of lease cars
** Other remuneration includes Additional Clinical Programmed Activity worked during the reported period (£8k) & Clinical Excellence award
*** Other remuneration includes Clinical Excellence award
**** Pension related benefits have been excluded from this calculation, as they are not known for all staff.

Expenses of Governors
At 31 March 2018 the Trust had 45 Governors (2016-17, 45), with 29 receiving reimbursement of expenses (2016-17, 35). The total amount reimbursed as expenses was £6,313, (£8,763 in 2016-17)

Pay Terms and Conditions

With the exception of directors, non-executives and medical staffing the workforce are covered by Agenda for Change. All inflationary uplifts for staff employed under national terms and conditions have been in accordance with nationally determined pay arrangements. All executive directors are on a permanent contract and have a notice period of 6 months.

The Remuneration Committee is responsible for Executive Directors pay.

Membership:
Mrs Lesley Bessant - Chairman
All Non-Executive Directors of the Trust Board

Colin Martin:
Chief Executive

Date:

Senior managers' pension benefits

Name and title	Real increase in pension at retirement age for time in post	Real increase in pension lump sum at retirement age for time in post	Total accrued pension at retirement age at 31 March 2018	Lump sum at retirement age related to accrued pension at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2017	Real Increase in Cash Equivalent Transfer Value for time in post
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000
Mr Colin Martin, Chief Executive	5.0-7.5	7.5-10.0	65-70	190-195	1,300	1,178	122
Mr Drew Kendall, Director of Finance and Information - started 01 May 2016, left - 31 March 2018	(2.5-5.0)	(17.5-20.0)	25-30	70-75	470	528	(58)
Mr Brent Kilmurray, Chief Operating Officer - left 01 December 2017 and Deputy Chief Executive	0.0-2.5	0.0-2.5	35-40	90-95	564	506	58
Dr Ahmed Khouja, Medical Director - started 01 March 2018	0.0-2.5	0.0-2.5	40-45	100-105	717	674	4
Mr David Levy, Director of Human Resources and Organisational Development	0.0-2.5	2.5-5.0	25-30	85-90	637	582	55
Mrs Elizabeth Moody, Director of Nursing and Governance	0.0-2.5	5.0-7.5	45-50	135-140	809	728	81
Mrs Jennifer Illingworth, Director of Quality Governance	0.0-2.5	0.0-2.5	30-35	75-80	507	454	53
Mrs Sharon Pickering, Director of Planning, Performance and Communications	0.0-2.5	0.0-2.5	35-40	95-100	664	604	60
Dr Ruth Briel, Senior Clinical Director, Kaizen Promotion Office	2.5-5.0	12.5-15.0	40-45	120-125	846	737	109
Mr Patrick Scott, Director of Operations - County Durham and Darlington	5.0-7.5	7.5-10.0	45-50	125-130	769	649	120
Mr David Brown, Director of Operations – Teesside - left 01 December 2017 and Chief Operating Officer - started 01 December 2017	2.5-5.0	10.0-12.5	40-45	130-135	955	824	131
Mr Levi Buckley, Director of Operations – Forensic Services	5.0-7.5	10.0-12.5	30-35	45-50	398	304	94
Mrs Adele Coulthard, Director of Operations – North Yorkshire - left 01 September 2017 and Director of Transformation - North Yorkshire - started 01 September 2017	0.0-2.5	0.0-2.5	35-40	90-95	644	588	56
Mr Phil Bellas, Trust Secretary	0.0-2.5	0.0-2.5	10-15	25-30	216	188	28
Mr Robert Cowell, Director of Operations - Estates and Facilities Management - left 01 March 2018 and Director of PFI Projects - started 01 March 2018	0.0-2.5	2.5-5.0	40-45	125-130	902	830	72
Mrs Ruth Hill, Director of Operations - York and Selby	0.0-2.5	0.0-2.5	30-35	75-80	493	444	49
Mr Paul Foxton Director of Operations - Estates and Facilities Management - started 08 January 2018	0.0-2.5	0.0-2.5	15-20	55-60	422	405	4
Mr Tim Cate*, Director of Operations – North Yorkshire - started 01 September 2017	0	0	0	0	0	0	0
Mr Dominic Gardner, Director of Operations – Teesside - started 01 December 2017	0.0-2.5	(0.0-2.5)	10-15	25-30	191	191	0
Mrs Sarah Dexter-Smith, Director of Therapies - started 16 October 2017	0.0-2.5	2.5-5.0	15-20	45-50	281	222	27

* Mr Tim Cate is not in the NHS Pension scheme

As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The reason for the negative increase in pension and lump sum for two senior managers is due to the inflation factor used (1.0%) being higher than the percentage growth in benefits.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Real increases are shown pro rata for the period employees were working as a senior manager for the Trust. If an employee left post, or started a role midway through the year.

Colin Martin: Date:
Chief Executive

Staff Report

Analysis of Staff costs and staff numbers

Employee expenses	**12 months ended 31 March 2018**			**12 months ended 31 March 2017**		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	205,586	197,516	8,070	198,641	190,858	7,783
Social security costs	17,507	16,802	705	16,541	15,843	698
Apprenticeship levy	981	942	39	0	0	0
Pension cost – employer contributions to NHS pension scheme	24,416	23,375	1,041	24,170	23,192	978
Pension cost – other contributions	17	17	0	15	15	0
Temporary staff – agency/contract staff	6,775	0	6,775	5,780	0	5,780
Gross employee expenses	**255,282**	**238,652**	**16,630**	**245,147**	**229,908**	**15,239**
Recoveries from other bodies in respect of staff cost netted off expenditure	0	0	0	(11)	(11)	0
Total employee expenses	**255,282**	**238,652**	**16,630**	**245,136**	**229,897**	**15,239**
Of which:						
Cost capitalised as part of assets	267	267	0	228	228	0
Analysed into Operating Expenditure :						
Employee expenses – staff & executive directors	252,881	236,366	16,515	242,923	227,753	15,170
Research & Development	631	516	115	509	440	69
Education & Training	1,503	1,503	0	1,476	1,476	0
Total employee expenses excluding capitalised costs	**255,015**	**238,385**	**16,630**	**244,908**	**229,669**	**15,239**

The salary cots of the capital development team are capitalised over the full costs of the Trust's capital schemes, of which in 2017-18 the largest scheme was an inpatient unit in York.

Average number of employees (WTE Basis)	**12 months ended 31 March 2018**			***Restated 12 months ended 31 March 2017**		
	Total Number	Permanently Employed Number	Other Number	Total Number	Permanently Employed Number	Other Number
Medical and Dental	338	296	42	352	311	41
Administration and estates	1,170	1,108	63	1,204	1,095	109
Healthcare assistants and other support staff	319	307	12	308	295	13
Nursing, midwifery and health visiting staff	3,892	3,484	408	3,776	3,458	318
Scientific, therapeutic and technical staff	788	726	63	729	699	30
Healthcare science staff	2	2	0	10	10	0
Social care staff	8	0	8	24	0	24
Total	**6,517**	**5,922**	**595**	**6,403**	**5,868**	**535**
Of which						
Number of Employees (WTE) engaged on capital projects	5	5	0	6	6	0

*restated following additional guidance.

Demographic Information

Our workforce is primarily white, broadly in line with our local population and at the end of March 2018 there were 5,235 female members of staff (78%) and 1,476 male (22%).

The number of male and female directors and senior managers (i.e. members of the Board of Directors and Executive Management Team) is 16 male and nine female.

Sickness absence figures (January to December 2017)

Average full time equivalent (FTE) staff in post	Adjusted FTE Sick days	FTE days available	FTE days lost to sickness absence *	Average sick days per FTE
5,915	67,990	2,159,106	110,295	11.5

*This figure is based on a calculation of actual working days available.

Our average sickness absence rate was 5.18%

Staff policies and actions taken

Human resource policies
We have a range of policies and procedures which support our commitment to being a good employer and to providing equal opportunities to present and potential employees.

- The Trust sickness absence procedure contains a provision for disability leave so that staff with a disability, who require regular treatment to maintain their health and attendance at work, can do so within an agreed number of days leave.
- The recruitment and selection policy is based upon national and Disability Confident recruitment standards and we guarantee to interview all applicants who declare they have a disability and who meet the minimum requirements for the post. The Trust will provide all reasonable adjustments to enable people with a disability to attend for interview. This applies not only to staff applying for their first post with the Trust but also to staff seeking promotion.
- The redeployment process provides the opportunity for staff who are no longer able to carry out their job either on health grounds or because of organisational change to secure suitable alternative employment with the Trust. This can involve a period of shadowing, training and a trial period to widen the suitable opportunities available.

- The Trust's staff development policy recognises that people learn in different ways and that a positive learning environment that endeavours to meet people's needs is likely to impact positively on the level of knowledge retained. Reasonable adjustments work positively in a learning environment as they remove barriers to learning. Staff are far less likely to learn and retain knowledge if they are worried or anxious. Everyone is different, so this could be something that impacts directly on a person within the learning environment or it could be that another factor outside the learning environment is having a detrimental impact on their ability to learn of participate in the training. Managers and staff are encouraged to contact the education and training department to discuss how the Trust can best meet the needs of people from protected groups whilst they are participating in education and training.
- During 2017/18 we made efforts to improve the training needs analysis by the greater involvement of services in speciality based training needs identification and planning activities.
- A new Trust Workforce Strategy was agreed in 2018 that describes how we intend to improve the quality of our services through workforce supply, development, health and wellbeing and engagement activities.

Occupational health

The 2017/18 staff flu campaign was the most successful to date with 65.62% of frontline healthcare workers receiving a flu vaccination (an increase of 10.19% over the previous year). Demand for physiotherapy and counselling services was significantly greater than expected however, access to these services was maintained during 2017/18. Pre-employment screening activity increased in line with the 5% growth in the number of staff employed by the Trust during the year. The Trust continued to work closely with its occupational health service provider as part of efforts to improve staff health and wellbeing. The occupational health service provider regularly participated in Trust sickness absence team meetings, the infection and prevention control committee, the health safety, security and fire committee, the health and wellbeing group, the mindful employer group, the staff flu vaccination group and health and wellbeing related improvement events.

Health, safety and security

In addition to ensuring that staff receive advice, support and training, incidents are investigated and lessons learnt, our Health, Safety and Security team work to continuously improve the services they provide to the Trust.

Improvements implemented this year include:

- Improving guidance to staff on setting up of their visual display screen equipment by launching a video on the Trust's training site.

- Completing a Kaizen event in relation to RIDDOR investigation process which aimed to speed up the investigation process by minimising re-work for the services and piloting the new system prior to roll out.

- Continued their programme of access audits focussing this year on outpatient locations.

- Completed an audit programme for Health, Safety and Security e-workbooks to give assurance that workbooks were in use throughout the Trust.

Fraud, bribery and corruption policies and procedures
The Trust has an established anti-fraud and corruption policy which aims to minimise the risk of fraud, bribery or corruption by detailing the key roles and responsibilities of employees and related parties; as well as promoting an anti-fraud culture throughout the Trust.

The policy and related materials are available on the Trust's intranet and counter-fraud information is prominently displayed both on the Trust's intranet and throughout the Trust's premises.

The Trust's Local Counter-Fraud Specialist (LCFS) reports to the Audit Committee quarterly and performs a programme of work designed to provide assurance to the Board with regard to fraud and corruption. The LCFS provides regular fraud awareness sessions to the Trust's staff, investigates concerns reported by staff and liaises with the police. If any issues are substantiated, the Trust takes appropriate criminal, civil or disciplinary measures.

Communicating and engaging with our staff
Our staff are our most important asset and we will only achieve our mission of improving the health of people with mental health or learning disability conditions if different groups of staff communicate well with each other and feel engaged with the organisation.

We have a number of key corporate mechanisms for communicating and engaging with staff and these include:

- Team briefing system
- Trust magazine (Insight)
- Intranet
- Weekly e-bulletin which includes a round-up of discussions at the Executive Management Team meetings
- Visits to services and teams by directors
- Quarterly leadership and management groups which give direct access to the Chief Executive
- An anonymous electronic mechanism for raising concerns which are responded to through e-bulletin and posted on the intranet.
- A Trust Freedom to Speak Up Guardian

Staff involvement and engagement is also key to the success of our quality improvement system. TEWV QIS empowers staff to identify and remove waste and streamline processes which enables them to focus on doing things that add value for

the people who use our services. We remain committed to improving the way we use of the staff friends and family test to engage with the workforce.

Consultations about proposed organisational changes, changes to workforce policies and procedures and terms and conditions issues have taken place at both a Trust and individual service level. This two way flow of information has helped to inform and improve decisions made.

Trust wide consultation takes place with staff side representatives via the bi-monthly joint consultative committee, with locality consultative committees taking place in the intervening months for issues specific to each locality. A number of groups have staff side representatives as members such as the health and wellbeing group, policy working group and health and safety committee. In addition staff side representatives are usually invited to join specific working groups when it is anticipated that there may be implications for staff.

Staff survey

Our results were compared with 27 other mental health trusts and were positive. We received the best scores in the country in two of the key findings covered by the survey.

Our top five ranking scores were:

- Effective use of patient/service user feedback (3.89 compared to a national average 3.72, out of a possible 5)
- Percentage of staff experiencing discrimination at work in the last 12 months (10% compared to a national average of 14%)
- Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (90% compared to a national average of 85%)
- Staff confidence and security in reporting unsafe clinical practice (3.84 compared to a national average of 3.71, out of a possible 5)
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (27% compared to a national average of 32%)

Our bottom five ranking scores were:

- Percentage of staff reporting errors, near misses or incidents witnessed in the last month (90% compared to a national average of 93%)
- Percentage of staff experiencing physical violence from staff in the last 12 months (3% compared to a national average of 3%)
- Percentage of staff reporting most recent experience of harassment bullying and abuse (59% compared to a national average of 61%)
- Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (22% compared to a national average of 22%)
- Percentage of staff satisfied with the opportunities for flexible working patterns (60% compared to a national average of 60%)

	2016		2017		Improvement/deterioration
Response Rate	**Trust**	**National**	**Trust**	**National**	
	49%	49%	52%	52%	**An improvement of 3%**
Top 5 ranking Scores	**Trust**	**National**	**trust**		
KF 32	3.84	3.70	3.89	3.72	**An improvement of 0.05**
KF 20	9%	14%	10%	14%	**A deterioration of 1%**
KF 21	94%	87%	90%	85%	**A deterioration of 4%**
KF 31	3.81	3.67	3.84	3.71	**A deterioration of 0.10**
KF 25*	28%	33%	27%	32%	**An improvement of 1%**
Bottom Ranking Scores	**Trust**		**Trust**		
KF29	92%	92%	90%	93%	**A deterioration of 2%**
KF23	3%	3%	3%	3%	**No change**
KF27	57%	60%	59%	61%	**An improvement of 2%**
KF22*	23%	21%	22%	22%	**An improvement of 1%**
KF15	61%	59%	60%	60%	**A deterioration of 1%**

*** The lower the score the better**

Despite a number of changes to the key finding scores, only eight were statistically significant.

Suggested areas for action

The feedback from the survey will be used to inform actions. The areas we intend focussing on are:

- Taking action to better support staff to minimise the impact of excessive work related stress by improving supervision, job design, work processes, staff skills and knowledge and communications
- Taking action to increase access for staff to flexible working arrangements by agreeing a new flexible working procedure and providing related awareness sessions for managers and their staff

The Trust Workforce Strategy identifies a number of actions that will complement efforts by the Trust to respond to the staff survey results. Localities and corporate services are considering their own results and forming local action plans where appropriate to support local improvement. Oversight of progress being made is undertaken by the Resources Committee.

Future Priorities and Targets
The 2017 Investors in People assessment report highlighted the importance of improving corporate communications and as part of the Making a Difference Together business plan priority we will:

Use crowdsourcing to improve engagement between the Trust and staff, service users and others.

Put in place a new Bullying and Harassment Resolution Procedure to help reduce conflict between staff by encouraging staff to come forward at an early stage to resolve issues in a non-adversarial way.

Introduce guidance and training for managers and staff about tackling abuse from service users and members of the public.

Use the ladder of participation to help promote and increase the level of co-production between the Trust and service users within training, recruitment and quality improvement activities.

Progress with implementation will be reported to and monitored by the Resources Committee, The Executive Management Team and the Recovery Programme Board on a regular basis throughout 2018/19.

Exit Packages (subject to audit)

Early retirement due to ill health

During 2017-18 the Trust had 11 employees retire early on the grounds of ill health; the value of these early retirements (from NHS Pensions) is £0.7m.

Cost of exit packages

	12 months ended 31 March 2018			12 months ended 31 March 2017		
Exit Package Cost	**Total number**	**Compulsory Redundancies number**	**Other Departures number**	**Total number**	**Compulsory Redundancies number**	**Other Departures number**
<10,000	**0**	**0**	**0**	**1**	**1**	**0**
£10,001 - £25,000	**1**	**1**	**0**	**4**	**4**	**0**
£25,001 - £50,000	**0**	**0**	**0**	**5**	**5**	**0**
£50,001 - £100,000	**0**	**0**	**0**	**0**	**0**	**0**
£100,001 - £150,000	**0**	**0**	**0**	**1**	**1**	**0**
£150,001 - £200,000	**0**	**0**	**0**	**0**	**0**	**0**
>£200,001	**0**	**0**	**0**	**0**	**0**	**0**
Total number of exit packages	**1**	**1**	**0**	**11**	**11**	**0**
Total resource	**23**	**23**	**0**	**368**	**368**	**0**

cost (£000's)

There were no other non-compulsory exit packages between 01 April 2017 and 31 March 2018, (2016-17, nil)

Consultancy costs

The Trust paid £496k in consultancy costs during 2017/18.

Off payroll arrangements

Off payroll arrangements longer than 6 months

No. of existing engagements as of 31 March 2018	7
Of which...	
No. that have existed for less than one year at time of reporting.	7
No. that have existed for between one & two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	7
Of which...	
No. assessed as caught by IR35	7
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to the entity) and are on the departmental payroll	7
No. of engagements reassessed for consistency / assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll board member/senior official engagements

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both off-payroll and on-payroll engagements.	29

Governance including the Foundation Trust Code of Governance Disclosures

In this section we give details of our governance structure. We explain who sits on the Board of Directors and Council of Governors, how they operate and the areas they have focussed on during the year. We also report on the work of the Board's committees.

The Foundation Trust Code of Governance including the Statement on the Application of the Code

The Foundation Trust Code of Governance, published by NHS Improvement, provides an overarching framework for corporate governance and complements the statutory and regulatory obligations placed on foundation trusts.

Tees, Esk and Wear Valleys NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Under the Code of Governance the Trust is required to disclose the following information on its governance arrangements:

Code ref:	**Summary of Disclosure Requirement**	Page(s)
A.1.1	A schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including the types of decisions to be taken by each body and which are delegated to the Executive Management Team on behalf of the Board of Directors.	66-67
A.1.1	A statement on how disagreements between the Council of Governors and Board of Directors should be resolved.	67
A.1.2	The names of: ▪ The Chairman ▪ The Deputy Chairman ▪ The Chief Executive ▪ The Senior Independent Director ▪ The chairmen and members of the Nominations Committee ▪ The chairmen and members of the Audit Committee ▪ The chairman and members of the Remuneration Committees	33-33, 73,76 & 84
A.1.2	The number of meetings of the Board of Directors and the Audit, Remuneration and Nominations Committees and individual attendance by directors	69-70, 73,76 & 84
A.5.3	The names of members of the Council of Governors, whether they are elected or appointed, the constituency or organisations they represent and the duration of their	80-83

	appointments.	
A.5.3	The name of the Lead Governor.	79
B.1.1	The names of the non-executive directors whom the Board determines to be independent, with reasons where necessary.	30-32 & 68
B.1.4	A description of each director's skills, expertise and experience.	30-33
B.1.4	A statement about the Board of Directors' balance, completeness and appropriateness to the requirements of the NHS foundation trust.	68
B.2.10	A description of the work of the Nominations Committee(s) including the process used in relation to board appointments.	76 & 84
B.3.1	The other significant commitments of the Chairman and any changes to them during the year.	30
B.5.6.	A statement on how the governors have undertaken and satisfied the requirement to canvass the opinion of the trust's members and the public (and for appointed governors the body they represent) on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and communicate their views to the Board of Directors.	85
B.6.1	A statement on how the performance evaluation of the board, its committees and its directors, including the Chairman, has been conducted.	71-72
B.6.2	The identity of any external facilitator who supported the performance evaluation of the board and whether they have any other connection with the trust.	72
C.1.1	An explanation from the directors of their responsibility for preparing the annual report and accounts. A statement that they consider the annual report and accounts, taken as a whole, are fair, balanced and reasonable and providing the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.	68-69
C.1.1	A statement from the External Auditors about their reporting responsibilities	212 (awaited)
C.1.1	An explanation from the directors of their approach to quality governance in the annual governance statement.	90-97

C.2.1	A report that the Board has conducted a review of the effectiveness of the Trust's system of internal controls.	67
C.2.2	Information on how the internal audit function is structured and the role it performs.	75
C.3.5	A statement from the Audit Committee, if applicable, explaining its recommendation on the appointment/reappointment of the external audit and the reasons why it was not accepted by the Council of Governors.	Not applicable
C.3.9	A description of the work of the Audit Committee in discharging its responsibilities including: ▪ the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; ▪ an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and ▪ if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	72-76
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Not applicable
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors.	87
E.1.5	A statement on how the Board of Directors, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust.	70
E.1.6	A report on the representativeness of Trust's membership and the level and effectiveness of member engagement.	86

The latest version of the code of governance is available on NHS Improvement's website: improvement.nhs.uk

How the Trust is governed

The governance arrangements of foundations trusts, as public benefit corporations, are set out in Schedule 7 of the National Health Service Act 2006, as amended.

Under this Act the Trust must have:

- A legally binding constitution
- A Non-Executive Chairman
- A Board of Directors comprising non-executive and executive directors
- A Council of Governors comprising elected public and staff governors and governors appointed by key stakeholder organisations
- A public and staff membership

The Chairman of the Trust leads both our Board of Directors and Council of Governors.

The statutory duties of our Council of Governors are:

- to hold the non-executive directors individually and collectively to account for the performance of the Board
- to represent the interests of the members of the Trust as a whole and the interests of the public

It has specific responsibilities:

- to develop our membership and represent their interests
- to assist with the development of the Trust's strategy
- to provide its views on any matter when consulted by the Board of Directors
- to appoint or remove the Chairman and the non-executive directors
- to determine the remuneration and allowances, and the other terms and conditions of office, of the Chairman and non-executive directors
- to approve the appointment of the Chief Executive
- to receive the annual accounts and annual report
- to appoint or remove the Trust's external auditor
- to determine proposals to increase the proportion of the Trust's income earned from non-NHS sources by 5% or more in any financial year
- to inform the Board whether or not it considers that any proposals to provide non-NHS services will interfere, to a significant extent, with the provision of NHS services
- to determine (in conjunction with the Board of Directors) any proposed changes to the Trust's Constitution
- to determine (in conjunction with the Board of Directors) any questions on mergers, acquisitions or separation of the Trust
- to determine (in conjunction with the Board of Directors) whether the Trust should be dissolved
- to determine any significant transactions (as defined in the Constitution) proposed by the Board of Directors
- to consider any matters raised by the Care Quality Commission or NHS Improvement which might affect the Trust's compliance with the terms of its Licence or its registration of services
- to determine whether any matter should be referred to a panel established by NHS Improvement on whether the Trust has failed or is failing to act in accordance with its Constitution, or to act in accordance with Chapter 5 of the NHS Act 2006.

A number of committees and task and finish groups, including the Council of Governors' Nomination and Remuneration Committee, support this work.

Our Board of Directors provides overall leadership and vision to the Trust and is ultimately and collectively responsible for all aspects of performance, including clinical and service quality, financial performance and governance.

The general statutory duty of our Board, and each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

Our Board of Directors:

- exercises certain functions in conjunction with our Council of Governors.
- has retained certain decisions to itself including the definition of the Trust's strategic goals and objectives, the approval of the annual plan (following consultation with our Council of Governors); the acquisition, disposal or change of use of land or buildings with a value in excess of £500,000; and the introduction or discontinuance of any significant activity or operation.

  Further details are provided in the "scheme of decisions reserved to the Board" which is available on our website as part of our constitution.

Any powers which the Board has not reserved to itself or delegated to a committee are exercised on its behalf by our Chief Executive.

The Board, through its Audit Committee, conducts a review on the effectiveness of internal control annually based on the findings of the Head of Internal Audit.

Under the leadership of our Chief Executive, the Executive Management Team (which comprises the executive, corporate and operational directors, the Trust Secretary and the Senior Clinical Director for the Kaizen Promotion Office) is accountable for the ratification of Trust-wide policies for implementation and for ensuring:

- performance against our objectives and key targets is reviewed
- the effective operation of our integrated assurance systems
- the provision of appropriate and accurate information to our Board of Directors.

A process has been established for the resolution of disputes between the Board and the Council of Governors.

Led by the Chairman or Deputy Chairman and supported by the Senior Independent Director, the process is based on a number of steps by which the matters in dispute are formally stated, considered and responded to.

If resolution cannot be achieved the view of the Board will prevail unless the issue falls within the Council of Governors' statutory powers.

Nothing within the process restricts the Council of Governors from informing NHS Improvement or the Care Quality Commission of relevant concerns.

Further details of the dispute resolution procedure are included in Annex 9 of our constitution.

The Board of Directors

Under our Constitution our Board of Directors comprises:

- a Non-Executive chairman
- five to seven non-executive directors

- five executive directors which must include the Chief Executive (as the accounting officer), the Finance Director, a registered medical practitioner (the Medical Director) and a registered nurse (the Director of Nursing and Governance).

Information on the Board Members as at 31st March 2018, including details of their skills and expertise, is provided in the Accountability Report.

The Trust's corporate directors, Sharon Pickering (Director of Planning, Performance and Communications) and David Levy (Director of Human Resources and Organisational Development) together with David Brown (Acting Chief Operating Officer) attend meetings of the Board in a non-voting capacity.

The Board considers that, as at 31st March 2018:

- Its composition meets the requirements of the National Health Service Act 2006 and the constitution and is appropriate for the organisation
- All its members are "fit and proper" persons to be directors of the Trust in accordance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- There is an appropriate balance and breadth of skills, knowledge and experience amongst the non-executive directors
- All the non-executive directors meet the independence criteria set out in the foundation trust code of governance.

Statement on the directors' responsibility for preparing the annual report and accounts

The directors are required under the National Health Service Act 2006, and as directed by NHS Improvement, to prepare accounts for each financial year.

NHS Improvement, with the approval of HM Treasury, directs that these accounts shall show, and give a true and fair view of the NHS foundation trust's gains and losses, cash flow and financial state at the end of the financial year. NHS Improvement further directs that the accounts shall meet the accounting requirements of the Department of Health Group Accounting Manual that is in force for the relevant financial year, which shall be agreed with HM Treasury.

In preparing these accounts, the directors are required to apply on a consistent basis, for all items considered material in relation to the accounts, accounting policies contained in the Department of Health Group Accounting Manual, make judgements and estimates which are reasonable and prudent; and ensure the application of all relevant accounting standards, and adherence to UK generally accepted accounting practice for companies, to the extent that they are meaningful and appropriate to the NHS, subject to any material departures being disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose, with reasonable accuracy, at any time the financial position of the Trust. This is to ensure proper financial procedures are followed, and that accounting records are maintained in a form suited to the requirements of effective management, as well as in the form prescribed for the published accounts.

The directors are also responsible for safeguarding all the assets of the Trust, including taking reasonable steps for the prevention and detection of fraud and other irregularities.

Each of the directors, holding office on 31st March 2018, confirms that the annual report and accounts, taken as a whole, are fair, balanced and reasonable and provide the information

necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.

Attendance at Board meetings

The following table provides details of the attendance at the eleven ordinary meetings and two special meetings of the Board of Directors held during 2017/18:

Board Member	Position	No of Board meetings attended
Lesley Bessant	▪ Chairman of the Trust ▪ Chairman of the Board's Nomination and Remuneration Committee ▪ Chairman of the Council of Governor's Nomination and Remuneration Committee ▪ Chairman of the Commercial Oversight Committee	13
Colin Martin	▪ Chief Executive ▪ Accounting Officer ▪ Chairman of the Executive Management Team	12
Hugh Griffiths	▪ Non-Executive Director ▪ Deputy Chairman (from 25/1/18) ▪ Chairman of the Quality Assurance Committee	13
Marcus Hawthorn	▪ Non-Executive Director ▪ Senior Independent Director ▪ Chairman of the Audit Committee (to 30/9/17) ▪ Chairman of the Resources Committee (from 1/10/17)	11
David Jennings	▪ Non-Executive Director ▪ Chairman of the Audit Committee (from 1/10/17)	10
Paul Murphy	▪ Non-Executive Director	13
Shirley Richardson	▪ Non-Executive Director	12
Richard Simpson	▪ Non-Executive Director ▪ Chairman of the Mental Health Legislation Committee	11
Jim Tucker (to 31/8/17)	▪ Non-Executive Director ▪ Deputy Chairman ▪ Chairman of the Resources Committee	5(5)
Drew Kendall	▪ Interim Director of Finance and Information	12
Ahmad Khouja	▪ Medical Director (from 1/2/18)	1 (1)
Brent Kilmurray	▪ Chief Operating Officer and Deputy Chief Executive	13

	(Brent stepped back from his role as the Chief Operating Officer on 1/12/17)	
Nick Land	▪ Medical Director (to 28/2/18)	11 (12)
Elizabeth Moody	▪ Director of Nursing & Governance	9
David Brown*	▪ Acting Chief Operating Officer (from 1/12/17)	3 (4)
David Levy*	▪ Director of Human Resources and Organisational Development	12
Sharon Pickering*	▪ Director of Planning, Performance and Communications	13

(Notes:
*1 * Indicates that the director holds a non-voting position on the Board of Directors*
2 The maximum number of meetings to be attended by those Board Members who held office during part of the year is shown in brackets)

Keeping informed of the views of governors and members
Our Board of Directors ensures it is kept informed of the views of governors and members in a number of ways, including:
- Regular private meetings between the Chairman and governors.
- Attendance at Council of Governors' meetings
- Receiving reports on the outcome of consultations with governors, for example on the business plan
- Updates provided by the Chairman and directors at Board meetings
- Attendance by governors at directors' visits to services (bi-monthly)
- Governors are encouraged to attend public meetings of the Board of Directors
- Attendance at governor development days.

Marcus Hawthorn, as the Senior Independent Director, is also available to governors if they have concerns regarding any issues which have not been addressed by the Chairman, Chief Executive or other usual business arrangements.

In general, with regard to attendance at meetings of the Council of Governors:
- The Chairman attends all meetings.
- There is a standing invitation for the non-executive directors to attend meetings.
- Executive and corporate directors attend meetings, if required, for example to deliver reports, or as observers.

The Council of Governors also has powers to require attendance of a director at any of its meetings, under paragraph 26 (2) (aa) of Schedule 7 of the National Health Service Act 2006, for the purpose of obtaining information on the Foundation Trust's performance of its functions or the directors' performance of their duties. The Council of Governors did not exercise these powers during 2017/18.

In total the Council of Governors held four ordinary meetings, one special meeting and the annual general meeting during 2017/18. Board Member attendance at these meetings was as follows:

Name	Number of Meetings Attended
Lesley Bessant	6
Colin Martin	4
Dr Hugh Griffiths	4
Marcus Hawthorn	4
David Jennings	5
Paul Murphy	6
Shirley Richardson	5
Richard Simpson	5
Jim Tucker	3 (3)
Drew Kendall	4
Brent Kilmurray	4
Dr Nick Land	2
Dr Ahmad Khouja	0 (0)
Elizabeth Moody	4
David Levy	3
Sharon Pickering	5
David Brown	1 (2)

(The maximum number of meetings to be attended by those Board Members who held office during part of the year is shown in brackets)

Evaluating Board performance

Each year the Board's performance is evaluated using a scheme initially developed by Deloitte LLP.

In 2017/18 this included assessments of the performance of:

- The Chairman by all other Board Members
- The Chairman by a focus group of governors on those aspects of her role which relate to the Council of Governors.
- Each Board Member by the Chairman and two non-executive directors and two executive Board members drawn at random
- The Board of Directors by all Board members
- The Audit Committee, the Resources Committee, the Mental Health Legislation Committee and the Quality Assurance Committee by the members of those committees.

The outcomes of the individual performance evaluations are used to inform the appraisals of Board Members. For the Chairman and Non-Executive Directors the outcomes of the evaluations are reported to the Council of Governors' Nomination and Remuneration Committee.

The outcomes of the collective Board assessment and those of its committees are reviewed by the Board to identity any developmental requirements.

During 2017/18 the Board also commissioned an independent external governance review from Grant Thornton LLP based on guidance published by NHS Improvement. This firm has no other connections with the Trust.

Terms of Office of the Chairman and Non-Executive Directors and how their appointments can be terminated

The terms of office for the Chairman and non-executive directors are usually for three years. They will be appointed for a second term of office, without the need for external competition, unless they fail to meet performance, independence or regulatory requirements or the skills and experience required on the Board have changed since their initial appointment. They may also be appointed to serve for more than six years (two three year terms) if it is in the Trust's interest for them to do so and the reasons for this must be approved by the Council of Governors.

The appointments of the Chairman and the non-executive directors can be terminated for the following reasons:

- by resignation
- by ceasing to be a public member of the Trust
- upon becoming a governor of the Trust
- upon being disqualified by the Independent Regulator
- upon being disqualified from holding the position of a director of a company
- upon being adjudged bankrupt
- upon making a composition or arrangement with, or granting a Trust deed for, his/her creditors
- upon being convicted of any offence and a sentence of imprisonment being imposed (whether suspended or not) for a period of not less than three months (without the option of a fine)
- upon removal by the Council of Governors at a general meeting
- if they cease to be a fit and proper person to be a director of the Trust in accordance with the Licence, the Constitution or the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Reports of the Board's Committees

The Board has standing audit, resources, quality assurance, mental health legislation, nomination and remuneration and commercial oversight committees.

Each committee has terms of reference, including reporting requirements, which have been approved by the Board. Copies of the terms of reference are available in our Integrated Governance Framework which is published on our website.

The membership, roles and activities of these committees are detailed in the following sections.

The Audit Committee

Role and responsibilities

The Audit Committee has overarching responsibility for providing assurance to the Board on the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

The responsibilities of the Audit Committee also include:

- reviewing the adequacy of all risk and control disclosure statements (e.g. the annual governance statement) prior to endorsement by the Board
- ensuring the internal audit function is effective, meets mandatory NHS internal audit standards and provides appropriate independent assurance
- making recommendations to the Council of Governors on the appointment, re-appointment or removal of the external auditor
- making recommendations to the Council of Governors on the terms of engagement of the external auditor and reviewing and monitoring the performance, independence and objectivity of the external auditor
- reviewing the work and findings of the external auditor and considering the implications and management responses to their work
- reviewing the findings of other assurance functions, both internal and external to the organisation (e.g. the Care Quality Commission, NHS Improvement, etc.) and considering the implications for the governance of the Trust
- reviewing and monitoring the integrity of any financial statements including any financial judgements contained in them and ensuring the completeness and accuracy of information provided to the Board
- reviewing arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters (the whistleblowing policy).
- overseeing counter fraud activities and monitoring compliance with the Bribery Act 2010
- commissioning value for money studies

Membership of the committee

The committee comprises not less than four members all of whom must be independent non-executive directors. There is also a standing invitation for all other non-executive directors to attend meetings of the committee and participate in discussions but not to vote.

The committee met five times during the year. Attendance by each member was as follows:

Marcus Hawthorn (Chairman to 30/9/17)	5
David Jennings (Chairman from 1/10/17)	4
Hugh Griffiths	5
Paul Murphy	5

The Director of Finance and Information, the external auditors and representatives of the Head of Internal Audit generally attend all meetings of the committee. The Trust Secretary is the secretary to the committee.

At least once a year, members of the committee are required to meet privately with the external and internal auditors without management being present.

The work of the Audit Committee in discharging its responsibilities

A key role of the committee is to monitor, oversee and provide assurance to the Board on the conduct of the audit of the Annual Report and Accounts.

In relation to the annual audit for the year ended 31st March 2018 the committee has:

- reviewed the terms of engagement with the external auditors and recommended them to the Council of Governors.
- Approved the external auditors' Audit Strategy Memorandum and Strategic Audit Plan and received progress reports on the conduct of the audit.
- Approved the Protocol for Liaison between the internal and external auditors including those areas of internal audit's work of specific interest to the external auditors for reliance.
- Reviewed and assured the Board that the Trust is, and is expected to remain, a "going concern" and that the accounts should be prepared on that basis.
- Approved the schedule of losses and special payments as part of the annual accounts process.
- Received the Annual Report of the Head of Internal Audit and considered its findings in relation to the Annual Governance Statement.
- Reviewed and commented on the Annual Governance Statement

A special meeting held on 18th May 2018 provided the Committee with the opportunity to review the Annual Report and Accounts building on conversations at previous meetings in relation to progress reports provided by the External Auditors and the draft Annual Governance Statement.

At the meeting the Committee received written responses to fifteen questions which they had posed, in advance, on having had sight of the draft accounts. The members of the Committee were content with the responses provided.

In relation to the Annual Report, the Committee raised specific questions about the consistency of disclosures relating to Roseberry Park; cyber security and the national WannaCry Ransomware Cyber-attack in 2017; the disclosures relating to senior manager remuneration; and the role of one of the Non-Executive Directors.

During the 2017/18 financial year the committee has also:

- sought and gained assurance on the development, coverage and resources available to deliver the clinical audit programme and received half yearly progress reports on its implementation
- reviewed and provided assurance to the Board on its ability to sign off certificates and the statements required by NHS Improvement in relation to the annual plan
- reviewed the strategic and operational internal audit plans ensuring that these were aligned to the principal risks facing the Trust and could be adequately resourced
- reviewed progress, at each meeting, against the internal audit plan and considered the outcome of reviews undertaken in the context of the Trust's controls and risk environment. In doing so, the committee has sought assurances from management on the implementation of actions to improve the adequacy and robustness of controls particularly in relation to the handling of patient property; risk management; and record keeping
- paid particular attention to the robustness of controls for tackling fraud, bribery and corruption together with the actions planned to address gaps in the Trust's arrangements against NHS Protect's self-review toolkit
- considered regular reports from the Local Counter Fraud Specialist noting action taken on increasing fraud awareness and in response to alleged cases of fraud in the Trust and elsewhere
- reviewed and provided assurance to the Board on the Trust's submission to NHS England on compliance with the Core Standards for emergency preparedness, resilience and response.
- sought and received assurances on the Trust's cyber security arrangements

- reviewed and commented on the draft organisational risk management policy prior to its presentation to the Board
- sought and received assurance on arrangements to update the Trust's processes and systems to reflect learning from NHS England independent investigations
- reviewed and commented on revisions to the standing financial instructions
- drawn the Board's attention to those matters which it considers have implications for the Trust's assurance framework
- considered corporate governance and accounting developments
- received briefings on cyber security; IT risks, agile working and good governance of IT projects; and NHS Improvement's never events policy and framework.

The external auditors

Mazars LLP are the Trust's external auditors.

The firm was appointed by the Council of Governors in 2013 for three years and, following a review by the Audit Committee and Governors, the contract was extended for a further two years (as allowed) i.e. until the completion of the 2017/18 audit.

With the expiry of the contract approaching, the committee, in conjunction with the Council of Governors established a working group to oversee a competitive tendering exercise to appoint the future supplier of external audit services.

The recommendation of the working group, that Mazars LLP should be appointed as the Trust's external auditors for a term of two years with an option to extend, per year, for each of the subsequent three years, was approved by the Council of Governors.

The cost of providing external audit services during 2017/18 was £48k including VAT. This includes the cost of the statutory audit, the review of the quality account, the independent review of the accounts of the charitable funds and the whole Government accounting return.

Details of the external audit fees, split between the statutory audit fees and other auditor remuneration, are provided in notes 3 and 5.5 to the accounts.

The internal auditors

Internal audit services are provided by Audit One; a not-for-profit provider of internal audit, technology risk assurance and courter fraud services to the public sector in the North of England.

Mr Stuart Fallowfield ACCA, the Director of Internal Audit at Audit One, is the Trust's Head of Internal Audit.

Each year the Audit Committee agrees an internal audit plan which sets out the reviews to be undertaken during the year which is aligned to the principal risks identified by the Trust.

Progress reports are provided by the internal auditors to each meeting of the committee and contribute to the Head of Internal Audit's annual opinion on the Trust's system of internal control, which is used to inform the annual governance statement.

Safeguarding auditor independence

The Audit Committee has agreed a policy to ensure that auditor objectivity and independence is safeguarded if the firm providing external audit services is commissioned to provide services outside of the external auditor's responsibilities. This policy stipulates that only the Chief Executive, Finance Director and Trust Secretary may commission the external

audit firm for non-audit services and the appointment must be approved by the Chairman of the Audit Committee. Safeguards are required that:

- external audit does not audit its own firm's work
- external audit does not make management decisions for the Trust
- no joint interest between the Trust and external audit is created
- the external auditor is not put in the role of advocate for the Trust
- the external audit firm does not undertake certain functions including: preparation of accounting records and financial statements, advising on the selection, implementation or running of IS/IT systems, staff secondments, employee remuneration or selection and recruitment and finance or transaction services work within the Trust
- The external auditor must ensure that the provision of non-audit services meets its own ethical standards and internal operational policies.

The Nomination and Remuneration Committee of the Board

The Nomination and Remuneration Committee is responsible for overseeing the appointment of executive directors and directors who report directly to the Chief Executive and is responsible for deciding their terms and conditions of service (where these are not determined nationally). The Committee is also responsible for authorising applications to NHS Improvement and HM Treasury for permission to make special severance payments to an employee or former employee.

The membership of the committee comprises the Chairman of the Trust and all the non-executive directors. The Chief Executive is also an ex officio member of the Committee in relation to all matters pertaining to the appointment of those director positions which fall within its remit.

Advice and/or services were provided to the Committee by Mr David Levy, Director of Human Resources and Organisational Development, and Mr Phil Bellas, Trust Secretary.

No external advice or support was commissioned by the committee during 2017/18.

The Committee met once during 2017/18 to:

- approve the annual uplift to be applied to the remuneration of the executive and other relevant directors
- consider arrangements to fill the substantive position of the Director of Finance and Information and the vacancy arising from the retirement of Dr. Land as the Medical Director
- consider and approve the settlements to be provided in response to successful employment tribunal claims.

All members of the committee were present at this meeting.

The annual statement from the Chairman of the Nomination and Remuneration Committee is provided in the remuneration report.

Resources Committee

The role of the Resources Committee is

- To provide assurance to the Board that the resources available to the Trust (both financial and non-financial) are appropriate and sufficient to deliver its Business Plan
- To provide assurance to the Board on the robustness, alignment and delivery of key strategies and plans

- To review proposals (including evaluating risks) for major business cases and their respective funding sources
- To keep under review potential changes in the external environment in the medium to longer term and to draw any material risks to the sustainability of the Trust to the Board's attention.
- To provide oversight of the management and administration of Charitable Funds held by the Trust.

As at 31st March 2018 the membership of the committee comprised:
- Marcus Hawthorn, Non-Executive Director (Chairman of the Committee)
- Lesley Bessant, Chairman of the Trust
- David Jennings, Non-Executive Director
- Paul Murphy, Non-Executive Director
- Richard Simpson, Non-Executive Director
- Colin Martin, Chief Executive
- David Brown, Acting Chief Operating Officer
- Drew Kendall, Interim Director of Finance and Information*
- Sharon Pickering, Director of Planning, Performance and Communications*
- David Levy, Director of HR and Operational Development*

*(*Note: These members are only expected to attend meetings when matters within their portfolios are being considered).*

The Committee met 9 times during the year.

Mental Health Legislation Committee (MHLC)

The role of the committee is:
- To provide assurance to the Board on the Trust's compliance with the Mental Health Act 1983 and the Mental Capacity Act 2005, including any statutory Codes of Practice relating them:
- To consider the implications of any changes to statute, including statutory Codes of Practice, or case law relating to the Trust's responsibilities as a provider of mental health services and to make recommendations, as required, for changes to the Trust's policies, procedures and practice
- To ensure appropriate arrangements are in place for the appointment and appraisal of associate managers and oversee managers' hearings

As at 31st March 2018 the membership of the committee comprised:
- Richard Simpson, Non-Executive Director (Chairman of the Committee)
- Lesley Bessant, Chairman of the Trust
- Paul Murphy, Non-Executive Director
- Shirley Richardson, Non-Executive Director
- Dr Ahmad Khouja, Medical Director
- David Brown, Acting Chief Operating Officer
- Elizabeth Moody, Director of Nursing and Governance
- Two public governors (as representatives of service users and carers)

The committee met four times during the year.

Quality Assurance Committee

The Quality Assurance Committee (QuAC) is the principal provider of assurance to the Board on quality, in particular, compliance with the fundamental standards prescribed in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The committee receives regular assurance reports from the Locality Management and Governance Boards and the corporate assurance groups in accordance with the Trust's quality governance arrangements.

Further information on the Trust's quality governance arrangements is provided in the Directors' Report.

As at 31st March 2018 the membership of the committee comprised:

- Dr. Hugh Griffiths, Non-Executive Director (Chairman of the Committee)
- Lesley Bessant, Chairman of the Trust
- Richard Simpson, Non-Executive Director
- Shirley Richardson, Non-Executive Director
- Colin Martin, Chief Executive
- David Brown, Acting Chief Operating Officer
- Dr. Ahmad Khouja, Medical Director
- Elizabeth Moody, Director of Nursing and Governance
- Jennifer Illingworth, Director of Quality Governance

The directors of operations and deputy medical directors attend, for the whole meeting, when the reports of their locality management and governance boards are considered by the committee.

The committee met, formally, 9 times during 2017/18.

Information on the Trust's progress against its quality priorities is included in the Quality Account.

The Commercial Oversight Committee

The Board established the Commercial Oversight Committee to oversee and provide assurance to the Board on the operation of the Trust's subsidiaries and other trading vehicles.

As at 31st March 2018 the membership of the committee comprised:

- Lesley Bessant, Chairman of the Trust (Chairman of the Committee)
- Marcus Hawthorn, Chairman of the Resources Committee
- David Jennings, Chairman of the Audit Committee
- Dr Ahmad Khouja, Medical Director

The committee met five times during 2017/18.

The Council of Governors

Report of the Lead Governor

As Lead Governor I am once again pleased to report that there have been no issues of concern with any aspects of the appointment process in the Trust or non-compliance with the constitution.

Training and development sessions remain a priority for Governors to ensure they have the skills and knowledge to enable both long standing and new Governors to challenge and ask appropriate questions on information presented to the Council of Governors. Governors are always made aware of new rules and regulations that affect the services provided by the Trust. Governors are informed at every Council of Governors meeting of the progress of the Quality Accounts and we review the Quality Accounts at the beginning of each year.

Recovery remains a very positive aspect of the Trust's values and vision and as we see more services users living and working in the community it continues to be an important part of patient's pathways to achieving confidence and independence. Governors have many links with the public and as ambassadors for the Trust have taken the opportunity to speak to community groups and organisations to tell them of the positive things the Trust is doing. Hopefully this can reduce some of the stigma about mental health and depression and encourage people to talk about mental health. We also try to encourage people to become Members of the Trust which can also give them a better understanding of issues to do with mental health.

A Task And Finish Group has been looking at how the Trust and the Council of Governors can improve how we engage with partners, services users, carers and the public. We recognise that engaging with young people is an important issue as we know there has been a rise in children with mental health issues.

The Council of Governors appreciate that this has been another challenging year due to the continued funding pressures of both the Trust and its partners and also the issues at Roseberry Park. It will be important that the Trust continues to work closely with all its partners to ensure the continued provision of high quality services. Finally, on behalf of the Council of Governors I would like to say that we appreciate the commitment and dedication of the staff in their endeavours to provide the best services possible to the patients and cares. We would also like to recognise the contribution of the volunteers which can add that extra help that some patients and carers need.

Cllr Ann McCoy
Lead Governor

The Composition of the Council of Governors as at 31st March 2018

Membership of the Council of Governors during 2017/18

The terms of office of governors and their attendance at the 6 meetings (including the Annual General Meeting) held during 2017/18 was as follows:

Public Governors (Elected)

Name	Constituency	Term of Office	To	Total Attended
Andrea Goldie	Darlington	01/07/2014	30/06/2017	0 (1)
Dennis Parry	Darlington	01/07/2017	10/07/2017	0 (0)
Dennis Haithwaite	Darlington	01/07/2014	30/06/2017	0 (1)
Maureen Powles	Darlington	14/07/2017	17/01/2018	1 (2)
Lesley Robertson	Darlington	01/07/2017	30/06/2020	1 (5)
Catherine Haigh	Middlesbrough	01/07/2016	23/01/2018	1 (4)
Mary Booth	Middlesbrough	01/07/2017	30/06/2020	3
Richard Thompson	Scarborough & Ryedale	01/07/2014	30/06/2017	1 (1)
Judith Webster	Scarborough & Ryedale	01/07/2017	30/06/2020	3 (4) *
Elizabeth Forbes-Browne	Scarborough & Ryedale	01/07/2016	30/06/2019	0
Bernard Cole	Scarborough & Ryedale	01/07/2017	18/03/2018	3 (5)

Claire Farrell	Redcar and Cleveland	01/07/2014	30/06/2017	0 (1)
Alan Williams	Redcar and Cleveland	01/07/2017	30/06/2020	3 (5)
Vanessa Wildon	Redcar and Cleveland	01/07/2016	30/06/2019	5
William Bailey *(previously known as Paul Emerson-Wardle - notified 08/06/2017)*	Stockton-on-Tees	12/11/2014	30/06/2017	0 (1)
Gillian Restall	Stockton-on-Tees	01/07/2017	30/06/2020	6
Mark Eltringham	Stockton-on-Tees	01/07/2017	30/06/2020	5 (5)
Gary Emerson	Stockton-on-Tees	01/07/2016	30/06/2019	4
Betty Gibson	Durham	01/07/2014	30/06/2017	0 (1)
Janice Clark	Durham	01/07/2014	30/06/2017	0 (1)
Anthony Heslop	Durham	01/07/2016	30/06/2017	1 (1)
Jacci McNulty	Durham	01/07/2017	30/06/2020	4 (5)
Mac Williams JP	Durham	01/07/2017	30/06/2020	4 (5)
Sarah Talbot-Landon	Durham	01/07/2016	30/06/2019	4
Cliff Allison	Durham	01/07/2017	30/06/2020	5
Graham Robinson	Durham	01/07/2017	30/06/2019	5 (5)
Keith Mollon	Durham	01/07/2016	30/06/2019	5
Dr Lakkur Murthy	Durham	01/07/2016	30/06/2019	5
Sandra Grundy	Durham	01/07/2017	30/06/2020	3 (4) *
Zoe Sherry	Hartlepool	01/07/2017	30/06/2020	5
Jean Rayment	Hartlepool	01/07/2016	30/06/2019	5
Colin Wilkie	Hambleton and Richmondshire	01/07/2014	30/06/2017	0 (1)
Angela Stirk	Hambleton and Richmondshire	01/07/2014	30/06/2017	1 (1)
Ailsa Todd	Hambleton and Richmondshire	01/07/2017	30/06/2020	4 (5)
Della Cannings QPM	Hambleton and Richmondshire	01/07/2017	30/06/2020	5 (5)
Hilary Dixon	Harrogate & Wetherby	01/07/2016	30/06/2019	5
Chris Gibson	Harrogate & Wetherby	01/07/2016	30/06/2019	5
Hazel Griffiths	Harrogate & Wetherby	01/07/2016	30/06/2019	2 (5) *
Dr Martin Combs	York	23/03/2016	30/06/2018	6
Nathaniel Drake	York	23/03/2016	30/06/2018	0
Dr Peter Harrison	York	23/03/2016	30/06/2018	6
Gemma Benson	Selby	01/07/2017	30/06/2020	4 (5)
Wendy Fleming-Smith	Selby	01/07/2017	30/06/2020	1 (5)

Staff Governors (Elected)

Name	Constituency	Term of Office	To	Total Attended
Simon Hughes	Teesside	01/07/2014	30/06/2017	1 (1)
Rachel Booth	Teesside	01/07/2017	30/06/2020	3 (4) *
Phil Boyes	County Durham & Darlington	01/07/2017	30/06/2020	5 (5)
Dr Judith Hurst	Corporate	01/07/2017	30/06/2020	5
Glenda Goodwin	Forensic	01/07/2017	30/06/2020	6
Wendy Pedley	North Yorkshire	10/10/2014	30/06/2017	0 (1)
Gary Matfin	York and Selby	19/02/2016	30/06/2018	6

Appointed Governors

Name	Appointing Organisation	Term of Office	To	Total Attended
Lisa Pope	Hambleton, Richmondshire and Whitby Clinical Commissioning Group / Scarborough and Ryedale Clinical Commissioning Group / Harrogate Clinical Commissioning Group / Vale of York Commissioning Group	01/11/2016	31/10/2019	0
Dr John Drury	Hartlepool and Stockton-on-Tees Clinical Commissioning Group / NHS South Tees Clinical Commissioning Group	01/07/2014	-	3
Dr David Smart	North Durham Clinical Commissioning Group / Durham Dales, Easington and Sedgefield Clinical Commissioning Group / Darlington Clinical Commissioning Group	25/09/2014	-	3
Marion Grieves	University of Teesside	29/04/2015	-	1
Professor Pali Hungin	Durham University	01/07/2014	30/06/2017	0 (1)
Professor Graham Towl	Durham University	23/10/2017	-	0 (2)
Cllr Ann McCoy	Stockton Borough Council	08/07/2014	30/06/2019	2
Cllr Kaylee Sirs	Hartlepool Borough Council	05/06/2017	-	0 (5)
Kevin Kelly	Darlington Borough Council	13/08/2015	-	0
Lee Alexander	Durham County Council	13/01/2017	-	2
Cllr Helen Swiers	North Yorkshire County Council	24/05/2016	-	4

Professor Angela Simpson	The University of York	27/01/2017	31/01/2018	1 (5)
Professor Steven Ersser	The University of York	01/02/2018	09/03/2018	0 (1)
Ian Hamilton	The University of York	09/03/2018	-	0 (0)
Cllr Ashley Mason	City of York Council	28/06/2016	-	0
Dr Suresh Joseph	Newcastle University	18/07/2017	16/01/2018	0 (4)
Prof Hamish McAllister-Williams	Newcastle University	06/03/2018	-	0 (0)

(Notes: Within the above tables -

- *The maximum number of meetings to be attended for those governors who held office during part of the year is shown in brackets*
- ** indicates that the Governor received a dispensation during the year from the attendance requirements set out in the Constitution for example due to ill-health)*

Details of company directorships or other material interests in companies held by governors where those companies or related parties are likely to do business, or are possibly seeking to do business with the Trust, are included in the "Register of Interests of the Council of Governors". This document is available for inspection on our website.

Elections held during 2017/18

Constituency Name	Date of Election	No of Seats	No. of candidates	No. of Votes cast	No. of eligible voters	Turnout (%)
Staff Governors						
Corporate	22/6/17	1	3	155	1066	14
County Durham and Darlington	22/6/17	1	1	-	-	-
Forensic	22/6/17	1	1	-	-	-
North Yorkshire	22/6/17	1	0	-	-	-
Teesside	22/6/17	1	1	-	-	-
Public Governors						
Darlington	22/6/17	2	3	51	755	6
Durham	22/6/17	5	9	174	2041	8
Hambleton and Richmondshire	22/6/17	2	3	78	531	14
Hartlepool	22/6/17	1	1	-	-	-
Middlesbrough	22/6/17	1	2	82	1162	7
Redcar and Cleveland	22/6/17	1	1	-	-	-
Rest of England	22/6/17	1	0	-	-	-
Scarborough and Ryedale	22/6/17	2	3	51	548	9
Selby	22/6/17	2	3	19	233	8
Stockton on Tees	22/6/17	2	2	-	-	-

All elections to the Council of Governors have been administered and overseen by Electoral Reform Services to ensure independence and compliance with the election rules contained within the Trust's Constitution.

Report of the Council of Governors' Nomination and Remuneration Committee

The Nomination and Remuneration Committee supports the Council of Governors undertake its duties regarding the appointment and setting the remuneration and terms of service of the Chairman and non-executive directors.

Meetings of the committee are chaired by the Chairman of the Trust except that the Senior Independent Director becomes a member of and chairs the committee for the matters relating to the appraisal and appointment of the Chairman.

During the year the committee:

- received assurance on the conduct and outcomes of the appraisals of the non-executive directors
- considered and recommended the re-appointment of Dr. Hugh Griffiths and David Jennings, as Non-Executive Directors, to the Council of Governors
- on the nomination of the Board, considered and recommended the appointment of Dr. Hugh Griffiths as the Deputy Chairman of the Trust
- considered the arrangements for future reviews of non-executive director remuneration
- reviewed the scheme for the payment of special responsibility allowances to the non-executive directors
- received and took assurance from benchmarking information on the remuneration of the non-executive directors

The membership of the committee, and attendance at its two meetings during 2017/18, was as follows:

Lesley Bessant	Chairman of the Trust	2
Betty Gibson	Public Governor	0 (1)
Colin Wilkie	Public Governor	1 (1)
Mary Booth	Public Governor	2
Della Cannings QPM	Public Governor	1 (1)
Mac Williams JP	Public Governor	1 (1)
Dr. Judith Hurst	Staff Governor	2

(Note: The maximum number of meetings to be attended by members of the committee during the year is shown in brackets)

Marcus Hawthorn, the Senior Independent Director was not required to attend the above meetings.

Advice and services were provided to the committee by Phil Bellas, Trust Secretary.

Training and Development

The Trust has a duty under the National Health Service Act 2006 to ensure that governors are equipped with the skills and knowledge they require to undertake their role.

To meet this requirement the Council of Governors has agreed a training and development programme based on the national "Governwell" programme and local opportunities including inductions for new governors and governor development days.

Assurance on the effectiveness of these arrangements is sought through the annual performance evaluation of the Council of Governors. Of those governors responding to the survey:

- 92% of governors, elected or appointed in the last 18 months, agreed/slightly agreed that the Trust provided an adequate induction programme
- 96% agreed/slightly agreed that relevant training was provided on an ongoing and timely basis and appropriate briefings were provided in relation to key topics being discussed.
- 96% agreed/slightly agreed that the governor development days and ad hoc briefings had assisted them develop their wider knowledge and understanding of their role and the Trust.

Governor participation in the development of the Operational and Business Plan

Governors, as representatives of the members of the Trust and the public, have a key role in the development of our operational/business plan through the business planning framework.

In 2017/18 the Council of Governors:

- held a workshop to support the identification of future priorities, the outcome of which was presented to the Board at its annual business planning event in October.
- considered and provided comments on the draft business plan during the course of its development

These arrangements enabled governors to engage with their members and partner organisations at key stages during the preparation of the operational/business plan.

Of those governors responding to the annual performance evaluation, 95% agreed/slightly agreed with the statement that the Council of Governors was successful in influencing the Trust's business plan/strategy.

Further information on the involvement and engagement with members is provided in the Membership Report.

Membership Report

Membership is important in helping to make us more accountable to the people we serve, to raise awareness of mental health and learning disability issues and assists us to work in partnership with our local communities.

- **Public membership**
  Anyone (unless eligible to join the staff constituency) aged 14 or over who lives in the area covered by the public constituencies (as described in the constitution) may become a public member of the Trust.

- **Staff membership**
  All staff employed by the Trust (including those on a temporary or fixed term contract of 12 months or more) are eligible to become members of the staff constituency.

  Members of staff are "opted in" upon commencement of employment and given the choice to "opt out" of membership in writing.

As at 31st March 2018 the Trust's membership was as follows:

- Public members – 9,531
- Staff members – 6,555

The following table provides an analysis of our public membership compared to the population covered by the Trust:

Public constituency	Number of members	Eligible membership
Age (years):		
0-16	30	377,412
17-21	679	121,890
22+	8,321	1,508,697
Ethnicity:		
White	8,706	1,897,919
Mixed	55	17,513
Asian or Asian British	158	40,256
Black or Black British	65	7,935
Other	17	5,452
Socio-economic groupings*:		
AB	2,101	116,754
C1	2,625	176,896
C2	2,159	136,350
DE	2,594	175,232
Gender analysis		
Male	3,249	986,283
Female	6,235	1,021,714

(Notes: On application:
- *501 members did not provide a date of birth*
- *530 members did not state their ethnicity*
- *47 members did not state their gender)*

Member engagement

The focus of the Trust is to grow a representative membership to ensure accountability through engaging with its members.

The Trust has levels of membership (support, informed, active and involved member) from which members can choose so that their engagement with the Trust is aligned to their aspirations.

A range of activities and actions are in place to support member engagement. Over the last 12 months these have included:

- Welcome packs are issued to every new public member with a unique membership card and number, welcome letters and details of staff governors issued to all new staff members.
- Issue of the insight magazine to all members signed up as an informed member and above which includes articles written by governors and service users and carers within the Members News section.
- Personal invitations issued to public members to attend member engagement events held in five different areas of the Trust.

- Communications and drop in events to support the awareness of Governor Elections.
- Delivery of the Annual General and Members Meeting with over 200 attendees.
- Website forum and increased use of social media
- A number of social / community events attended such as Durham Pride, Time to Talk Day and Darlington's Tea Dance.
- Attendance at College Fresher and wellbeing days.
- Invitations to formal public consultations held within Hambleton and Richmondshire on the provision of inpatient services at The Friarage Hospital and the development of Community Services in the area
- Consultation on the business plan priorities including seeking views of the public and formal consultation with the Council of Governors to enable them to engage with their membership.

All involvement and engagement activity is monitored through the Council of Governors' Involvement and Engagement Committee.

The Council of Governors has also established a task and finish group to review the involvement of service users and carers across the Trust looking for best practice and identifying where improvements can be made. The group is due to provide a report on its findings, including recommendations, during 2018/19.

Members wishing to contact Governors and/or Directors of the Trust can do so via the Trust Secretary's Department on 01325 552314, email tewv.ftmemberhsip@nhs.et or visit our website www.tewv.nhs.uk

Please also use these contact details if you would like to become a member.

NHS Improvement's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's *Risk Assessment Framework* (RAF) was in place. Information for the prior year and first two quarters of 2016/17 relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

NHS Improvement has placed the Trust in segment 1 (maximum autonomy).

This segmentation information is the Trust's position as at 31st March 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Area	**Metric**	**2017/18 scores**				**2016/17 scores**	
		Q4	**Q3**	**Q2**	**Q1**	**Q4**	**Q3**
Financial sustainability	Capital service capacity	3	3	3	3	2	2
	Liquidity	1	1	1	1	1	1
Financial efficiency	I&E margin	1	1	1	1	1	1
Financial controls	Distance from financial plan	2	2	2	2	1	1
	Agency spend	2	2	2	2	1	1
Overall scoring		**2**	**2**	**2**	**2**	**1**	**1**

Statement of the chief executive's responsibilities as the accounting officer of Tees, Esk and Wear Valleys NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Tees, Esk and Wear Valleys NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Tees, Esk and Wear Valleys NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.
To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

Colin Martin
Chief Executive **22nd May 2018**

Annual Governance Statement 2017/18

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Tees, Esk and Wear Valleys NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Tees, Esk and Wear Valleys NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Chief Executive is the Trust's Accounting Officer responsible for ensuring that the principles of risk management are embedded throughout the organisation.

Oversight and assurance to the Board on the operation of the Trust's risk management arrangements (both clinical and non-clinical) are provided by the Audit Committee. The Quality Assurance Committee also approves the clinical audit programme and monitors its delivery. The terms of reference of these committees, together with overlapping membership, ensures that there is a co-ordinated and complementary approach to risk management.

Guidance and training in the risk assessment process is aimed at all levels of staff. This is achieved through the inclusion of risk assessment techniques and processes in the Trust Training programme.

The risk and control framework

The Trust's approach to Risk Management is contained in the Integrated Governance Framework which is subject to regular review. The principal risks to compliance with the NHS foundation trust condition 4 (FT governance) and actions identified to mitigate these risks are detailed below

Key elements of the Risk Management Strategy are:

- To provide clear management structures and responsibilities throughout the organisation leading to the Board of Directors
- To identify a Lead Executive responsibility for each risk
- To outline the Trust's approach to Risk Management and identifying risks
- To outline and implement a system for assessing risk
- To select the approach for dealing with the risk
- Monitoring and reporting of risk
- Use of an integrated risk register for prioritising and reviewing risks
- Decision making on acceptability of risk
- Training and awareness of Risk Management
- Assurance framework mapping objectives to risks, controls and assurances

Risk is identified using a number of internal and external mechanisms including; NHS Resolution (NHSR), Care Quality Commission (CQC), serious incident investigations, complaints management, litigation, staff surveys, task groups, Trust risk register, clinical audit and internal and external audit.

The embedding of risk management can be demonstrated in the Trust by;

- Clear structures and responsibilities with clear reporting arrangements to Trust Board
- A system for risk assessment in place to identify and minimise risk as appropriate
- Consideration of acceptability of risk
- Development of reporting arrangements on serious investigations and complaints
- Framework for assessing and managing clinical risk and harm minimisation
- Development of risk registers at strategic and operational level
- Awareness training for all staff.
- The embedding of an action plan to further strengthen risk management and Board Assurance Framework processes as outlined in the Head of Audit Opinion.
- Assurances provided by reviews undertaken by the Internal Auditors (Audit One)

Public stakeholders are involved in identifying risks and providing assurance that they are mitigated in a variety of ways:

- The Council of Governors
- Patient satisfaction surveys
- Complaints, claims and Patient Advice and Liaison(PALS) concerns
- The Trust involves patients and the public in the development and evaluation of services
- The Trust maintains close links with local authority social services departments to ensure the delivery of integrated care and treatment

In addition an Assurance Framework was in place at 31 March 2018; remains in place up to the date of approval of the annual report and accounts; and continues to be maintained for the financial year ahead.

The main risks to the Trust meeting its principal objectives have been identified within the framework together with the key controls in place to manage these risks. Although

the Trust has not identified any significant control issues, it is improving the control and management of some of the risks in the following areas:

The Trust continues to use a process of Quality Impact Assessments (QIA) which are designed to assess and approve all Cash Releasing Efficiency Savings (CRES) schemes for the impact they have on clinical performance, and ultimately, patient care.

A considerable amount of work has been undertaken to strengthen clinical audit arrangements. Improvements have been made to processes for planning and management of the programme and additional resources have been deployed to increase clinical audit capacity. Action plans are in place to further strengthen and embed clinical audit procedures.

The Trust currently has an ongoing contractual dispute regarding Roseberry Park. The outcome of this legal process has not yet concluded; however, it is not expected that it will have an adverse impact on the Trust. This position will continue to be reviewed as more detail is known, including reporting to Board.

The Trust has continued to strengthen and further embed both its training provision and monitoring controls within its devolved information risk management framework.

Further work has been carried out continuing the improvements put in place in prior years in the development of a robust workforce performance management framework.

Plans are also in place to further develop the Trust's information systems to support the organisation's objectives (including data quality, the implementation of mental health currencies including quality and outcome measures) and the Trust's approach to managing counter fraud.

A key focus has been the issue of Cyber security and ensuring that the Trust has actions in place to meet all of the 10 steps for Data Security and protection and the recommendations from the Lessons Learned Review of the WannaCry Ransomware Cyber-attack. The Trust has established a Digital Safety Board, to further strengthen and embed Cyber security protocols, to minimise the risk to the Trust.

In all cases mitigation plans are in place to ensure that these gaps are removed as soon as is practical. This process is managed by the Trust Board's sub committees and reported to the Board.
The Trust recognises the importance of gaining independent assurance that its controls are operating effectively and that its action plans to strengthen controls are successfully implemented. To do this the Trust uses information received from other organisations which is timely, accurate and recorded. This supports robust governance processes that provide assurance that the Trust is compliant with the provisions of the licence

The Trust is committed to meeting the requirements of the Department of Health's Information Governance Assurance Programme. An overall score of 88% was achieved against the Information Governance Toolkit in 2017/18 with all sequences achieving, at least, level 2 compliance. The Director of Finance and Information is the senior

information risk owner (SIRO) at Board level. The Trust operates a SIRO network (information asset owners and administrators), which has increased Information Governance awareness, training and understanding of standards. The network is supported by an Information Governance Campaign to delivery of these activities.

The Trust has an established anti-fraud and corruption policy which aims to minimise the risk of fraud, bribery or corruption by detailing the key roles and responsibilities of employees and related parties; as well as promoting an anti-fraud culture throughout the Trust.

The policy and related materials are available on the Trust's intranet and counter-fraud information is prominently displayed both on the Trust's intranet and throughout the Trust's premises.

The Trust's Local Counter-Fraud Specialist (LCFS) reports to the Audit Committee quarterly and performs a programme of work designed to provide assurance to the Board with regard to fraud and corruption. The LCFS provides regular fraud awareness sessions to the Trust's staff, investigates concerns reported by staff and liaises with the police. If any issues are substantiated, the Trust takes appropriate criminal, civil or disciplinary measures.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Trust has agreed a process to ensure that resources are used economically, efficiently and effectively that involves:

- Agreeing a rolling 3 year annual financial strategy and plan (including capital)
- A rigorous process of setting annual budgets and a detailed cost improvement programme including a Quality Impact Assessment (QIA).
- Annual review of Standing Financial Instructions and Schemes of Delegation
- Robust performance management arrangements

- A programme of supporting directorates to better understand and manage their relative profitability
- Breaking the trust's overall reference cost indicator down to Specialty / directorate
- Levering efficiencies through internal and collaborative procurement initiatives
- Using benchmarking and nationally published performance metrics to inform plans for improved bed and community service efficiency
- Rationalising, improving and developing the estate
- Improving workforce productivity
- Benchmarking management costs
- Commissioning external consultancy where the Trust believes economy and efficiency can be improved
- Embedding the Quality Improvement Systems (QIS) methodology to review how the Trust operates, maximising efficiency and minimising waste
- Values based recruitment process
- Supporting staff to raise issues through whistleblowing and a "fair blame culture"

The Board plays an active role by:

- Determining the level of financial performance it requires and the consequent implications (including QIA)
- Reviewing in detail each month financial performance, financial risk and delivery against the detailed CRES
- Agreeing the integrated Business Plan, Quality Report and Self Certification submitted to NHS Improvement.
- Considering plans for all major capital investment and disinvestment

The Trust's Audit Committee has a key role on behalf of the Board in reviewing assurance through its audit programme on the effective use of resources. The Trust also gains assurance from:

- Internal audit reports, including review of CRES
- External audit reports on specific areas of interest
- The Care Quality Commission reports

Information Governance

There were fifteen incidents reported on the Information Governance Toolkit during this period of which all were responded to by the Information Commissioner's Office (ICO). Of the responses received by the ICO none required the Trust to take further action. Each incident occurred because of unauthorised access to the patient record and all staff involved received the appropriate sanction for this type of Information Breach.

The Trust continues to prepare for the implementation of The General Data Protection Regulations (GDPR), through the Digital Safety Board, in May 2018.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has

issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The following steps have been put in place to ensure that the Quality Accounts present a balanced and accurate view:

- The Quality Assurance Committee is responsible for producing the Quality Accounts with the Director of Nursing and Governance and the Director of Planning and Performance being lead Directors. The Quality Assurance Committee has received reports throughout the year regarding the development of the Quality Accounts, including an early draft of the accounts.

- Priorities for improvement have been identified from an analysis of serious untoward incidents, complaints, and mortality reviews as well as feedback from users and other stakeholders. Theses priorities have been shared with wider stakeholders for comment and were approved by the Quality Assurance Committee before final sign off by the Board of Directors and Council of Governors.

- The Director of Finance and Information is the corporate lead for data quality and chairs an internal group which has the responsibility for ensuring data quality within the Trust. Furthermore data quality is also discussed at monthly performance meetings between the Director of Finance, Director of Planning and Performance and the Chief Operating Officer with each clinical directorate.

- Data quality is included within the corporate risk register which is used by the Board of Directors to monitor the risk of incomplete and inaccurate data. The Trust continues to develop a Data Quality Strategy which provides a framework for improvements in this important area. A Data Quality Strategy Scorecard is also in place to enable the Board of Directors to track progress.

- The Trust has the following policies linked to data quality:

    - Data quality policy
    - Minimum standards for record keeping
    - Policy and procedure for PARIS (Electronic patient record / information system)
    - Care programme approach (CPA) policy
    - Information governance policy
    - Information systems business continuity policy
    - Data protection policy

    The policies incorporate national standards where available and are regularly reviewed. All the policies are held on the intranet and are available to staff at all times. When policies have been reviewed (or new ones published) there is a mechanism to inform staff through team brief.

- A significant amount of training is provided to support staff using the electronic patient record (PARIS) and to ensure compliance with CPA. Training is provided where issues around data quality have been identified.

- As part of performance reporting to the Board actual data is used to forecast future positions thus improving the decision making process.

- All data returns are submitted in line with agreed timescales.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Quality Assurance Committee and Mental Health Legislation Committee; and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by

- The Care Quality Commission
- NHS Resolution Clinical Negligence Scheme for Trusts (CNST)
- Internal Audit
- External Audit
- Health and Safety Executive
- Internal Clinical Audit Team

The following groups and committees have been involved in maintaining and reviewing the effectiveness of the system of internal control;

- The Board of Directors is responsible for setting the strategic direction of the organisation and monitoring the progress of the organisation against targets. The Board also receives minutes and reports from its sub committees.
- It is the Council of Governors duty to hold the non-executive directors to account for the performance the Board of Directors, and to represent the interests of the public.
- The Audit Committee provides an independent view of internal control by reviewing financial systems, overseeing audit services and providing assurance to the Board on governance issues including reviewing commenting on the clinical audit programme.
- The Quality Assurance Committee oversees on behalf of the Board of Directors all clinical governance activity including a review of the clinical audit processes and programme.
- Internal Audit provides an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's objectives. The Head of Internal Audit opinion provided good assurance for this area, and all issues raised have been considered appropriately.
- The external auditor provides progress reports to the Audit Committee.
- The annual report and accounts are presented to the Board of Directors for approval.

Conclusion

In summary, the Trust has not identified any significant internal control issues within 2017/18, and has a sound system of Internal Control and Governance in place which is designed to manage the key organisational objectives and minimise the Trust's exposure to risk. The Board of Directors is committed to continuous improvement and enhancement of the systems of internal control.

Colin Martin
Chief Executive Date: 22nd May 2018

Quality Report
(subject to independent review)

Part 1: Statement on quality from the Chief Executive of the Trust

I am pleased to be able to present Tees, Esk and Wear Valleys NHS Foundation Trust's (TEWV) Quality Account for 2017/18. This is the 10th Quality Account we have produced and it details what we have done to improve the quality of our services in 2017/18 and how we intend to make further improvements in 2018/19.

TEWV primarily serves the populations of:

- County Durham;
- Darlington;
- North Yorkshire (not including Craven district, but including Wetherby);
- Teesside (the boroughs of Hartlepool, Middlesbrough, Redcar & Cleveland and Stockton);
- The Vale of York (which includes York, Easingwold, Pocklington, Tadcaster and Selby).

Our specialist services such as Child and Adolescent Mental Health Services (CAMHS) inpatient wards, adult eating disorder wards and forensic secure adult wards serve patients from elsewhere in the North East, Cumbria, Yorkshire and the Humber and further afield.

The improvement priorities and metrics in this plan apply to the whole of the area served by TEWV.

Our Mission, Vision & Strategy

The purpose of the Trust is:

To minimise the impact that mental illness or a learning disability has on peoples' lives

and our vision is:

'To be a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations'

Our commitment to delivering high quality services is supported by our second strategic goal:

'To continuously improve the quality and value of our work'

It is also supported by our **Quality Strategy** 2017-2020. This outlines our quality vision for the future, which is:

- We will provide care which is patient, carer and staff co-produced, recovery-focused and meets agreed expectations.
- We will provide care which is sensitive to the distress and needs of patients, carers and staff. Staff will respond with kind, intelligent and wise action to enable the person to flourish.
- Care will be flexible and proactive to clinical need and provided by skilled and compassionate staff with the time to care.
- Care will be consistent with best practice, delivered efficiently and where possible, integrated with the other agencies with whom we work.
- We will support staff to deliver high-quality care and will provide therapeutic environments which maintain safety and dignity.

The Quality Strategy contains three goals which are:

- Patients, carers and staff will feel listened to and heard, engaged and empowered and treated with kindness, respect and dignity.
- We will enhance safety and minimise harm.
- We will support people to achieve personal recovery as reported by patients, carers and clinicians.

TEWV's 2017 Community Mental Health Survey results show:

- The response rate of 29% was above the national response rate of 26%.
- When comparing TEWV survey results with those of the other organisations the scores were identified as being 'about the same' as other organisations across all 10 sections.
- Whilst there were no questions identified as scoring 'better' than other Trusts, TEWV scored well in three questions.
- TEWV scored 'about the same' as most other Trusts in all but one of the individual questions, which scored 'worse' (question 31: *Were these treatments or therapies explained to you in a way you could understand?)*.
- The overall rating on care experience was 70.9% in 2017 which has declined from the 2016 score of 74.3%. To improve this position, the Trust will examine the data to identify questions which scored low and concentrate improvement activity on these areas.

Each goal has high-level measures which the Trust will monitor for assurance that the Trust's vision for quality is being delivered. These measures will be scrutinised by our Quality Assurance Committee (QuAC) and Board. In addition, we have identified a number of supporting actions, established and new, which will each be monitored.

What we have achieved in 2017/18

- We have continued to work to deliver new services to meet the needs of those who use our services. For example we have:
  - Established a 24/7 Adult Learning Disability crisis access service across the Vale of York and North Yorkshire.
  - Set up an Adult Learning Disability Enhanced Crisis Preventative Community Service in Durham, Darlington and Teesside.

- Improved the number of people with Learning Disabilities seen in collaboration with Adult Mental Health (AMH) services under Greenlight arrangements in York and Selby, both inpatient and outpatient. We also now have champions for Positive Behavioural Support in our York Adult Learning Disability teams.
- Co-produced a vision for the future of services for people with autism and developed a training programme for staff.
- Introduced a new care planning process and format for Children and Young People's services, which are now written during an appointment with the service user, and written in the first person.
- Been granted planning permission for a new mental health hospital serving adult and older people at Haxby Road in York.
- Received Clinical Commissioning Group (CCG) agreement on a preferred model for the future mental health services for people living in Hambleton and Richmondshire. This will lead to investment into community services that will help to reduce admissions. It also means that there will no longer be mental health beds at The Friarage Hospital. Residents of this area who require inpatient treatment will be admitted to West Park, Roseberry Park or Auckland Park hospitals. These wards provide purpose built modern accommodation that supports the delivery of high quality care.
- Further increased the number of paid and voluntary experts by experience at the Trust. This is having a positive impact on staff culture and practice. Increasingly policies are being co-produced and recovery-friendly language is in use.
- Started work to establish the key features of a recovery oriented community team, enabling a TEWV recovery accreditation scheme to be developed.
- Expanded the range of courses at our Durham Recovery College.
- Launched an online Recovery College, accessible by service users as well as staff across the whole TEWV area.
- Achieved Investors in People (IiP) Gold Accreditation using the revised and more challenging IiP standard, and the Care Quality Commission (CQC) rated the Trust's leadership as "Good" in their most recent Well Led Review.

In the 2017 national NHS Staff Survey, the Trust had a response rate of 52% (3354 of 6402 eligible staff), the average response rate for Mental Health and Learning Disability Trusts.

The Trust scored the same or better than average on 30 of the 32 areas covered by the staff survey, two of which were the best score for Mental Health.

- We have also worked to improve our quality through staff training and, communication. For example we have:
  - Commenced the delivery of Trauma Informed Care (TIC) training.
  - Introduced training for all new inpatient staff in relation to patient leave and time away from the ward.

- As well as the examples above, we have also continued to drive improvements in the quality of our services through using the TEWV Quality Improvement System (QIS). This is the Trust's approach to continuous quality improvement and uses

tried and tested techniques to improve the way services are delivered. Some notable examples of what we have achieved in 2017/18 are that we have:

- Redesiged many of our clinical pathways and clinical link pathways (CLiPs).
- Spread the existing Purposeful Inpatient Admissions (PIPA) approach from our Adult wards to our Older People's wards. This reduces delays in assessment, treatment and discharge, encourages multi-disciplinary team working and reduces inconsistenices in approach between different localities within TEWV.
- Improved and standardised practice across our two adult Psyciatric Intensive Care Units (PICUs) leading to a more recovery oriented approach and better arrangments for transfer back to assessment and treatment wards.
- Agreed Crisis Team triage and assessment standards, and criteria for admission and home based treatment interventions by these teams.
- Agreed Visual Control Boards (VCB) for the home-based treatment component of care (including extended assessment where indicated).
- Brought about improvements in the psychological input to the treatment of older people in our services (by improving the processes for referral to psychology). This is reducing waiting times from initial referral to first contact, improving the standard process for formulation, and ensuring more equity in length of time in therapy.
- Observed the daily practice of community mental health teams in all specialities and piloted new ways of entering patient information into our electronic patient record (Paris). This has increased the proportion of time that clinicians can spend with service users.
- Following a patient safety incident, utilising QIS principles, our Durham and Darlington Learning Disabilities service has implemented a new system to make sure that physical health and other checks for people taking lithium is taking place. It also ensures that there are timely reviews of care and intervention.
- Our Children and Young People's Services (CYPS) reviewed their existing care pathways to make them more Learning Disability compatible. This included ensuring any information gathering in the early stages would feed into a decision on whether a Leaning Disability assessment was needed and also contribute to that assessment. These new arrangements were piloted in Durham and Redcar.

Our Staff *Friends and Family Test (FFT)* results include:

- 81% are likely or highly likely to recommend treatment at TEWV.
- 70% would recommend TEWV as a place to work.
- 83% agree that they are able to make suggestions for improvement.

- In addition we have worked with our partners to improve services. For example we have:
  - Established a Service Level Agreement (SLA) with a local acute Trust to provide tissue viability advice, support and training for staff (for any pressure ulcer of grade 2 or above).
  - Supported the development of the voluntary and community sector's (VCS) adult learning disability workforce. We have done this by training TEWV staff in an Active Support 'train the trainer' Programme and mentoring other

providers' staff through Positive Behavioural Support BTEC (Business and Technology Council) courses.

- Developed good informal research relationships with the higher education sector in York and with potential new providers of medical and nursing / Allied Health Professional (AHP) training.
- Continued to organise the TEWV Learning Disability Quality conference. This has now been running for 11 years and each year it has become more successful and popular with over 200 people now attending. It showcases engagement and collaborative working. Service users are at the heart of the conference and are involved in the development, production and delivery of the conference.
- Worked with NHS England (NHSE), Northumberland, Tyne and Wear NHS Foundation Trust (NTW) and other providers to progress our pilots that are testing our provider-led management of NHSE commissioning budgets. We have active projects in adult secure (forensic) and CYPS specialist inpatient services. The CYPS work is most advanced and has led to investment in Crisis / Intensive Home Treatment teams across the area served by the Trust, and a reduction in admissions. We have also developed an Accountable Care Partnership (ACP) with the CCGs across Durham, Darlington and Teesside. In its first phase this has carried out reviews into over 60 Adult Learning Disability NHS funded placements and brought about many improvements in both the quality and value for money of these.

In 2017/18 the Trust was also recognised externally in a number of national awards where we won or were shortlisted. Awards won / highly commended by TEWV teams or staff members are shown in the table below:

Awarding Body	Award status	Name / Category of Award	Team / individual
British Medical Journal (BMJ) Awards 2017	Highly commended	Education category	Delirium team / Dr Mani Santhanakrishnan
Division of Forensic Psychology	Winner	2017 Senior Award for Distinguished Contributions to Professional Practice in Forensic Psychology	Ruby Bell
Yorkshire Personal Assistant (PA) awards	Runner-up	Best team	Community Learning Disabilities team - secretaries, York
Faculty for the psychology of older people in the British Psychological Society	Awarded	Mid-career - Bill Downes award	Sarah Dexter-Smith
Royal College of Psychiatrists' Centre for Quality Improvement	Awarded	Enabling Environment award	The PIPE (Psychologically Informed Planned Environment) team at HMP/YOI Low Newton
Royal College of Psychiatrists	Awarded	AIMS (Accreditation for Mental Health Inpatient Services)	Esk and Danby wards at Cross Lane Hospital, Scarborough
	Awarded	CCQI (College Centre for Quality Improvement) Quality Network for Inpatient CAMHS Accreditation	Westwood Centre

Awarding Body	Award status	Name / Category of Award	Team / individual
Royal College of Psychiatrists	Winner	Psychiatric Communicator of the Year	Dr Mani Santhanakrishnan
	Winner	Psychiatric Team of the Year: Non age-specific	Women's Forensic Learning Disabilities Secure Service
	Winner	Foundation Doctor Category	Dr Megan Brown
Positive practice in mental health awards 2017	Highly commended	Specialist Services category	Rollercoaster (parent support group)
	Highly commended	Co-production of care	Rollercoaster (parent support group)
	Highly commended	Innovation in Children and Young People's MH	Rollercoaster (parent support group)
	Winner	Psychological Therapies for People with 'Common Mental Health Problems'	Mindfulness team
	Highly commended	Mental wellbeing of staff	The TEWV Employee Support Service
	Highly commended	Integration of physical and mental healthcare	Harrogate Vanguard team
Australian College of Mental Health Nurses	Awarded	Research award 2017	David Ekers
The Investing in Children (IiC) Membership Award Scheme	Awarded	IiC Accreditation - Investing in Children Membership Award	CAMHS Hartlepool
Positive practice in mental health awards 2017	Winner	Carer / Parent / Sibling award	Rollercoaster (parent support group)

Awards where TEWV or one of its teams / staff were shortlisted for an award but did not win that award in 2017/18 were:

Awarding Body	Name / Category of Award	Team / individual
Student nursing times awards 2017	Mentor of the year	Claire Baird
	Student nurse of the year: learning disabilities	Catherine Thompson
BMJ awards 2017	Prevention team	Suicide prevention training
Royal College of Nursing (RCN) Nursing awards 2017	Mental health practice award	Perinatal mental health pathway team at HMP/YOI Low Newton
Health Service Journal (HSJ) Value in Healthcare Awards	Improving the value of NHS support services	Workforce development team
Patient Safety Awards 2017	Mental health	Mental Health Services for Older People, suicide prevention training team

Awarding Body	Name / Category of Award	Team / individual
Nursing Times awards	Nursing in Mental Health	Developing a perinatal mental health pathway within a female prison - a collaborative, cross-agency approach
Royal College of Psychiatrists	Specialty Doctor / Associate Specialist of the Year	Dr Ajith Suryadevara
	Psychiatric Team of the Year: Working-age adults	Teesside Crisis Service / Crisis Assessment Suite
		Teesside Rehabilitation Services
	Psychiatric Team of the Year: Older-age adults	Mental Health Services for Older People, Durham and Darlington
	Psychiatric Team of the Year: Quality Improvement	Adult Learning Disability Unit, Durham
		Durham and Darlington Child and Adolescent Mental Health Services Senior Management Team
	Carer Contributor of the Year	Sheena Foster
		Hazel Griffiths (Governor for the Trust)
NHS innovations North Bright ideas in Health	Research Delivery Impact	An innovative method of delivering RESEARCH AWARENESS to TEWV service users, carers and staff
Health Heroes Awards 17	Clinical Support Worker of the Year	Cheryl Young
Dementia Friendly Awards 2017	Dementia Friendly Community of the Year	Dementia Friendly Hartlepool
Health Business Awards	NHS Collaboration Award	Tees, Esk and Wear Valleys NHS Foundation Trust / Durham Constabulary - Street Triage
Patient Experience Network National Awards (PENNA)	Measuring, Reporting and Acting	Tees, Esk and Wear Valley NHS Foundation Trust - Making best use of technology to collect, report and use feedback to improve services

Structure of this Quality Account document

The structure of this Quality Account is in accordance with guidance that has been published by both the Department of Health and the Foundation Trust regulator, NHS Improvement and contains the following information:

- **Part 2** – Information on how we have improved in the areas of quality we identified as important for 2017/18, the required statements of assurance from the Board and our priorities for improvement in 2018/19.
- **Part 3** – Further information on how we have performed in 2017/18 against our key quality metrics and national targets and the national quality agenda.

The information contained within this report is accurate, to the best of my knowledge.

A full statement of Directors' responsibilities in respect of the Quality Account is included in **appendix 1**. This is further supported by the signed limited assurance report provided by our external auditors on the content of the 2017/18 Quality Account which is included in **appendix 2**.

I hope you find this report interesting and informative.

If you would like to know more about any of the examples of quality improvement or have any suggestions on how we could improve our Quality Account please contact:

- Sharon Pickering (Director of Planning, Performance and Communications) at sharon.pickering1@nhs.net; or
- Elizabeth Moody (Director of Nursing and Governance) elizabeth.moody@nhs.net.

Mr. Colin Martin **22nd May 2018**
Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust

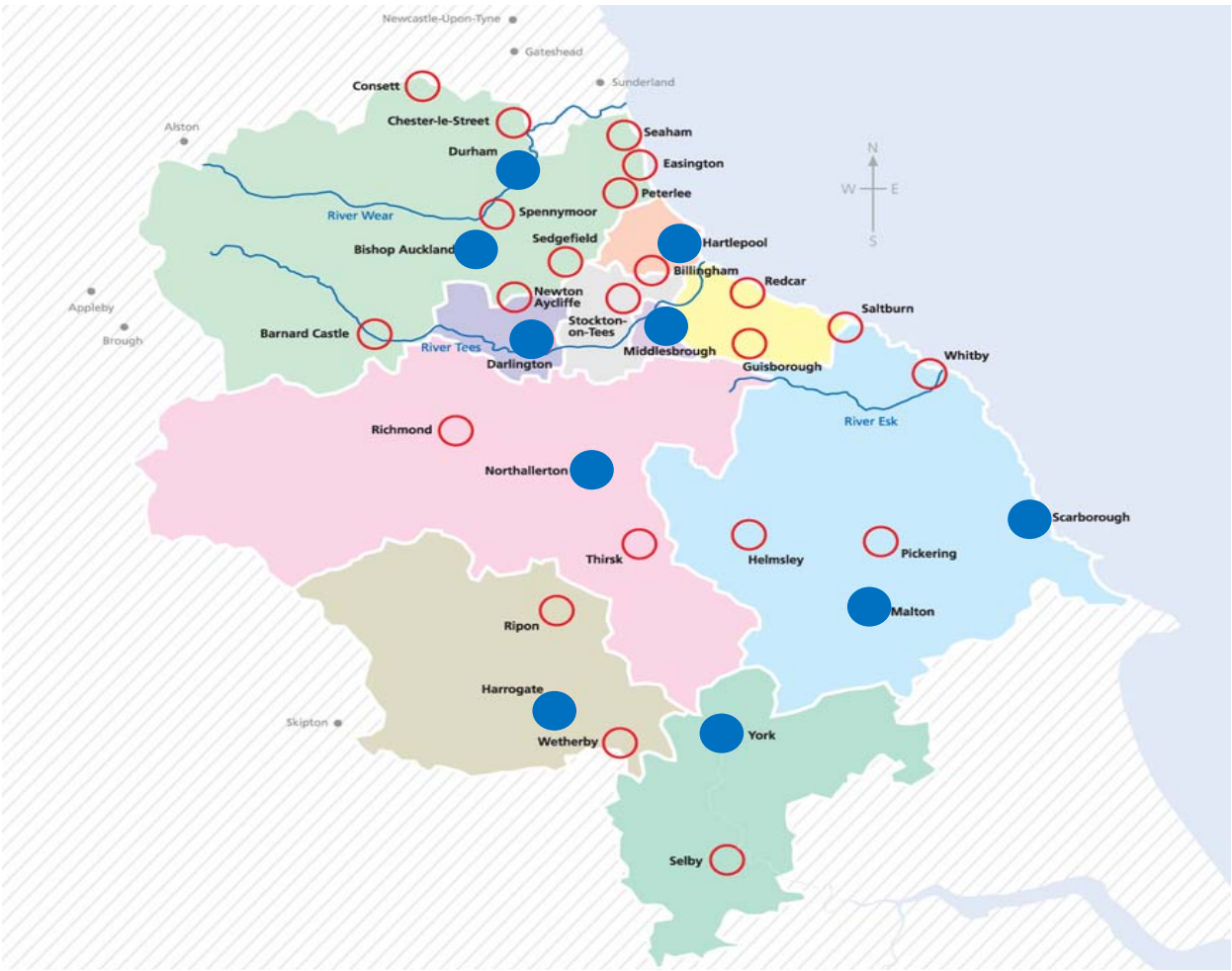
A Profile of the Trust

The Trust provides a range of mental health, learning disability and autism services for around two million people living in County Durham, Darlington, Teesside, North Yorkshire (other than Craven district) and the Vale of York. This area covers 4,000 square miles (10,000 square kilometres). A map showing this area is provided on the following page. The Trust also provides some regional specialist services (e.g. forensic services, children and young people tier 4 services and specialist eating disorder services) to the North East and Cumbria region and beyond. The Trust is also commissioned as part of a national initiative to provide inpatient care to Ministry of Defence personnel, and provides mental health treatment to prisoners in North East England and parts of the North West.

Services commissioned by CCGs are managed within the Trust on a geographical basis in four localities covering Durham and Darlington; Teesside; North Yorkshire and York & Selby. There is also a locality covering Forensic Services. Each is led by a Director of Operations and a Deputy Medical Director who report to the Chief Operating Officer and Medical Director.

- Our income in 2017/18 was **£350m**.
- On 31st March 2018 there had been **153,271** people who had received care from TEWV during 2017/18.
- During 2017/18 on average we had **2,348** patients occupying an inpatient bed each day (this equates an average occupancy rate of **86%**[1]).
- Our community staff made more than **2.19 million** contacts with patients during 2017/18.
- We have a total of **6,517** whole time equivalent employees or **5,951** permanently employed whole time equivalents.

[1]This occupancy rate refers to all TEWV beds, not just to Assessment and Treatment beds (where the occupancy rate is higher than this average figure).



Key				
Main Towns	O		Main town and location of TEWV inpatient beds	●

Part 2: Priorities for improvement and statements of assurance from the Board

Update on 2016/17 quality priorities

In last year's Quality Account we reported on our progress with our quality priorities for 2016/17. Within this we also noted some further actions for 2017/18. In some cases, these actions were to be included within the quality priorities for 2017/18, and therefore, are reported within this Quality Account. In other cases, these quality priorities were discontinued in the Quality Account but remained a priority for the Trust. The following is a brief summary of our progress with the quality priorities that were not continued in the Quality Account priorities for 2017/18.

Implement and embed the revised harm minimisation and risk management approach	The Harm Minimisation Project was formally closed down at the end of March 2017. In April 2017 the mandatory Clinical Risk Assessment and Management e-learning was replaced with the new Harm Minimisation e-learning package. The e-learning was co-developed with experts by experience and allows the learner to provide reflective accounts of the harm minimisation and recovery agenda. These reflections are printed off and can be used for supervision / appraisal and as evidence for professional revalidation where appropriate. Given its central importance to good clinical practice, this training will be required every 2 years. Feedback on the e-learning has been mostly positive with staff commenting that doing reflections rather than questions is better and that the service user's narrative within the training is extremely powerful. It was recognised however that to enable the Trust to achieve the cultural change required to move toward recovery orientated harm minimisation which focuses on narrative development and co-production of recovery / safety plans, face to face training would need to continue for at least another year. Therefore during 2017/18 face to face training has continued to be provided by the established project training team consisting of one nurse and two part time experts by experience. The aim for 2017/18 was to deliver training (either face to face or e-learning) to 90% of all clinical staff by the end of quarter four 2017/18. To date 91% of all clinical staff have completed harm minimisation training. Of these, 79% have completed face to face training and the remainder e-learning. Of the 79% who have attended face to face training 67% have attended centrally booked training and the remaining 33% team training. Quarterly progress reports are sent to the recovery programme board and weekly updates to the Chief Operating Officer and Director of Nursing and Governance.

Further implementation of the nicotine replacement programme and smoking cessation project	Work has progressed well for the Nicotine Management Project with 2,971 staff receiving training to date and a full training programme available for staff for 2018/19. The Project Lead has presented at a number of national conferences and is part of the newly formed North East "Smoke free NHS / Treating Tobacco Dependency Taskforce" to further support the smoke free agenda in the region. As part of the work for 2017/18 the team reviewed the Nicotine Management Policy which is planned to be available for internal consultation around May / June 2018. The yearly audit looking at Trustwide smoking rates has been completed and once the final data and draft report are available future actions will be identified. The initial data highlights a reduction in smoking rates in all services Trustwide with Children and Young People Service (CYPS) and adult Learning Disabilities (LD) services having 0% smokers at the time of the audit. With regards to the Project Lead's support for the North East Prisons going smoke free, all eight North East prisons have now safely gone smoke free. Work will continue within 2018/19 to develop new training packages for delivery to prison staff and the development of a "train the trainer" model which will support the sustainability of prison smoke free services for the future.

2017/18 Priorities for improvement – how did we do

As part of our 2016/17 Quality Account following consultation with our stakeholders, the Board of Directors agreed five quality priorities to be addressed via the Quality Account during 2017/18:

Priority 1: Implement phase two of our Recovery Strategy;
Priority 2: Ensure we have Safe Staffing in all our services;
Priority 3: Improve the clinical effectiveness and patient experience in times of transition from Child to Adult services;
Priority 4: Reduce the number of preventable deaths;
Priority 5: Reduce the occurrences of serious harm resulting from inpatient falls.

Progress has been made against these five priorities and the following section provides updates against each.

It is important to note that the achievement of these priorities should not be seen as the end point. These priorities are often a key milestone in a journey of quality improvement and further work will continue to embed good practice and deliver further improvements in experience and outcomes for our patients.

Priority 1: Implement phase two of our Recovery Strategy

Why this is important:

Supporting the recovery and wellbeing of individuals is the core aim of the services we provide. Patients and carers continue to make it clear that they want services to go beyond reducing the symptoms of mental health. They want support to live meaningful and fulfilling lives irrespective of whether or not they experience a reduction in symptoms.

In 2013 the Trust developed a three year Recovery and Wellbeing strategy for 2013-2016. Within this strategy it was recognised that cultivating the required change would take an iterative approach over many years.

While significant progress was made, both internal and external stakeholders had identified that further work was required to further embed a recovery and wellbeing approach within all our services. The Trust recognised that this remains a key priority and has been committed to large scale change, ensuring all systems and processes are reviewed from a recovery perspective and as described within our Recovery and Wellbeing strategy for 2017-2020.

Our stakeholders and Board therefore agreed it was important that this remained a key Quality Account priority for 2017/18.

The benefits / outcomes we aimed to deliver for our patients and their carers were:

- That the care they receive is designed to support and achieve their own personal goals.
- To receive assistance that supports them to live a fulfilling and meaningful life.
- To feel listened to, heard and understood.
- To have access to services which involve them in decision making regarding their care and be given meaningful choice wherever possible
- To receive support that enables them to feel more empowered and take charge of their lives.
- To feel more hopeful about their future or have support to identify more hopeful moments in what can be difficult times.
- To be supported to develop and maintain an identity beyond that of their symptoms or diagnosis, building on their interests and strengths.
- Their views and personal expertise by experience is valued and the services they receive are both designed and delivered alongside them.
- To receive support that identifies and acknowledges the impact of previously experienced adversity and trauma, responding to this with compassion.
- To be supported to come to an understanding of their difficulties that is meaningful to them.

What we did in 2017/18:

The following is a summary of the key actions we have completed in 2017/18:

What we said we would do	What we did
• Recovery College Online available online to people living in the TEWV area by Q1 2017/18.	Recovery College Online was launched in March 2017 and made available to staff, service users, carers and the public. It has continued to be developed throughout the year and now has 85 self-management pages available to the public worldwide with six self-management courses and a tutorial course available to: 1. Individuals living in the TEWV catchment areas; 2. Trust staff. We have linked developments with other strategic priorities, for example we have an online introduction to Trauma course. There are a further nine courses in development. We have secured funding from the Academic Health Science Network to support a pilot in which we will offer Cumbria and Northumberland, Tyne and Wear NHS Trusts access to the resource. Additionally TEWV has provided funding for the next financial year to specifically support the development of CYPS resources. This is further being supported by some additional funding from commissioners in CYPS. The online college will continue to be developed and delivered as a 'business as usual' development.
• Develop a Recovery Demonstration Site [*a team which is excellent in promoting recovery and which others can learn from*] in community adult services by Q3 2017/18.	A significant piece of work has been conducted to set up a Recovery Demonstration site in adult services. Work with two teams has identified core areas which will further support the delivery of recovery and wellbeing orientated services. Core areas identified and being developed include: • The need for leaders to create socially safe environments for staff teams including supporting teams to understand team member working style preferences and strengths. • The embedding of shared decision making within practice. • The introduction of peer workers into clinical services. • Expanding levels of participation and aspiring to co-production at individual service level. • The need to enhance relational elements of care and create a framework to support validation and listening. • Embedding of a different language with language guide in development. Additional areas identified as essential is our organisations ability to review and implement a Care Programme Approach (CPA) process that supports recovery and wellbeing. The demonstration site work will be expanded into the next financial year in parallel with progressing the roll out of training of leaders and will inform the design of a recovery accreditation scheme.

• Development of a Recovery for Leaders training programme by Q4 2017/18.	Essential areas of content for the recovery for leaders programme have been identified via the demonstration site work. Some core training materials are in development. The Trust has embedded a programme approach to manage interdependencies across several strategic programmes and priorities over the last year. This has identified the need to co-ordinate all programme requirements relating to leadership teams resulting in the timeline for agreeing and developing the final recovery for leaders programme being extended into the next financial year.
• Continue to expand Involvement Peer roles by having at least 15 new roles in place by Q4 2017/18.	We have continued to set up new Involvement Peer Roles within the Trust but were unable to meet the final quarter four target due to the need for additional resource allocation to sustain this development. The Trust has funded half of a full time staff member to support this expansion in the next financial year and this post is due to go out to be recruited to in April 2018. It is anticipated that this will support future expansion.
• Develop an infrastructure for embedding a trauma informed approach by Q4 2017/18.	A large scale project to embed Trauma Informed Care (TIC) has been set up and the year one project plan is on target to be delivered. The project has delivered a large programme of training across a range of specialities which will continue into next year. One to one and group trauma informed psycho-education materials have been developed with a plan in place to pilot these interventions. A range of resources have been developed including an online course on Recovery College Online. The development of networks and consultations / supervision networks has progressed and remains an ongoing development. A research plan is in place for a number of research projects. Work has commenced and progressed on guidelines for planning in the event of a disaster and work has commenced on identifying needs of staff in relation to working with and experiencing trauma. Funding for the next financial year is in place and year two action plans are in development.

How we know we have made a difference:

The following table shows how we have performed against the targets we set ourselves for this priority:

Indicator	Target	Actual	Timescale
• To continue to expand the number of paid lived experience / peer roles within the Trust (we currently have 6 of these).	5 new	7	Q4 2017/18
• Number of newly registered involvement peer roles (we currently have 23 of these).	15 new	16	Q4 2017/18
• Recovery College Online will expand the number of: 1. Self-management pages (from a baseline of 30) and; 2. Self-management courses available (2016/17 baseline = 1).	50 7	290 6 + 1 tutorial	Q4 2017/18 Q4 2017/18

Indicator	Target	Actual	Timescale
• Increase the number of staff receiving trauma informed care training (from 100 to 300).	300	772	Q4 2017/18

What we plan to do in 2018/19:

We will:

- Peer support - first training course recruited to and delivered by Q1 2018/19.
- First Peers recruited by Q1 2018/19.
- Commence harm minimisation training to serious incident and safeguarding teams by Q1 2018/19.
- Extend recovery to all specialties - identify and employ recovery leads and undertake baseline assessment by Q1 2018/19.
- Work with other leadership programmes in TEWV to ensure an integrated approach by Q2 2018/19.
- Deliver to a minimum of 60 additional super-cell leads (recovery for leaders training) by Q3 2018/19.
- Develop CYP materials for the Recovery College Online by Q4 2018/19.
- Develop team / service accreditation pack and gain initial approval by Q4 2018/19.
- Develop a draft recovery / TIC team / service accreditation tool by Q4 2018/19.
- Develop a research plan to improve the evidence base for TIC to allow TEWV to lead nationally / internationally by Q4 2018/19.
- Develop a culture measurement via a 3 year PhD programme of work by Q4 2018/19.

What we plan to do in 2019/20:

- Commence pilot implementation by Q1 2019/20.
- Develop and seek approval for Phase 3 of the Recovery strategy (sign off by December 2019) by Q3 2019/20.

Priority 2: Ensure we have Safe Staffing in all our services

Why this is important:

Safe Staffing is essential for the delivery of safe, high quality, evidenced-based patient care. So it's important that we don't just have enough staff on our wards and in our community teams, but also that our staff have the right skills and competencies to deliver excellent care for people with mental health needs and / or with a learning disability.

This is an issue across the country and so the National Quality Board (NQB) provided updated guidance to all NHS providers in July 2016. In 2017 there was a publication of specific guidance for Learning Disability and Mental Health services. Our stakeholders and Board of Directors agreed that it is important we follow these principles and guidance to help us make local decisions on staffing that will support the delivery of quality within our existing staffing resource and better understand how staffing capacity impacts on the quality of care.

The Carter[2] productivity and efficiency report made it clear that improved workforce efficiency can benefit patient care through better recruitment and retention of permanent staff, better rostering, reduced sickness absence, matching work patterns to patient need and reducing reliance on agency staff.

This agenda is particularly challenging because of the national shortage of qualified nurses, and increasingly other clinical professions such as psychologists, AHPs and doctors. It is therefore important that we focus on developing our future workforce so that we can continue to safely deliver new models of care and new ways of working.

The benefits / outcomes we aimed to deliver for our patients and their carers were:

- That their care is of high quality and timely because it is being delivered by a team with the right staff and right skills, at the right place and time, in line with the 2016 NQB guidance.
- To feel that the Trust is well informed of its 'pressure areas' around safe staffing and has systems in place to act upon these quickly to reduce the risk of harm to patients.
- That the Trust robustly thinks through what staff with what skills will be needed when service changes are planned.
- That the Trust will do everything it can to ensure continuity for patients – keeping staffing changes (and use of bank and agency staffing) to a minimum.
- More staff recruited externally to the Trust.
- To increase staff retention rates.
- That the Trust will develop new roles (such as Nursing Associates) to make sure that all our clinicians' skills are being used to the maximum extent to benefit patients.

[2] https://hee.nhs.uk/hee-your-area/west-midlands/about-us/our-governance/our-letcs/mental-health-institute-letc/safe-staffing-tools-mental-health-learning-disability

What we did in 2017/18:

What we said we would do	What we did
• Establish governance structures by Q1 2017/18.	The programme board is now fully functional with regular reports / updates provided to the Trust's Strategic Change Oversight Board (SCOB) and Executive Management Team (EMT) as a result of this.
• Agree the Programme Plan which will include benefits and work-streams by Q1 2017/18.	The initial programme plan, benefits and workstreams were in place by quarter one. These have subsequently been revised due to the restructure and extended scope of the programme. An updated programme plan has been established, workstreams identified and benefits reviewed.
• Further actions and metrics will be developed for 2017/18 and 2018/19 upon set-up of programme board by Q2 2017/18.	After the increase in scope of the programme, actions were reviewed and developed further; these metrics have been identified to measure the benefits of the programme.
• Implement the agreed actions for 2017/18 by Q4 2017/18.	Actions have been agreed and are in place. Revised actions due to restructure and extended scope were developed and agreed, all of which have been achieved.
• Introduce a new report for ward managers which brings together data on staffing and other quality and safety indicators [*timescale to be confirmed as dependent upon information technology issues*].	Monthly and 6-monthly reports are in place (based on safe staffing levels). There remains a technical issue due to the supplier not being able to provide what we require. Mitigations have been put in place locally to support local gathering of information until a solution can be found. Discussions with the IT supplier continue to be explored.

How we know we have made a difference:

The following table shows how we have performed against the targets we set ourselves for this priority:

Indicator	Target	Actual	Timescales
Monitoring of escalation processes.	100%	100%	Q2 2017/18
Staffing review using the national evidence based Hurst[1] tool.	100%	100%	Q3 2017/18
Review of rostering process to ensure best use of existing resources.	100%	100%	Q3 2017/18

[1] https://hee.nhs.uk/hee-your-area/west-midlands/about-us/our-governance/our-letcs/mental-health-institute-letc/safe-staffing-tools-mental-health-learning-disability

What we plan to do in 2018/19:

We will:
• Produce improved training packages on effective rostering by Q1 2018/19.
• Build Right Staffing* intranet (InTouch) website by Q1 2018/19.
• Develop an operational plan and procedure for effective rostering and data quality improvements by Q2 2018/19.
• Develop an extended plan to support staff recruitment and retention by Q2 2018/19.
• Develop a plan and framework for ongoing and regular establishment reviews annually for all wards by Q2 2018/19.
• Evidence-based staffing establishments: Delivery of proposed plan - phase two by Q3 2018/19.
• Develop strategy and plan for Training & Development and Workforce Roles by Q3 2018/19.
• Enhance and update the plan and framework for establishment reviews based on clinical pathways (linked with work on model wards) by Q4 2018/19.
• Begin implementation of Training & Development and Workforce Roles plan by Q4 2018/19.

*This priority has been renamed 'Right Staffing / Workforce'.

Priority 3: Improve the clinical effectiveness and patient experience in times of transition from Child to Adult services

Why this is important:

We define transitions for this Quality Account Priority as a purposeful and planned process of supporting young people to move from children's to adults' services. Young people with ongoing or long-term health or social care needs may be required to transition into AMH services, other service provision or back to their GP. The preparation and planning around moving on to new services can be an uncertain time for young people with health or social care needs. There is evidence of service gaps where there is a lack of appropriate services for young people to transition into, and evidence that young people may fail to engage with services without proper support (Watson 2005[3]; Singh 2009[4]).

Transition takes place at a pivotal time in the life of a young person. It is often at a time of the cultural and developmental changes that lead them into adulthood. Individuals may be experiencing several transitions simultaneously. A loss of continuity in care can be a disruptive experience, particularly during adolescence, when young people are at an enhanced risk of psychosocial problems.

The particular importance of improving the transition from children and young people's services to adult services was recognised by our Quality Account Stakeholders in 2015. We agreed to put a two year quality improvement priority in place, focussing on this specific transition. The actions below are those for the

[3]Watson AR (2005) Problems and pitfalls of transition from paediatric to adult renal care. Paediatric Nephrology 20: 113–7
[4] Singh SP (2009) Transition of care from child to Adult Mental Health services: the great divide. Current Opinion in Psychiatry 22: 386–90

second year of this priority to further embed the improvements commenced in 2016/17.

The benefits / outcomes we aimed to deliver for our patients and their carers were:

- An improvement in the experience of young people during their transition from Children and Young People's to Adult services.
- Greater involvement in decisions about the care received when they transfer into Adult services.
- To receive care informed by NICE's[5] (National Institute for Clinical Excellence) evidence-based guidelines, which will result in better clinical outcomes.

What we did in 2017/18:

What we said we would do	What we did
• Using the audit action plan, further embed the Safe Transitions and Discharge Protocol by monitoring the agreed actions and timescales by Q2 2017/18.	The Commissioning for Quality and Innovation (CQUIN) Steering Group members ensured that the audit action plan was monitored and actioned within the agreed timescales. This included: • Evidence of transitions panel meetings taking place. • Transition plans developed, agreed and shared with the young person. • The GP / referrer being informed of the discharge and provided with a copy of the plan.
• Undertake an additional audit of the protocols to include further collection of patient and carer experience feedback by Q2 2017/18.	The audit undertaken within quarter two showed successful implementation of the protocol. Patient surveys were developed in quarter two and are given to those young people who transitioned out of CAMHS during their last appointment within CAMHS. Young people are encouraged by the clinician to complete the questionnaire and return it to the service.
• Establish mechanisms to provide stakeholders and staff with regular feedback by Q2 2017/18.	The use of inTouch (the Trust's intranet site for staff), e-bulletins and attendance by the CQUIN Team at locality meetings (CAMHS and AMH) has ensured staff members have been given feedback. Other meetings where feedback to staff have been provided are: • CQUIN Steering Group; • Service Development Groups (SDGs); • Quality Assurance Groups (QUAGs). The use of Facebook and attendance at parent support group meetings and young people's meetings has ensured stakeholders have been given feedback.

[5] http://www.rcpch.ac.uk/system/files/protected/page/Transition%20from%20children%E2%80%99s%20to%20adults%E2%80%99%20services%20-%20FULL%20published_1.pdf

• Review the outcome of the audit, updating the current action plan by Q3 2017/18.	Following the audit an action plan was developed which included the following: • Panel meeting to take place 6 months (or within one month if new to service) prior to transition; • Transition plan to be developed, agreed and shared with the young person in 100% of cases; • The GP/referrer to be informed of the transition/discharge plan and the discharge plan will be shared with the GP. This has been shared with members of the CQUIN Steering Group and at locality meetings.
• Collect patients' stories in writing to gain detailed accounts of young people's experiences by Q3 2017/18.	There have been very few young people and / or parent / carers who are willing to share their experiences. To overcome this, the CQUIN team have a system in place whereby those young people who have transitioned from CAMHS to AMH and are still in service are being given the opportunity to complete a post transitions survey. The case worker is being asked if the young person would be willing to share their experiences by way of phone call with the CQUIN transitions Project Manager. The CQUIN transitions Project Manager will attend the parent / carer and young people's meetings asking for them to share their experience. The feedback we receive is then used to help us learn, adapting our services accordingly.
• Complete an evaluation report on the effectiveness of implementation of the new protocol and feedback to relevant stakeholders by Q4 2017/18.	An evaluation report has been completed. It evaluates the effectiveness of implementation of the new protocol using both quantitative review of the audit data and qualitative feedback from patient stories and staff. Feedback will be provided to stakeholders within quarter one of 2018/19.
• Continue to use patient surveys to gain feedback from young people (ongoing each quarter during 2017/18).	Since July 2017 young people who have transitioned out of CAMHS are given the opportunity to complete a transitions survey. As of 9th March 2018 a total of 35 transitions surveys and 2 post transitions surveys have been returned.

How we know we have made a difference:

The following table shows how we have performed against the targets we set ourselves for this priority:

Indicator	Target	Actual	Timescale
• Percentage of joint agency transition action plans in place for patients approaching transition.	80%	88%	Q4 2017/18
• Percentage of patients who reported feeling prepared for transitions at the point of discharge.	80%	79%	Q4 2017/18
• Percentage of patients who have transitioned to AMH from CYPS who indicate they have met their personal goals as agreed in their transition plan.	70%	100%	Q4 2017/18

What we plan to do in 2018/19:

This will continue to be an improvement priority for us. Our plans for 2018/19 are set out in **Part 2, 2018/19 Priorities for Improvement section**.

Priority 4: Reduce the number of preventable deaths

Why this is important:

Normally death is a naturally occurring event. Therefore not all deaths of people receiving mental health services from the Trust will represent a failing or problem in the way that person received care. However, sometimes healthcare teams can make mistakes or parts of the system do not work together as well as they could. This means that when things go wrong, a death may have been preventable. In December 2016 the CQC published their report, *Learning, Candour and Accountability* which made recommendations for the improvements that need to be made in the NHS, to be more open about these events.

The Trust already has systems in place to review and investigate deaths in line with national guidance in order to learn from them. We believe it is important to continue to strengthen the way we identify the need for investigations into the care provided and the way we carry these out. It is recognised that people with a mental health problem or learning disability are likely to experience a much earlier death than the general population; therefore a key focus for the Trust will be to have an increased focus on mortality review processes for this group of people.

It is important that families and carers are fully involved in reviews and investigations following a death as they offer a vital perspective on the whole pathway of care that their relative experienced.

In order to reduce preventable deaths, it is also important that learning from deaths is shared and acted on with an emphasis on engaging families and carers in this learning. During last year, through our investigation process, we identified a number of preventable deaths of inpatients which took place while they were on leave. We put actions in place for improvements in this area and it is important that we continue this work to ensure our patients do not suffer preventable harm.

The benefits / outcomes we aimed to deliver for our patients and their carers were:

- That our processes will reflect national guidance and best practice which will ensure we are delivering the best, evidence based care and treatment to our patients.
- A reduction in the number of preventable harm incidents and deaths of inpatients on leave from hospital.
- To feel listened to during investigations of death and consistently treated with kindness, openness and honesty.
- Increased confidence that investigations are being carried out in accordance with best-practice guidelines and in a way that is likely to identify missed opportunities for preventing death and improving services.

- That the Trust learns from deaths, including identifying any themes early so that actions can be taken to prevent future harm.

What we did in 2017/18:

What we said we would do	What we did
• Develop an action plan from recommendations of an external review into Serious Incidents of patients when on a period of leave by Q1 2017/18.	As a result of several Serious Incidents which were related to people who took their own lives or suffered serious harm while on a period of leave from inpatient care the EMT commissioned an independent thematic review into this matter. The scope of the review was to consider whether there were any specific themes apparent relating to these incidents and to identify any learning opportunities. The North of England Mental Health Development Unit (NEMHDU) was requested to carry out this review which was completed in February 2017 (thematic review of 15 Serious Incidents relating to patients on leave during the period February 2015-October 2016). The completed report from this review was presented at the Patient Safety Group on 19th June 2017 where the action plan was agreed and is being subsequently monitored. In January 2018 the group were provided with the quarter three update regarding the Trustwide action plan for episodes of planned leave. The group noted that one action relating to training for bank / new staff remained outstanding, however further training dates have now been provided. The group will continue to receive quarterly updates regarding progression. It is pleasing to note that within the Patient Safety Report (at quarter one and quarter two 2017/18) leave planning did not appear as a theme in the deaths that had been investigated. This was felt to be very positive.

What we said we would do	What we did
• Evaluate the current pilot process of reviewing mortality, revising it accordingly following the review by Q1 2017/18.	TEWV now has a mortality review policy and process which builds on the pilot of work completed across the region and remains under review as new advice / guidance is published. The Mazars report into the investigation of Serious Incidents by Southern Health NHS Foundation Trust was published in December 2015. The most significant piece of work for Trusts to undertake as a result of this report is to commence a process of mortality review, over and above the usual Serious Incident Review processes that are already in place. Several regional meetings were held throughout 2017/18 in conjunction with Mazars to progress the findings of the report. Key pieces of work from this group are as follows: • Drafting a North of England charter which sets out the common values and identifies the key work streams required to meet them. • Working towards common terms of reference for mortality review processes. • Drafting a 'Responding to Deaths' policy in line with NQB guidance. Whilst the regional work continues, within the Trust the Patient Safety Group monthly reviews all deaths of service users on CPA (other than those that result in a Serious Incident) and decides whether or not the circumstances fit the criteria for a mortality review. Following the draft 'regional' Policy, TEWVs version was ratified on the 27th September 2017, with appendix 1 outlining the mortality review process within TEWV. For those cases which require a mortality review a member of the Patient Safety group currently carries out a structured judgement case review using the methodology guidance developed by the Royal College of Physicians and the findings are taken back to the next Patient Safety Group for discussion. A discussion will then be had regarding availability of death / learning and good practice. Whilst the pilot has proved successful this process is under continual review as new advice/guidance is published.
• Establish quarterly reporting mechanisms for mortality review processes by Q1 2017/18.	NHSE produced a mortality dashboard as a tool to aid the systematic recording of deaths and learning from the care provided by all NHS Trusts and there is a requirement that Trusts publish this data on a quarterly basis. The TEWV dashboard continues to evolve based on learning from other Trusts across the region as well as nationally with the principle aim of enhancing future learning and the continuous improvement of patient care. We have developed this approach and reported formally to the Board of Directors mortality information for quarters one, two, three and four of 2017/18.

What we said we would do	What we did
• Ensure systems are in place to regularly train all new inpatient staff and monitor compliance in relation to leave and time away from the ward Q2 2017/18.	All new inpatient staff have received training in relation to leave and time away from the ward and will continue to do so via the Mental Health Act (MHA) team. As of April 2018 this has become part of the new mandatory MHA e-learning package. Whilst there are systems in place to monitor the training being delivered the information is not as yet available on the Trust IIC (Integrated Information Centre) which would enable us to more easily identify who has accessed the training. There is a work programme to make this happen.
• Complete spot compliance audits quarterly to ensure staff are adhering to the leave policy by involving family in leave arrangements and conducting risk assessment and formulation prior to periods of leave by Q4 2017/18.	Audits have been completed regarding Section 17 (S17) leave by the audit team alongside the MHA team. Audits are currently underway by the audit team regarding those with time away from the ward i.e. patients who are not detained under the MHA and therefore not subject to S17 leave.
• Complete a review of the root or contributory causes of Serious Incidents each quarter and agree focused areas for targeted implementation by Q4 2017/18.	Each quarter the QuAC receives a quarterly assurance report which identifies the key themes from root and contributory causes and identifies the key pieces of work to address them. The report also provides a Trustwide overview of the incidental findings and each locality also receives a locality specific version of this information.
• Undertake a review of the national guidance in relation to mortality each quarter by Q4 2017/18.	As a result of the Learning from Deaths requirements following the Southern Health report there is ongoing review of any national guidance in relation to mortality – any updates are discussed at the Patient Safety Group and incorporated into the TEWV processes as required. This includes for example NHS Improvement provider weekly bulletins which identify any new guidance and learning / case studies from other Trusts.
• Participate quarterly in the regional provider forum focused on learning from preventable deaths by Q4 2017/18.	Several regional meetings have been held throughout the year in conjunction with Mazars to progress the findings of their report (as mentioned above). Key pieces of work from this group are as follows: • Drafting a North of England charter which sets out the common values and identifies the key workstreams required to meet them. • Working towards common terms of reference for mortality review processes. • Drafting a 'Responding to Deaths' policy in line with NQB guidance.
• Report quarterly to the QuAC on progress of the reviewed mortality review processes to enhance learning by Q4 2017/18.	The Trust QuAC now receives a quarterly assurance report from the Trust monthly Patient Safety Group. The report identifies the key areas for learning within the Trust which corresponded with the themes identified from audit.

How will we know we are making a difference?

The following table shows how we have performed against the targets we set ourselves for this priority:

Indicator	Target	Actual	Timescale
• To increase the proportion of deaths that are reviewed as part of the mortality review processes (this is in addition to the existing serious incident process).	90 cases	90*	Q4 2017/18
• To eliminate preventable deaths of inpatients during periods of leave.	0 deaths	1**	Q4 2017/18

*As this is a new process 90 is the baseline figure of case record reviews, deaths reviewed as part of the mortality process by 28/02/2018.
**Whilst there has been one preventable death of inpatients during periods of leave this is in comparison to 12 that occurred in 2015/16.

What we plan to do in 2018/19:

This will continue to be an improvement priority for us. Our plans for 2018/19 are set out in **Part 2, 2018/19 Priorities for Improvement section**.

Priority 5: Reduce the occurrences of serious harm resulting from inpatient falls

Why this is important:

Falls affect a patient's quality of life including suffering distress, pain, injury, loss of confidence; loss of independence and in some circumstances can lead to death. Falling also affects the family members and carers of people who fall.

Despite work being undertaken in the Trust to implement best practice and NICE guidance, the number of falls within our premises and grounds have risen (but severity of harm has reduced). It is important therefore that the Trust is doing everything possible to ensure that falls are being appropriately managed with the aim of reducing the number and severity of harm from falls.

The benefits / outcomes we aimed to deliver for our patients and their carers were:

- A reduction in moderate and severe harm as a result of falls.
- More falls are prevented during hospital stays.
- To feel more informed about the risks and benefits around falls interventions.
- Their values and preferences informing care.
- That care is managed in line with NICE guideline 161 *'Falls: assessment and prevention of falls in older people*' (2013)[6] and in line with actions from the National Patient Safety Agency '*how to guide for reducing harm from falls in mental health inpatient settings*' (2012)[7].

[6] https://www.nice.org.uk/guidance/cg161.
[7] https://www.rcplondon.ac.uk/file/927/.

- Care delivered by staff with the appropriate skills and competencies to prevent and manage falls.
- Appropriate assessment and treatment is given to people who have fallen.

What we did in 2017/18:

What we said we would do	What we did
• Undertake a baseline assessment of preventable falls by severity, completed by Q1 2017/18.	Each locality undertook a review of their own data which determined that the majority of falls occur within MHSOP. This data formed a baseline assessment of the number of preventable falls. The improved revised Trustwide Falls report is produced quarterly, the data and information is shared with each locality who then analyse their own data adding narrative quarterly. The Falls report now identifies: • category of falls; • severity of falls; • time of day of fall; • identifies multiple fallers and across multiple locations.
• Complete a thematic analysis by Specialty completed including direct observations of practice by Q1 2017/18.	Falls data analysis completed, this information was shared and accepted by Durham, Darlington and Tees Clinical Quality Reference Group (CQRG).
• Develop an action plan developed in line with outcome of thematic analysis by Q2 2017/18.	There was a 'Kaizen' event held to review the falls CLiP within quarter two 2017/18. As a result of this there was an action to progress with a frailty CLiP which incorporates falls as a frailty syndrome. This is in line with the outcome of the thematic review.
• 'Plan, Do, Study, Act' (PDSA) cycles agreed to address key issues identified via observations by Q2 2017/18.	There are five wards piloting frailty syndrome CLiP with full roll out planned following the outcome of the pilot. This will determine the next plans. As part of the pilot process, PDSA cycles have been agreed to address any key issues identified.
• Complete a Trustwide implementation of new processes based on PDSA cycles by Q3 2017/18.	A focused implementation will form part of the roll out of the all age frailty CLiP. Other specialities CLiPs are awaiting the outcome of the pilot of the frailty CLiP.
• Undertake a baseline assessment of falls by severity and theme reassessed by Q4 2017/18.	There is ongoing work as part of the Falls Executive Group and ownership and scrutiny of information by service which is included in the Trustwide quarterly falls report and compared to the baseline assessment identified at the beginning of 17/18.

How will we know we are making a difference?

The following table shows how we have performed against the targets we set ourselves for this priority:

Indicator	Target	Actual	Timescale
• A reduction in the number of people who suffer serious harm as a result of a fall.	Less than 9	3	Q4 2017/18

What we plan to do in 2018/19:

We will:
• The Falls Executive Group will continue to meet quarterly, with Trustwide / service user representation. • The work plan for 2018/19 has been developed and is in the process of being finalised. It will include Trust localities analysing their own data and action planning where appropriate. • Development of a root cause analysis report for fractured neck of femur with appropriate oversight within Nursing & Governance.

Statement of Assurances from the Board 2017/18

The Department of Health and NHS Improvement require us to include our position against a number of mandated statements to provide assurance from the Board of Directors on progress made on key areas of quality in 2017/18. These statements are contained within the blue boxes. In some cases additional information is supplied and where this is the case this is provided outside of the boxes.

Review of services

During **2017/18** TEWV provided and/or sub-contracted **20** relevant health services.

TEWV has reviewed all the data available to them on the quality of care in **20** of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents **100%** per cent of the total income generated from the provision of the relevant health services by TEWV for 2017/18.

In line with our Clinical Assurance Framework the review of data and information relating to our services is undertaken monthly by the relevant Quality Assurance Group (QuAG) for each service. A monthly report is produced for each QuAG which includes information on:

- **Patient safety** – including information on incidents, serious untoward incidents, levels of violence and aggression, infection prevention and control and health and safety.
- **Clinical effectiveness** – including information on the implementation of NICE guidance and the results of clinical audits.
- **Patient experience** – including information on patient satisfaction; carer satisfaction; the Friends and Family Test (FFT); complaints; and contacts with the Trust's patient advice and liaison service.
- **Care Quality Commission (CQC)** – compliance with the essential standards of safety and quality, and the Mental Health Act.

Following discussion at the QuAG any areas of concern are escalated to the relevant Locality Management and Governance Board (LMGB) and from there to the QuAC the sub-committee of the Board which has responsibility for Quality Assurance. The QuAC receives formal reports from each of the LMGBs on a bi-monthly basis.

We also undertake an internal peer review inspection programme, the content of which is based on the Fundamental Standards of Quality and Safety published by the CQC. These inspections cover all services and a typical inspection team will include members of our Compliance Team, patient and carer representatives from our Fundamental Standards Group and peers from other services. In advance of the visit the inspection team review a range of information on the quality of the service being inspected, for example: incident data, Patient Advice and Liaison Service (PALS) / complaints data, CQC compliance reports and Mental Health Act visit reports as well

as any whistleblowing information. At the end of each internal inspection verbal feedback is given to the ward or team manager and any issues are escalated to the Head of Service, Head of Nursing and Director of Quality Governance. An action plan is produced and implementation is assured via the QuAGs, LMGBs and QuAC, as described above, and in line with the Trusts Clinical Assurance Framework.

In addition each month members of the Executive Management Team and the Non-Executive Directors undertake visits to our wards and teams across the Trust. They listen to what patients, carers and staff think and feel about the services we provide.

The Trust also continues to develop its IIC which is a data warehouse that integrates information from a wide range of source systems e.g. patient information, finance, workforce and incidents. The information within the IIC is updated regularly from the source systems and allows clinical staff and managers to access the information on their service at any time and 'drill' down to the lowest level of the data available. The IIC also sends prompts to staff which ensure that they can be proactive about making sure their work is scheduled in a timely manner thus improving patient experience and patient safety.

Finally, in addition to the internal review of data / information we undertake as outlined above, we also regularly provide our commissioners with information on the quality of our services. We hold regular Clinical Quality Review meetings with commissioners where they review all the information on quality that we provide, with a particular emphasis on trends and the narrative behind the data. At these meetings we also provide information on any thematic analysis or quality improvement activities we have undertaken and on our responses to national reports that have been published.

Participation in clinical audits and national confidential inquiries

During 2017/18, **5** national clinical audits and **2** national confidential inquiries covered the health services that TEWV provides.

During 2017/18, TEWV participated in **80%** (4/5) of national clinical audits and **100%** (2/2) of national confidential inquiries which it was eligible to participate in.

The national clinical audits and national confidential inquiries that TEWV was **eligible to participate in** during 2017/18 were as follows:

- POMH Topic 17a: Use of depot/long-acting antipsychotic injections for relapse prevention (ongoing);
- POMH Topic 15b: Prescribing Valproate for Bipolar Disorder (ongoing);
- POMH Topic 16b: Rapid Tranquilisation;
- EIP National Self-Assessment Audit 2017/18 (ongoing);
- National Clinical Audit of Psychosis (NCAP) (ongoing);
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH);
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

The national clinical audits and national confidential inquiries that TEWV **participated in** during 2017/18 are as follows:

- POMH Topic 17a: Use of depot/long-acting antipsychotic injections for relapse prevention (ongoing);
- POMH Topic 15b: Prescribing Valproate for Bipolar Disorder (ongoing);
- EIP National Self-Assessment Audit 2017/18 (ongoing);
- National Clinical Audit of Psychosis (NCAP) (ongoing);
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH);
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

The national clinical audits and national confidential inquiries that TEWV participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of the national audit or inquiry.

Audit Title	Cases Submitted	% of the number of registered cases required
POMH Topic 17a: Use of depot/long-acting antipsychotic injections for relapse prevention	241	Not applicable
POMH Topic 15b: Prescribing Valproate for Bipolar Disorder	191	Not applicable
EIP National Self-Assessment Audit 2017/18	889	Not applicable
National Clinical Audit of Psychosis (NCAP)	272	91%
National Confidential Inquiry into Suicide & Homicide by People with Mental Illness.	57	81%
National Confidential Enquiry into Patient Outcome and Death	n/k*	Unknown

*Cases are submitted confidentially and directly by individual consultants, and therefore, the number of cases submitted is unknown.

Due to the timings of the national audits, the provider had not reviewed the reports for any of the national audits or confidential inquiries at the time of the publication of this report. Upon receipt of final reports the Trust will formally receive these reports and agree actions to improve the quality of healthcare provided.

The reports of **163** local clinical audits were reviewed by the provider in 2017/18 and TEWV intends to take actions to improve the quality of healthcare provided.

Appendix 4 includes the actions we are planning to take against the **8** key themes from these local clinical audits reviewed in 2017/18.

*To be confirmed within final version.

In addition to those local clinical audits reviewed (i.e. those that were reviewed by our Quality Assurance Committee and Clinical Effectiveness Group), the Trust undertook a further **12** clinical audits in 2017/18 which include clinical effectiveness projects undertaken by Junior Doctors, Consultants or other Directorate / Specialty Groups. These clinical audits were led by the services and individual members of staff for reasons of service improvement and professional development.

Participation in clinical research

The number of patients receiving relevant health services provided or subcontracted by TEWV in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was **1341**.

Of the **1341, 1299** were recruited to **32** National Institute for Health Research (NIHR) portfolio studies. This compares with **952** patients involved as participants in NIHR research studies during 2016/17.

Recruitment into research has increased this year due to a number of higher recruiting studies including the Health and Wellbeing Survey (Mental health) study which has recruited 212 participants and the CYGNUS (Dementia) study which recruited 101 participants. The Trust contributes to the overall Clinical Research Network: North East and North Cumbria targets for recruitment and the Mental Health, Dementia and Neurodegenerative Diseases Research Network (DeNDRoN) and Health Service Delivery specialties that we contribute to have all exceeded recruitment targets for this year.

We continue to be involved with large scale national research across a variety of clinical disciplines such as psychosis, forensic mental health, dementia, learning disabilities, personality disorder and CYPS. Our ongoing participation in clinical research through 2017/18 reflects our firm commitment to improving the quality of care we provide, as well as contributing to the broader goals of mental health, learning disability and dementia research. The Trust has also supported national research into the implications of later retirement ages in the NHS.

Examples of how we have continued our participation in clinical research include:

- We were involved in conducting **96** clinical research studies during 2017/18. **53** of these studies were supported by the NIHR through its networks and **16** new portfolio studies approved through the Health Research Authority approval process.
- **29** members of our clinical staff participated as researchers in studies approved by a research ethics committee, with **11** of these in the role of principal investigator for NIHR supported studies.
- **50** members of our staff were also recruited as participants to NIHR portfolio studies.
- **40** researchers from outside the organisation were granted access under the National Research Passport Scheme to perform research with us compared to **28** from 2016/17. This reduced number was due to issuing 37 letters of access for research teams to access research participants in the York and Selby region last year.
- We have developed a new 5 year Research & Development Strategy with a strong focus on Patient and Public Involvement (PPI) engagement and academic collaborations which provides us with the aim of becoming a lead research site with further opportunities for research involvement for our patients. We continue

to be co-applicants on large scale grant applications in collaboration with our university partners.

- We have setup a clinical trials pharmacy department which will provide the infrastructure to enable us to participate in future CTIMP studies.
- We have research champions embedded across all of our memory services which provides a link to ensure equality of access to research opportunities across the Trust. Our research champions promote the national Join Dementia Research (JDR) system and we have been a pilot site for a 'JDR' on prescription scheme in collaboration with the Alzheimer's Society.

Goals agreed with commissioners

Use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework

A proportion of TEWV's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between TEWV and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at http://www.tewv.nhs.uk/site/content/About/How-well-are-we-doing.

As part of the development and agreement of the 2017/19 mental health contract, we were provided with a list of nationally mandated CQUINs and then were given an option to add one further local CQUIN which the Trust opted to do in agreement with the commissioners. This included indicators around physical healthcare, staff health and wellbeing and discharge and resettlement within specialist services. These are monitored at meetings every quarter with our commissioners.

An overall total of £4,896,823 was available for CQUIN to TEWV in 2017/18 conditional upon achieving quality improvement and innovation goals across all of its CQUINs. A total of £4,532,823 (92.56%) is estimated to be received for the associated payment in 2017/18; however this will not be confirmed until May (the estimate for 2017/18 has still to go through all the required governance processes for full approval). This represents 1.5% of the Trust income rather than 2.5% as in previous years. For the first year 0.5% was allocated for engagement in STPs and a further 0.5% towards achieving our control total. Including this 1% a total of £7,328,422 was available and £6,963,647 (95.02%) is estimated to be achieved. This compares to:

- £6,418,793 in 2016/17 (92.2%);
- £6,452,069 in 2015/16 (99.2% from the TEWV CQUIN prior to the Vale of York contract and 100% from the Vale of York CQUIN);
- £5,765,066 (98.0%) in 2014/15;
- £5,777,218 (99.3%) in 2013/14.

Some examples of CQUIN indicators which the Trust made progress with in 2017/18 were:

- Improving the uptake of flu vaccinations for frontline clinical staff. This was a CQUIN in 2016/17 as well as going forward into the 2017/19 scheme. Before this became a CQUIN, the 2015/16 Trust uptake of the flu jab was 39%. Over the last two years the Trust has committed to a flu vaccination scheme, introducing staff incentives. In 2016/17 we achieved a 16% increase of staff taking up the offer of a flu jab in 2017/18 achieved a further 11% increase. This gives us an overall increase of 27% over the two years which is a real achievement and helps to keeping our staff and patients safe from flu. We aim to further increase this uptake in 2018/19.
- Virtual Recovery College. This was our local scheme agreed with the commissioners and one that we felt very important. The Trust has a physical recovery college based in Durham; however acknowledged that due to the geography of the Trust this was not accessible to a lot of our patients and therefore the decision was made to set up a virtual recovery college (known as recovery college online). Since its launch at the start of the year the site now hosts over 80 pages, which are accessible to all internet users and 7 courses, which are accessible to people within the Trust's geographical area and there are over 1000 people viewing the site every month.
- Discharge and Resettlement within specialist services. This CQUIN spans all specialist services and looks to reduce delayed discharges by ensuring that discharge planning is started right from the point of the patients admission by setting an expected discharge date. This CQUIN involved setting up a whole new system within each service and devising a two year strategy on how the services were going to look to reduce delayed discharges. During its first year services have successfully embedded all of the processes required to ensure the success of the CQUIN. All patients have had an expected discharge date set within the required 12 weeks of admission and there have been some cases of patients being discharged before their expected discharge date which is fantastic progress for the first year of the CQUIN.
- Patient Experience within Street Triage. This is the first year that we have had a CQUIN from the Health and Justice contract and it has definitely been a success. The Street Triage team already had a patient experience measure in place as part of the Trust monitoring; however work has been undertaken to assess how best to offer the patient experience surveys, as it is acknowledged that due to the nature of the work it is not the best time when the patient is being seen. The team has seen satisfaction scores increase from 82% at the start of the year to 100% by the end of the year. The team have also, as an additional measure, developed an experience survey for the police who are involved in the cases they worked with and have received very positive feedback via this.

What others say about the provider

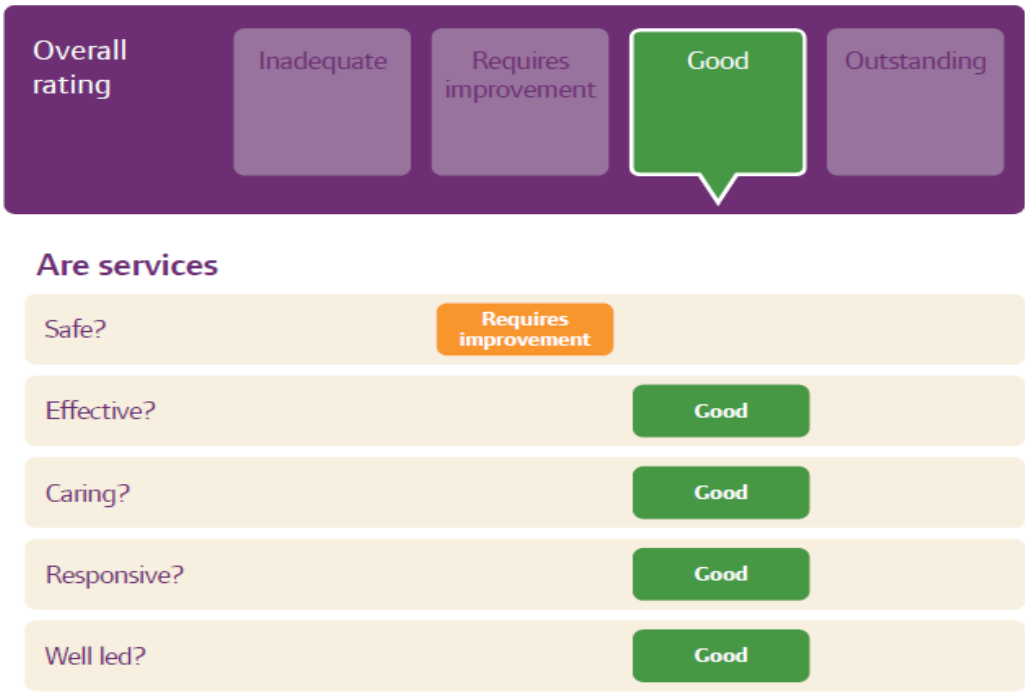
Registration with the Care Quality Commission (CQC) and periodic / special reviews

TEWV is required to register with the Care Quality Commission (CQC) and its current registration status is **registered to provide services with no conditions attached**. The CQC **has not** taken enforcement action against TEWV during 2017/18.

TEWV **has not** participated in any special reviews or investigations by the CQC during the reporting period.

The Trust has not received any CQC compliance inspections during 2017/18 and the overall Trust rating remains **Good**.

The Trust CQC ratings for each domain are currently as follows:



In July 2017, Her Majesty's Inspectorate of Prisons conducted an unannounced inspection of Holme House Prison, a category B local prison near Stockton-On-Tees. Following inspection the CQC issued the Trust with a Requirement Notice regarding Regulation 9: Person Centred Care. This states that 'The care and treatment of service users must be appropriate, meet their needs and reflect their preferences'. In response, the Trust reviewed processes and put in place required improvement actions to ensure that appropriate care was consistently provided to meet the needs of patients and reflect their preferences.

The Trust also has two premises that are registered with Ofsted. The two Units are classified by Ofsted as children's home premises. The Units provide care and

accommodation for children and young people who have a learning and/or physical disability for short breaks. Following registration with Ofsted in August 2017, both units received their first inspections with one unit being rated as 'Good' and the other as 'Requires Improvement'. All improvement requirements have been met and formal responses submitted to Ofsted to ensure compliance with statutory guidance and the requirements of the Care Standards Act 2000.

Mental Health Act Inspections

34 Mental Health Act inspections were undertaken by the Care Quality Commission during 2017/18:

Ward	Service Type	Location
Acomb Garth	Wards for older people with mental health problems	York
Bankfields Court	Wards for people with learning disabilities or autism	Middlesbrough
Bedale Ward	Acute wards for adults of working age and psychiatric intensive care units	Teesside
Birch Ward	Acute wards for adults of working age and psychiatric intensive care units	Darlington
Brambling Ward	Forensic inpatient (low/medium)	Middlesbrough
Bransdale Unit	Acute wards for adults of working age and psychiatric intensive care units	Middlesbrough
Cedar (PICU)	Acute wards for adults of working age and psychiatric intensive care units	Darlington
Cherry Trees	Wards for older people with mental health problems	York
Danby Ward	Acute wards for adults of working age and psychiatric intensive care units	Scarborough
Ebor Ward	Acute wards for adults of working age and psychiatric intensive care units	York
Eagle/Osprey	Forensic inpatient (low/medium)	Middlesbrough
Elm Ward	Acute wards for adults of working age and psychiatric intensive care units	Darlington
Farnham Ward	Acute wards for adults of working age and psychiatric intensive care units	Durham
Hamsterley Ward	Wards for older people with mental health problems	Bishop Auckland
Harland Ward	Ward for people with learning disability or autism	Durham
Ivy/Clover Ward	Forensic inpatient (low/medium)	Middlesbrough
Jay Ward	Forensic inpatient (low/medium)	Middlesbrough
Kirkdale Ward	Long stay/rehabilitation mental health wards for working age adults	Middlesbrough
Langley Ward	Forensic Learning Disability Low Secure	Durham
Lark Ward	Forensic inpatient (low/medium)	Middlesbrough
Lincoln Ward	Acute wards for adults of working age and psychiatric intensive care units	Hartlepool
Mandarin Ward	Forensic inpatient (low/medium)	Middlesbrough
Maple ward	Acute wards for adults of working age and psychiatric intensive care units	Darlington
Merlin Ward	Forensic inpatient (low/medium)	Middlesbrough
Newtondale	Forensic inpatient (low/medium)	Middlesbrough
Northdale Centre	Forensic inpatient (low/medium)	Middlesbrough
Oak Ward	Wards for older people with mental health problems	Darlington
Ramsey Ward	Wards for people with learning disabilities or autism	Durham
Rowan Lea Ward	Wards for older people with mental health problems	Scarborough
Sandpiper Ward	Forensic inpatient (low/medium)	Middlesbrough
Westerdale North	Wards for older people with mental health problems	Middlesbrough
Westerdale South	Wards for older people with mental health problems	Middlesbrough

Ward	Service Type	Location
Westwood Centre	Child and adolescent mental health wards	Middlesbrough
Willow Ward	Long stay/rehabilitation mental health wards for working age adults	Darlington

Quality of data

TEWV submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS number was **99.79%** for admitted patient care.
- Which included the patient's valid General Medical Practice Code was **98.40%** for admitted patient care.

TEWV Information Governance Assessment Report overall score for 2017/18 was **88%** and was granted as **satisfactory***.

*The colour green represents the Information Governance Toolkit rating of satisfactory.

The Information Governance (IG) Toolkit measures performance in the following areas:

- Information Governance Management;
- Confidentiality & Data Protection;
- Information Security Assurance;
- Clinical Information Security Assurance;
- Secondary Use Assurance;
- Corporate Information Assurance.

A satisfactory score in the toolkit is important to patients as it demonstrates that the Trust has safe and secure processes in place to protect the sensitive personal information that we process. It demonstrates that our staff have completed training in areas such as confidentiality and information security. It also shows the Trust carries out its legal duties under the Data Protection Act 1998 and Freedom of Information Act 2000.

88% (satisfactory*) means that we have achieved at least level 2 on all of the 45 requirements of the toolkit, however, in a significant number of elements we attained level 3 (the highest score). Sixteen toolkit requirements scored level 2, 29 toolkit requirements scored level 3.

*The colour green represents the Information Governance Toolkit rating of satisfactory.

The IG toolkit changed in April 2018 and is now known as the Data Security and Protection Toolkit. The 45 requirements of the former IG toolkit have been replaced by 'assertions' that relate to the 10 National Data Guardian standards.

TEWV was **not** subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

NHS England and NHS Improvement issued guidance in December 2016 for the contracting period 2017-2019. This continued the need for Mental Health Service providers to report:

- **Clinically Reported Outcome Measure (CROM):** this is the Health of the Nation Outcome Score (HoNOS) and reported via the Mental Health Services Data Set (MHSDS). Commissioners receive quarterly reports describing complexity of current caseload and clinical outcomes for discharged patients using an established model of clinical significance. The IIC will routinely report this information during 2018/19.
- **Patient Reported Outcome Measure (PROM):** the Trust has implemented the use of the patient reported wellbeing measure, the short version of the Warwick-Edinburgh Mental Well-being Scale (SWEMWBS). Commissioners receive quarterly reports describing complexity of current caseload and clinical outcomes for discharged patients using an established model of clinical significance. The IIC will routinely report this information during 2018/19. EIP services have replaced SWEMWBS with The Process of Recovery Questionnaire (QPR) for all new patients from 1st March 2018. Discussions with commissioners will agree how QPR reporting will be integrated in existing commissioner reports.
  A training program is ongoing with regards to cluster accuracy and factors affecting the ability to report outcomes effectively and accurately. Performance relating to clinical outcomes is monitored and managed throughout TEWV.
- **CAMHS services:** Child Outcome Rating Scale (CORS)/Outcome Rating Scale (ORS) were introduced into the CAMHS services from February 2018 and will be used to report clinical outcomes. Ongoing discussions with commissioners will agree the integration into existing reports.
  Performance reports are being managed via a CAMHS currency development steering group and training and support to staff is ongoing.

At the end of March 2018:

96% of service users on the Adult Mental Health (AMH) and **98%** of services users on the Mental Health Services for Older People (MHSOP) caseloads were assessed using the mental health clustering tool.
90% of service users on the Adult Mental Health (AMH) and **91%** of services users Mental Health Services for Older People (MHSOP) caseloads were reviewed within the guideline timeframes.

Further work for 2018/19 includes:

- Consideration of clinical outcome metrics for Learning Disability services.

TEWV will be taking the following actions to improve data quality:

- We are currently in the process of producing a revised Data Quality (DQ) Strategy and scorecard, with a plan for this to have a much broader focus than the previous version and be inclusive of all Trust data, rather than just patient focused data. The draft strategy has been written and engagement / consultation was conducted with a variety of groups within the Trust, including LMGB's, Operational Management Team (OMT) and service users. The draft strategy was submitted and approved at the Managing the Business April 2018 meeting - this group is chaired by the Director of Finance and Information and meets monthly. Other Directors also attend the meetings from Planning, Performance and Communication, Nursing and Governance and Human Resources. It is expected that the Data Quality Strategy will be approved by EMT in quarter one 2018/19.
- The Trust has a new DQ working group which is a sub group of the Managing the Business Group. It is chaired by the Head of Supporting Users and has representation from Planning, Performance and Communications, Quality Data, Human Resources and Information attend. The DQ working group will focus on issues with data quality identified either by corporate or clinical services and attempt to provide resolutions. For example, this may be to help with training on how to enter information correctly in Paris or it may be working with services to provide clarity on recording of activity.
- Data Quality Improvement Plans (DQIPs) have been agreed with commissioners for 2017/18. Over 40 DQIPs have either been delivered or are on track for being delivered this financial year. Additional DQIPs are in the final process of being agreed for 2018/19.
- New reports continue to be developed within the IIC to allow services to easily identify data quality concerns and target improvement work. A data quality IIC dashboard has been developed and evidences data quality completeness of key data items within the clinical record. A development plan for the IIC for 2018/19 was finalised in April 2018.

Learning from deaths

During 2017/18 2,322 of TEWV patients died[1]. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 541 in the first quarter;
- 524 in the second quarter;
- 574 in the third quarter;
- 683 in the fourth quarter.

By 31st March 2018, 106 case record reviews and 126 investigations have been

carried out in relation to 2,322 of the deaths included in the figures above.

In 2 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 65 in the first quarter;
- 47 in the second quarter;
- 67 in the third quarter;
- 53 in the fourth quarter.

11 representing 0.47% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 1 representing 0.18% for the first quarter;
- 3 representing 0.57% for the second quarter;
- 4 representing 0.69% for the third quarter;
- 3 representing 0.43% for the fourth quarter.

These numbers have been estimated using the findings from Serious Incident investigations[2]. Where there has been a root cause found from the incident review then this has been used as a way to determine if the patient death may have been attributable to problems with care provided[3].

A summary of what TEWV has learnt from case record reviews and investigations conducted in relation to the deaths identified above:

Root or contributory findings from serious incident reviews undertaken in 2017/18 have highlighted the following areas for learning and improvement:

- Risk assessment;
- Physical health deterioration/recognition of symptoms;
- Adherence to procedure/policy/pathway;
- Family Involvement;
- Access to services/referral processes;
- Communication and information sharing;
- Medicines Management;
- Record keeping.

A description of the actions which TEWV has taken in 2017/18, and proposes to take following 2017/18, in consequence of what TEWV has learnt during 2017/18:

Our Harm Minimisation policy and training for staff is a recovery-orientated approach to clinical risk assessment and management. Experts by experience were employed as part of the Harm Minimisation Project team to co-produce and co-deliver face to face harm Minimisation training and a mandatory e-learning harm minimisation training package is also available.

The Trust Care Programme Approach (CPA) project lead is currently undertaking work in relation to care/intervention planning. Both the CPA and Harm Minimisation Projects support the principles of family involvement and shared decision making which are also core principles of the Trust Recovery Strategy.

The Trust has a Physical Health project team in place to assist with the education and training of staff in physical health related matters. The team developed a set of Physical Health Standards and then visited all inpatient services to offer support to clinical staff to implement the standards and improve the physical health of their patients.

These key pieces of work will continue through 2018/19 in addition to on-going service improvements across the organisation. Improved family involvement will be a particular focus and we intend to launch family friendly versions of some of our patient safety policies.

An assessment of the impact of the actions described above which were taken by the TEWV during 2017/18:

A widespread audit has been undertaken in relation to the quality of our risk assessment and care plan documents. The purpose of the audit is to provide a baseline assessment for future work which will also support improvements to our community and in-patient services and help with the delivery of the Recovery Strategy. One of the themes identified by the Trust in 2016/17 was inadequate leave planning. A key piece of work was undertaken across the Trust to remind clinical staff of their responsibilities in relation to this which included training for all registered nurses and a policy refresh. This does not appear as a theme in the Serious Incidents from 2017/18 which would suggest a positive impact from the remedial actions taken.

16 case record reviews and 25 investigations completed after 31st March 2017 which related to deaths which took place before the start of the reporting period.

1 representing 0.04% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the findings from Serious Incident investigations. Where there has been a root cause found from the incident review then this has been used as a way to determine if the patient death may have been attributable to problems with care provided[3]..

10 representing 0.43% of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Notes to accompany above table

1. In mental health and learning disability services the majority of our patients live in the community and many have infrequent contact with our teams. This can lead to a delay in us being notified of a death occurring in some cases. All deaths which are reported through our incident management system (1,622 in 2017/18) are

subject to an initial review by a senior clinician in the patient safety team. We also have undertaken some analysis of the average age of the service users who have died and it was found to be 85 years.

2. The Serious Incident Framework (2015) forms the basis of the Trust policy which guides our staff about the reporting, investigating and learning from incidents, including deaths. The Learning from Deaths policy, which was approved by our Board of Directors in September 2017, further enhances the processes of investigation and learning.

3. There is no agreed or validated tool to determine whether problems in the care of the patient contributed to a death within mental health or learning disability services. We have decided to use the approach of considering a root cause being found in an incident review until a nationally agreed tool becomes available. This means that currently mental health and learning disability organisations are using differing ways of assessing this.

Mandatory quality indicators

The following are the mandatory quality indicators relevant to mental health Trusts, issued jointly by the Department of Health and NHS Improvement and effective from February 2013.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127382/130129-QAs-Letter-Gateway-18690.pdf.pdf

For each quality indicator we have presented a mandatory statement and the data on NHS Digital for the most recent and the previous reporting period available.

Care Programme Approach 7 day follow-up

The data made available by NHS Digital with regard to the percentage of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period. As per Single Oversight Framework guidance, this reports all patients discharged that were followed up within 7 days.

TEWV actual quarter four 2017/18	****National benchmarks in quarter three 2017/18***	***TEWV actual quarter three 2017/18***	***TEWV actual quarter two 2017/18***	***TEWV actual quarter one 2017/18***
Trust final reported figure: **96.52%**	NHSIC reported: Highest/best MH Trust = **100%**	Trust final reported figure: **97.13%**	Trust final reported figure: **95.80%**	Trust final reported figure: **96.46%**
Figure reported to NHSI: N/A**	National average MH Trust = **95.9%**			
NHS Digital reported: **Not available**	Lowest/worst MH Trust = **69.2%**	NHS Digital reported figure: **97.2%**	NHS Digital reported figure: **95.2%**	NHS Digital reported figure: **96.4%**

*Latest benchmark data available on NHS Digital at quarter three 2017/18.
**We are no longer required to report performance to NHSI following the change in the Regulatory Framework in October 2016.

TEWV considers that this data is as described for the following reasons:

- The discrepancy between the NHS Digital and the Trust is due to the fact the NHS Digital data is submitted at a CCG level, and therefore, excludes data where the CCG is unspecified in the patient record. The Trust figure includes all discharges.
- The **key reasons** why **95** people during 2017/18 to date were not followed up within 7 days were:
  - difficulties in engaging with the patient despite efforts of the service to contact the patient (58 patients); and
  - breakdown in processes within the service (30 patients).

TEWV **has taken** the following actions to improve this percentage, and so the quality of its services:

- Investigating all cases that were not followed up and identifying lessons to be

learned at service level.

- Undertaking an improvement programme led by the Chief Operating Officer to improve proactive performance management and eliminate waste in both clinical and corporate services.
- Continuing to utilise the report out process and Trust performance management system to pro-actively monitor performance and ensure compliance. Supporting the adherence to standard process to ensure patients discharged to other services (e.g. 24 hour care unit) are not overlooked, including the introduction of visual control boards.
- Continuously raising awareness and reminding staff at ward / team meetings of this national requirement and why it is important to patient safety, the need to follow the standard procedure and the need to record data accurately considering appropriate exclusions.

Crisis Resolution Home Treatment Team acted as a gatekeeper

The data made available by NHS Digital with regard to the percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.

TEWV actual quarter four 2017/18	****National benchmarks in quarter three 2017/18***	***TEWV actual quarter three 2017/18***	***TEWV actual quarter two 2017/18***	***TEWV actual quarter one 2017/18***
Trust final reported figure: **97.53%**	NHSIC Reported: National average MH Trust = **98.3%**	Trust final reported figure: **96.57%**	Trust final reported figure: **97.55%**	Trust final reported figure: **97.58%**
Figure reported to NHSI: N/A**	Highest/best MH Trust = **100%**			
NHS Digital Reported: **Not available**	Lowest/worst MH Trust = **84.3%**	NHS Digital Reported: **96.3%**	NHS Digital Reported: **97.3%**	NHS Digital reported: **97.6%**

*Latest benchmark data available on NHS Digital at quarters 3 2017/18.
**We are no longer required to report performance to NHSI following the change in the Regulatory Framework in October 2016.

TEWV considers that this data is as described for the following reasons:

- The discrepancy between the NHS Digital and the Trust / NHSI figures is due to the fact the NHS Digital data is submitted at a CCG level, and therefore, excludes data where the CCG is unspecified in the patient record. The Trust figures include these cases.

  The **key reasons** why **46** people in 2017/18 were not assessed by the Crisis team prior to admission were:
  - breakdown in process due to failure to follow the standard procedure (29 patients); and
  - high levels of demand on the Crisis team (7 patients).

TEWV **has taken** the following actions to improve this percentage, and so the quality of its services, by:

- Investigating instances where patients were not seen by a crisis team prior to admission and identifying lessons to be learned at service level.
- Undertaking an improvement programme led by the Chief Operating Officer to improve proactive performance management and eliminate waste in both clinical and corporate services.
- Continuing to utilise the report out process and Trust performance management system to pro-actively monitor performance and ensure compliance. Supporting the adherence to standard process to ensure patients discharged to other services (e.g. 24 hour care unit) are not overlooked, including the introduction of visual control boards.
- Continuously raising awareness and reminding staff at ward / team meetings of this national requirement and why it is important, the need to follow the standard procedure and the need to record data accurately considering appropriate exclusions.

Patients' experience of contact with a health or social care worker

The data made available by NHS Digital with regard to the Trust's "patient experience of community mental health services" indicator score regarding a patient's experience of contact with a health or social care worker during the reporting period. The figures we have included are from the CQC website but at the time of writing comparative figures were not available from NHS Digital.

An overall Trust score is not provided, due to the nature of the survey, therefore it is not possible to compare Trusts overall. For 2017, we have reported the Health and Social Care Workers section score which compiles the results from the questions used from the survey detailed below the table.

TEWV actual 2017	***National benchmarks in 2017***	***TEWV actual 2016***	***TEWV actual 2015***	***TEWV actual 2014***
Overall section score: **7.7** (sample size 232)	Highest/Best MH Trust = **8.1** Lowest/Worst MH Trust = **6.4** Average Score**=7.6**	Overall section score: **7.8** (sample size 234)	Overall section score: **8.0** (sample size 239)	NHSIC Reported: **8.1** (sample size 188)

CQC design and collate the results of the community mental health patient experience survey. Since 2014 the survey has asked community service users the following questions about their contacts with a NHS health worker or social care worker:

- Did the person or people listen carefully to you?
- Were you given enough time to discuss your needs and treatment?
- Did the person or people you saw understand how your mental health needs affect other areas of your life?

TEWV considers that this data is as described for the following reasons:

Based on information derived from the NHS Patient survey report the individual scores for TEWV in relation to the above are described as follows:

- *Did this person listen carefully to you*: TEWV mean score of **8.1**. The lowest national mean was 7.2 and the highest 8.7.
- *Were you given enough time to discuss your needs and treatment*: TEWV mean score of **8.0**. The lowest national mean was 6.2 and the highest 8.1.
- *Did the person or people you saw understand how your mental health needs affect other areas of your life*: TEWV mean score of **7.0**. The lowest national mean was 5.8 and the highest 7.8.

The report identifies if Trusts perform 'better' 'about the same' or 'worse' based on a statistic called the expected range. When comparing TEWV survey results with those of the other organisations the scores were identified as being 'about the same' as other organisation across all 10 sections. As with the 2016 survey, there was no overall rating of 'better' or 'worse' than others for any section of the survey (in 2015 TEWV had 4 sections being rated as better than other organisations).

The CQC has published detailed scores for TEWV which can be found at http://www.cqc.org.uk/provider/RX3/survey/6.

TEWV **intends to take** the following actions to improve this indicator, and so the quality of its services, by:

- Reviewing the way we do care planning in the Trust to make them more personal (a Quality Account priority for 2018/19).
- Recruiting experts by experience (including peer workers) to help make services think more about the patient experience.
- Taking action to re-provide care from outdated wards in York, Northallerton and Harrogate so that all inpatient wards will have single en-suite bedrooms by 2019/20.
- Continuing to carry out our local inpatient and community surveys with established mechanisms in place for action plan development and feedback.
- Transferring to the new external provider Optimum Health, which is a live system that enables managers to monitor level of feedback received and act upon any issues in a timely manner.
- A pilot of SMS/Web based surveying using staff smartphones is coming to an end and will be rolled out Trustwide in April.

In addition, patient experience kiosks are now installed in 31 sites where there is a high footfall of patients and carers, which enables them to complete the survey anytime, and a quarterly narrative audit is undertaken to ensure areas address issues from narrative feedback.

The Trust continues to carry out regular patient experience surveys across all services which includes the FFT. Between April 2017 and March 2018 the Trust received feedback from 20,568 patients with an average of 87% who would be extremely likely or likely to recommend TEWV services.

Patient safety incidents including incidents resulting in severe harm or death

The data made available by NHS Digital with regard to the number of patient safety incidents, and percentage resulting in severe harm or death, reported within the Trust during the reporting period. The next reporting period is March 2018.

TEWV actual quarters three & four 2017/18	***National benchmarks in quarters three & four 2017/18***	***TEWV actual quarters one & two 2017/18***	***TEWV actual quarters three & four 2016/17***
Trust Reported to NRLS: **7,244** incidents reported of which 85 **(1.17%)** resulted in severe harm or death	NRLS Reported: National average MH Trusts: incidents reported of which resulted in severe harm or death. Lowest MH Trust: **603** incidents reported of which **5** resulted in severe harm and **13 (2.2%)** in death. Highest MH Trusts: **6,447** incidents reported of which **2 (0%)** resulted in severe harm and **14 (0.2%)** in death. The highest reported rate of deaths as a proportion of overall incidents was **3.8%.**	Trust Reported to NRLS: **7,372** incidents reported of which **47 (0.64%)** resulted in severe harm or death* NRLS reported: **7,372** incidents reported of which **47 (0.64%)** resulted in severe harm or death* *15 Severe Harm and 32 Death.	Trust Reported to NRLS: **6,244** incidents reported of which **54 (0.86%)** resulted in severe harm or death. NRLS reported: **6,244** incidents reported of which **54 (0.86%)** resulted in severe harm or death.

TEWV considers that this data is as described for the following reasons:

- The Trust reported and National Reporting & Learning System (NRLS) reported data for quarters one and two 2017/18 showed no variance in what was reported. This improved position from last year is due to a significant amount of data quality improvement work the Trust has undertaken.
- The number of incidents reported by TEWV to the NRLS for quarters one and two 2017/18 was improved compared to the previous two quarters. However, it is not possible to use the NRLS data to comment on a Trust's culture of incident reporting or the occurrence of incidents. The absolute numbers of incidents reported is a factor of the relative size of a Trust and the complexity of their case-mix. We have noted that:
  - The reporting of patient safety incidents in the Trust in quarters one and two 2017/18 has considerably increased when compared to with quarters three and four 2016/17. This is due to the implementation of a new web-based version of our incident reporting process which has had the positive impact of raising staff awareness of reporting.
  - Amongst the most common themes reported are self-harming behaviour, patient accident, disruptive, aggressive behaviour and medication which account for three-quarters of all incidents leading to harm.

- During 2017/18 TEWV reported 178 incidents as Serious Incidents, of which 156 were deaths due to unexpected causes (as at end of February 2018).

TEWV **has taken** the following actions to improve this indicator, and so the quality of our services by:

- Analysis of all patient safety incidents. These are reported and reviewed by the Patient Safety Group which is a sub group of the Trust's Quality Assurance Committee. A monthly report is circulated to the QuAC. Safety incidents are reported to commissioners via the Clinical Quality Review Process.
- Making permanent the central approval team which was put in place to ensure consistent grading of incidents and to improve the overall quality of reporting.
- Ensuring all serious incidents (i.e. those resulting in severe harm or death) are subject to a serious incident review. This is a robust and rigorous approach to understand how and why each incident has happened, to identify any causal factors and to identify and share any lessons for the future.
- Introducing mortality reviews on those deaths that are not classed as unexpected. We are following national guidance as it is published in this area – the National Guidance on Learning from Deaths was released in March 2017 and have implemented its recommendations throughout 2017/18.

2018/19 Priorities for Improvement

During 2017/18 we held two events inviting our stakeholders to take part in our process of identifying quality priorities for 2018/19 to be included in the Quality Account. These events took place in July 2017 and February 2018: further information can be found in **Part 3, Our Stakeholders' Views section**. The four quality priorities which we identified from this engagement also sit within TEWV's 2018/19-2020/21 Business Plan. The Business Plan includes a further 10 priorities all of which will have a positive impact on the quality of Trust services. Details of these priorities can be found in **appendix 5**.

Our four agreed 2018/19 priorities for inclusion in the Quality Account are:

Priority 1: Reduce the number of preventable deaths;
Priority 2: Improve the clinical effectiveness and patient experience in times of transition from Child to Adult services;
Priority 3: Making Care Plans more personal;
Priority 4: Develop a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services.

Priority 1: Reduce the number of preventable deaths

Why this is important:

As mentioned in **Part 2** (above) where we provided an update on our Quality Priorities for 2017/18, the Trust identified that this was an important priority for our Quality Account because:

- Sometimes healthcare teams can make mistakes or different teams / organisations do not work together as well as they could. This means that when things go wrong, a death may have been preventable.
- The CQC made recommendations for the improvements that need to be made in the NHS regarding deaths.
- We believe it is important to strengthen the way we identify the need for investigations into the care provided and the way we carry these out.
- It is important that families and carers are fully involved in reviews and investigations following a death.
- To reduce preventable deaths, it is important that learning from deaths and near misses are shared and acted on with an emphasis on engaging families and carers in this learning.

The benefits / outcomes we aimed to deliver:

- Our processes will reflect national guidance and best practice which will ensure we are delivering the best, evidence based care and treatment to our patients.
- A reduction in the number of preventable harm incidents and deaths of inpatients on leave from hospital.
- That patients and carers feel listened to during investigations of death and consistently treated with kindness, openness and honesty.

- Increased confidence that investigations are being carried out in accordance with best-practice guidelines and in a way that is likely to identify missed opportunities for preventing death and improving services.
- The Trust learns from deaths, including identifying any themes early so that actions can be taken to prevent future harm.

What we will do in 2018/19:

We will:
• Develop a co-produced family and carer version of the learning from deaths policy by Q1 2018/19.
• Produce an engagement plan to involve family, carers and non-Executive Directors within the review process by Q2 2018/19.
• Implement the engagement plan by Q3 2018/19.
• Hold a family conference in conjunction with Leeds and York Partnership Foundation Trust. This will allow us to share good practice and continue to develop the further involvement of families and carers in the preventable deaths process by Q3 2018/19.
• Evaluate the level and effectiveness of engagement with families, carers and Non-Executive Directors by Q4 2018/19.

How will we know we are making a difference?

In order to demonstrate that we are making progress against this priority we will measure and report on the following metrics:

Indicator	Target	Timescale
• Increase the proportion of deaths that are reviewed as part of the mortality review processes (this is in addition to the existing serious incident process).	120	Q4 2018/19
• Eliminate preventable deaths of inpatients during periods of leave.	0	Q4 2018/19
• Reduce the number of Serious Incidents where it was identified that the Trust contributed to the incident.	37	Q4 2018/19

Priority 2: Improve the clinical effectiveness and patient experience in times of transition from Child to Adult services

Why this is important:

As mentioned in **Part 2** (above) where we provided an update on our Quality Priorities for 2017/18, the Trust identified that this was an important priority for our Quality Account because:

- Young people with ongoing or long-term health or social care needs may be required to transition into AMH services, other service provision or back to their GP.

- The preparation and planning around moving into new services can be an uncertain time for young people with health and / or social care needs.
- There is evidence of service gaps where there is a lack of appropriate services for young people to transition into. There is also evidence that without proper support young people may fail to engage with services (Watson 2005[8]; Singh 2009[9]).
- Transition takes place at a pivotal time in the life of a young person.
- A loss of continuity in care can be a disruptive experience, particularly during adolescence, when young people are at an enhanced risk of psychosocial problems.
- The particular importance of improving the transition from children and young people's services to adult services was recognised by our Quality Account Stakeholders in 2015.

The benefits / outcomes we aimed to deliver:

- An improvement in the experience of young people during their transition from Children and Young People's to Adult services.
- Greater involvement in decisions about the care received when they transfer into Adult services.
- To receive care informed by NICE's[10] evidence-based guidelines, which will result in better clinical outcomes.

What we will do in 2018/19:

We will:
• Implement actions from the thematic review (conducted at the end of 2017/18) of patient stories by Q1 2018/19. • Registered CAMHS and AMH staff to undertake further specific training on the transitions process by Q1 2018/19. • Review transition panels already in place (set up during 2017/18), gain additional service user perspective and set relevant targets and metrics by Q3 2018/19. • Produce an engagement plan to involve family and carers in the process by Q4 2018/19.

[8]Watson AR (2005) Problems and pitfalls of transition from paediatric to adult renal care. Paediatric Nephrology 20: 113–7
[9] Singh SP (2009) Transition of care from child to Adult Mental Health services: the great divide. Current Opinion in Psychiatry 22: 386–90
[10]http://www.rcpch.ac.uk/system/files/protected/page/Transition%20from%20children%E2%80%99s%20to%20adults%E2%80%99%20services%20-%20FULL%20published_1.pdf

How will we know we are making a difference?

In order to demonstrate that we are making progress against this priority we will measure and report on the following metrics:

Indicator	Target	Timescales
• Percentage of joint agency transition action plans in place for patients approaching transition.	80%	Q4 2018/19
• Percentage of patients who reported feeling prepared for transitions at the point of discharge.	80%	Q4 2018/19
• Percentage of patients who have transitioned to AMH from CYPS who indicate they have met their personal goals as agreed in their transition plan.	70%	Q4 2018/19

Priority 3: Making our Care Plans more personal

Why this is important:

Personalisation is defined in the skills and education document by NHS England 'Person Centred Approaches' (2016) as *'Recognising people as individuals who have strengths and preferences and putting them at the centre of their own care and support. Personalised approaches involve enabling people to identify their own needs and make choices about how and when they are supported to live their lives'*.

Feedback from service users shows that our current approach to care planning does not always promote a personalised approach. By undertaking the actions agreed for 2018/19 we aim to improve the experience of service users and carers. For this to be sustainable a change in culture will be required.

The benefits / outcomes our patients and carers should expect:

- To have their personal circumstances viewed as a priority when planning care and treatment.
- To have an accessible, understandable and personalised crisis plan containing contact details of those people and services that are best placed to help when the need arises.
- To have discussions that lead to shared decision making and co-production of meaningful care plans.
- To have agreed plans recorded in a way that can be understood by the service user and everybody else that needs to have this information.
- To receive information about getting support from people who have experience of the same mental health needs.
- To have help with what is important to the service user and carers.

What we did in 2017/18:

We will:
• Completed and reported on an in-depth quality focused audit of the Care Programme Approach, including the care plan.

What we will do in 2018/19:

We will:
• Co-produce an action plan with service users, carers and staff teams based on the findings and recommendations of the audit by Q1 2018/19. • Co-produce guidance about what Personalised Care Planning means and how to demonstrate this through clinical records by Q1 2018/19. • Co-develop training and development packages aligning these to, and incorporate where possible, the training and development work of other programmes, projects and business as usual – these must include evaluation measures by Q2 2018/19. • Co-deliver training and development packages – Trustwide by Q3 2018/19. • Re-audit and report as per Q4 2017/18 by Q4 2018/19.

How will we know we are making a difference?

In order to demonstrate that we are making progress against this priority we will measure and report on the following metrics:

Indicator	Target	Timescale
The following indicators are for TEWV from the National Mental Health Community service user Survey 2017 (% for 2017) • Do you know who to contact out of office hours if you have a crisis? (64.8%) • Were you involved as much as you wanted to be in deciding what treatments or therapies to use? (68%) • Have you been given information by NHS mental health services about getting support from people who have experience of the same mental health needs as you? (32.8%) • Do the people you see through NHS mental health services help you with what is important to you? (66.9%) • Were you involved as much as you wanted to be in agreeing what care you will receive? (70.8%) • Were you involved as much as you wanted to be in discussing how your care is working? (75.5%) • Does the agreement on what care you will receive take your personal circumstances into account? (74.9%)	All 2017 indicators to increase by 10% points minimum	Q4 2018/19

Priority 4: Develop a Trustwide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services.

Why this is important:

Service users with severe mental health problems who are also misusing substances (known as **dual diagnosis**) have high risks of harm to themselves or others, poor outcomes and high treatment costs. Changes in commissioning arrangements of substance misuse services could lead to increased risk of have service gaps for patients with a dual diagnosis. The Trust has recognised the importance of adapting to these changes and become more proactive in developing services that address the specific needs of this group of service users.

The benefits / outcomes our patients and carers should expect:

- That service users with mental health and co-existing substance misuse get the same level of care than people without substance misuse.
- Staff treat every service user with the same level of respect, without judging someone because they abuse drugs or alcohol.
- Support for family and carers of service users with dual diagnosis.
- Staff will work collaboratively across organisations, with a creative, flexible and proactive approach.
- The Trust will consider the whole picture when considering the discharge of service users who have started / increased their misuse of substances.
- The organisation will learn from incidents if things go wrong.

What we will do in 2018/19:

We will:
• Circulate Dual Diagnosis CLiP to all Localities, specialties and specialty sub-groups for them to agree the most appropriate place to integrate within their pathways by Q1 2018/19.
• Establish a process with the patient safety team that incorporates dual diagnosis in investigations / reviews by Q1 2018/19.
• Directorate specialties to confirm their use of Dual Diagnosis CLiP (proportionate to their need) within relevant pathways by Q2 2018/19.
• Introduce a Training Needs Analysis (TNA) which includes dual diagnosis and identify those staff with dual diagnosis capabilities by Q2 2018/19.
• Establish a training structure linked to Locality and speciality requirements by Q3 2018/19.
• Ensure all services have at least 1 person trained or have access to a trained clinician (proportionate to each directorate's needs) as a contact regarding dual diagnosis issues by Q4 2018/19.
• Complete an annual thematic review of risks and Serious Incidents involving service users with Dual Diagnosis by Q4 2018/19.
• Establish links with the confidential enquiry process and identify whether there are any potential missed mental health factors in recorded drug-related deaths by Q4 2018/19.

- Engage partner and stakeholders to agree a future approach and produce the framework/document which outlines the forward view for dual diagnosis by Q4 2018/19.

What we will do in 2019/20:

We will:
• Complete an audit of staff dual diagnosis capabilities and skills by Q4 2019/20, and then repeat this every two years.

How will we know we are making a difference?

In order to demonstrate that we are making progress against this priority we will measure and report on the following metrics:

Indicator	Target	Timescale
• Percentage of services* that have at least one person trained or have access to a trained clinician.	100%	Q4 2018/19
• Percentage of services* which have access to an identified staff member who has enhanced dual diagnosis capabilities.	100%	Q4 2018/19

*AMH, CYPS, MHSOP, Learning Disabilities and Forensics.

Monitoring Progress

The Trust will monitor its progress in implementing these priorities at the end of each quarter and report on this to the QuAC and Council of Governors.

We will also feedback progress made during quarter one at our July Quality Account stakeholder event, send a six monthly update to all of our stakeholders, and provide a further update of the position as of 31 December 2018 at our February 2019 Quality Account Stakeholder workshop.

Part 3: Other information on Quality Performance 2017/18

Our performance against our quality metrics

During 2016/17 we reviewed and revised our Trust's Quality Strategy. In approving the new strategy the Trust Board agreed a set of metrics to be routinely monitored each quarter to show the progress that is being made in delivering the objectives within the strategy. As a consequence we revisited the quality metrics to be used in the 2017/18 Quality Account to ensure they are aligned to the metrics in the Quality Strategy.

The following table provides details of our performance against our set of agreed quality metrics for 2017/18. As the majority of these metrics now align to the Trust Quality Strategy, they do vary from those we have reported in previous years.

The targets in the table below are taken from TEWV's Quality Strategy 2017/18 to 2020/21. We intend to achieve these targets by March 2021. In the first year we have started progress towards these, and we expect a year-on-year improvement in these figures as we get nearer to achieving these 3 year targets.

Quality Metrics

Quality Metrics		2017/18		2016/17	2015/16	2014/15	2013/14
		Target	Actual	Actual	Actual	Actual	Actual
Patient Safety Measures							
1	Percentage of patients reported 'yes always' to the question, 'do you feel safe on the ward'?	88%	**62.30%**	NA	NA	NA	NA
2	Number of incidents of falls (level 3 and above) per 1000 occupied bed days (for in patients)	0.35	**0.12**	0.37	NA	NA	NA
3	Number of incidents of physical intervention / restraint per 1000 occupied bed days	19.25	**30.65**	20.26	NA	NA	NA
Clinical Effectiveness Measures							
4	Existing Percentage of patients on Care Program Approach who were followed up within 7 days after discharge from psychiatric in-patient care	> 95.00%	**94.78%**	98.35%	97.75%	97.42%	97.86%
5	Percentage of clinical audits of NICE Guidance completed	100%	**100%**	100%	100%	100%	97%
6a	Average length of stay for patients in Adult Mental Health and	AMH <30.2	**27.64**	30.08	26.81	26.67	31.72

Quality Metrics		2017/18		2016/17	2015/16	2014/15	2013/14
		Target	Actual	Actual	Actual	Actual	Actual
6b	Mental Health Services for Older People Assessment & Treatment Wards	MHSOP <52	**67.42**	78.06	62.67	62.18	54.08
Patient Experience Measures							
7	Percentage of patients who reported their overall experience as excellent or good	94%	**90.50%**	90.53%	NA	NA	NA
8	Percentage of patients that report that staff treated them with dignity and respect	94%	**85.90%**	NA	NA	NA	NA
9	Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	94%	**87.20%**	86.58%	85.51%	NA	NA

Notes on selected metrics

4. Data for CPA 7 day follow up is taken from the Trust's patient systems and is aligned to the national definition.
5. The percentage of clinical audits of NICE Guidance completed is based on the number of audits of NICE guidelines completed against the number of audits of NICE guidelines planned. Data for this metric is taken from audits undertaken by the Clinical Directorates supported by the Clinical Audit Team.
   As at the 28th February, there were no NICE audits due for completion. There are three to be completed by the end of March 2018.
6. Data for average length of stay is taken from the Trust's patient systems.

Comments on Areas of Under-Performance

Metric 1: Percentage of patients reported 'yes always' to the question, 'do you feel safe on the ward'?

The end of year position was 62.33%, which relates to 2,290 out of 3,674 surveyed. This is 25.67% below the Trust target of 88.00%.

All localities underperformed this year. Durham and Darlington is closest to the target with 69.58% and Forensic Services are furthest away with 48.78%.

The Trust's Patient Safety Group is conducting a "deep dive" to better understand the data for this action and are developing an action plan to monitor and resolve any issues highlighted.

Metric 3: Number of incidents of physical intervention / restraint per 1000 occupied bed days.

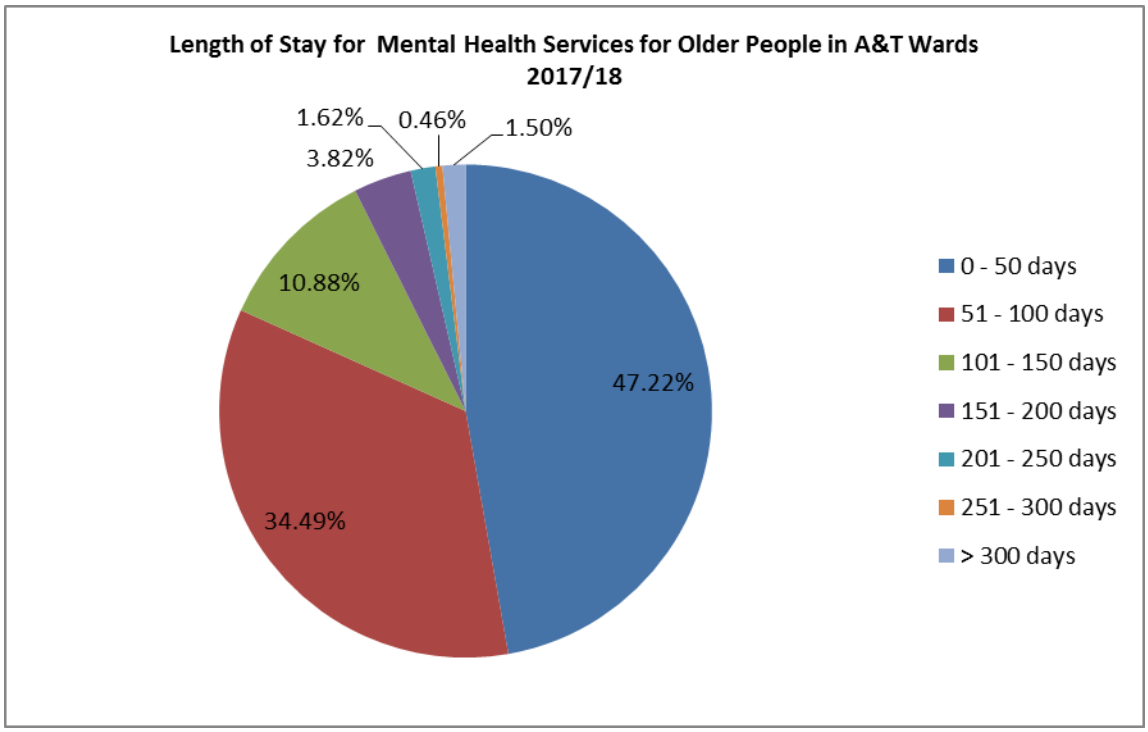
The end of year position was 30.65, which relates to 8,492 incidents out of 277,030 occupied bed days. This is 11.40 above the Trust target of 19.25.

Durham & Darlington and North Yorkshire achieved the target during year. Of the underperforming localities Forensic Services is closest to the target with 24.28 and Teesside are furthest away with 55.91.

Metric 6b: Average length of stay for patients in Mental Health Services for Older People assessment and treatment wards.

The average length of stay for older people has been worse than target since quarter three 2013/14 reporting 67.42 days as at March 2018, which is 12.42 worse than target but an significant improvement compared to the position reported in 2016/17. The pie chart below shows the breakdown for the various lengths of stay during 2017/18.

The median length of stay was **53** days, which is only one day above the target of 52 days and demonstrates that the small number of patients that had very long lengths of stay have a significant impact on the mean figures reported.



The length of stay of patients (for both adults and older adults) is closely monitored by all services within the Trust. The reasons for the increase in the average length of stay for patients are due to a small number of patients who were discharged after a very long length of stay, which has distorted the overall average. In total 77.88% of lengths of stay were between 0-50 days, with 14.54% between 51 – 100 days. There were 63 patients who had a length of stay greater than 200 days; the majority were attributable to the complex needs of the patients (including physical health problems) and delays in accessing suitable placements for patients subsequent to discharge.

Metric 7: Percentage of patients who reported their overall experience as excellent or good.

The end of year position was 90.50%, which relates to 13,772 out of 15,218 surveyed. This is 3.50% below the Trust target of 94.00%.

All localities underperformed this year. Teesside is closest to the target with 91.98% and Forensic Services performing furthest away with 79.90%.

Metric 8: Percentage of patients that report that staff treated them with dignity and respect.

The end of year position was 85.94%, this relates to 14,567 out of 16,950 surveyed and is 8.06% below the Trust target of 94.00%.

All localities underperformed this year. North Yorkshire is closest to the target with 90.08% and Forensic Services performing furthest away with 64.45%.

Metric 9: Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment.

The end of year position was 87.22%, which relates to 12,424 out of 14,244 surveyed. This is 6.78% below the Trust target of 94.00%.

All localities underperformed this year. Teesside is closest to the target with 89.08% and Forensic Services performing furthest away with 72.63%.

Our performance against the Single Oversight Framework Targets and Indicators

The following table demonstrates how we have performed against the relevant indicators and performance thresholds set out in appendix three of the Single Oversight Framework November 2017, representing the position as at February 2018**.

Single Oversight Framework

Indicators		2017/18		2016/17	2015/16	2014/15	2013/14
		Threshold	Actual	Actual	Actual		
A	Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral*	50%	**74.11%**	70.04%	55.91%		
B	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards*	90%	**92.50%**				

Indicators		2017/18		2016/17	2015/16	2014/15	2013/14
		Threshold	Actual	Actual	Actual		
C	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services**	90%	**91.00%**				
D	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental health services (people on CPA)*	65%	**74.39%**				
E	IAPT/Talking Therapies - proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	50%	**50.44%**	48.32%			
F	Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral	75%	**95.49%**	95.44%	84.01%		
G	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral	95%	**99.89%**	99.14%	95.93%		
H	Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care	> 95.00%	**96.52%**	98.35%	97.75%	97.42%	97.86%
I	Admissions to adult facilities of patients who are under 16 years old		**1**				
J	Inappropriate out of area placements (OAPs) for adult mental health services		**1913**				

*This figure is different to that published elsewhere for 2017/18 due to the timing of data extracted.
**The figures provided are based on a Trust assessment of the sample audit data.

Notes on the Single Oversight Framework Targets and Indicators

The data represents the Trust's position as monitored through internal processes and reports.

Where available the historic information shown for 2013/14 has been taken from the Board of Directors Dashboard report or the Monitor/Single Assessment Framework report at year end.

Metric I: Admissions to adult facilities of patients who are under 16 years old

In July one patient aged 14 years old was admitted to an adult ward. The admission was the most appropriate option to keep the patient safe until a CAMHS learning disability bed became available; however this was not clinically appropriate and therefore a serious incident report was raised.

Metric J: Inappropriate out of area placements for adult mental health services

The Trust is currently seeking clarity from NHS Improvement on the calculation of this metric as it appears that the guidance issued for the Quality Account conflicts with that for the Single Oversight Framework (SOF) and we believe the two should align. In the interim the figure shown in the table is based on the calculation within the SOF. This allows providers a certain amount of interpretation in its application for internal OAPs and we have been commended by NHS Improvement and NHS England on our interpretation and transparent application of the metric. However, this means that direct comparison between providers may not be possible.

Using the SOF definition for this indicator the rolling three month position for the period ending 31st March 2018 was 1,913 inappropriate out of area placement bed days. This equates to a monthly average of 638 for each of the months in question. This may appear quite high, however all of these were internal OAPs within the Trust as opposed to an external OAP.

An internal OAP is where the patient remains within their home organisation, but the location of the receiving unit disrupts their continuity of care. An external OAP is where the sending organisation is paying another provider to care for their patient, usually because they do not have an available bed. We have now agreed a trajectory with the CCGs to improve performance and we plan to reduce this figure by 10% each year which has been discussed with NHS England who are supportive of our approach. Representatives from the Trust have met with CCGs to develop action plans to support this delivery.

External Audit

For 2017/18, our external auditors are required to provide a limited assurance report on whether two of the mandated indicators included in the Quality Account have been reasonably stated in all material respects. In addition the Council of Governors (CoG) have the option to choose one further local indicator for external assurance. The three indicators which have been included in the external assurance of the Quality Account 2017/18 are:

- Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral.
- Inappropriate out-of-area placements for adult mental health services.
- Number of incidents of physical intervention / restraint per 1000 occupied bed days (Governor selected indicator).

The full definitions for these indicators are contained in **appendix 6.**

Our stakeholders' views

The Trust recognises the importance of the views of our stakeholders as part of our assessment of the quality of the services we provide and to help us drive change and improvement.

How we involve and listen to what our stakeholders say about us is critical to this process. In producing the Quality Account 2017/18, we have tried to improve how we involved our stakeholders in assessing our quality in 2017/18.

Our stakeholder engagement events were held in a location central to the Trust's area, and included a mixture of presentations on current progress against quality priorities and collective discussion among stakeholders about the focus of future quality improvement priorities. We achieved a balanced participation both geographically and between different types of stakeholders (e.g. Trust Governors, CCGs, Local Authorities and Healthwatch). Staff engagement is through staff governors' involvement in the stakeholder event, and also the engagement the Trust carries out with staff on our business plan, which includes our proposed quality priorities.

The positive feedback we have received was mostly within the following themes:

- *Well organised useful event with a good structure and feedback.*
- *Table discussions work well.*
- *Good mix of knowledge on tables.*
- *Really positive information sharing exercise.*
- *Good range of topics covered.*
- *Interesting agenda and good speakers.*
- *Everything was excellent and very informative.*
- *Clear ideas and aims / decisions.*

In line with national guidance, we have circulated our draft Quality Account for 2017/18 to the following stakeholders:

- NHS England;
- North East Commissioning Support;
- Clinical Commissioning Groups (x9);
- Health & Wellbeing Boards (x8);
- Local Authority Overview & Scrutiny Committees (x8);
- Local HealthWatch organisations (x8).

All the comments we have received from our stakeholders are included verbatim in **appendix 7**.

The following are the general themes received from stakeholders in reviewing our Quality Account for 2017/18:

- Stakeholders welcomed the opportunity to receive and comment on the Quality Account;
- Recognise the progress made on our 2017/18 quality priorities and agree our plans to achieve the 2018/19 quality priorities;
- Understand that there are issues affecting the Trust in terms of staffing levels and recruitment;
- Note the difficult financial position affecting health and mental health but are pleased to see the Trust financial position;
- Note that not all the quality metric targets were met but agree with the mitigations have been put in place;
- Acknowledge the progress on learning from incidents but feel that further work is needed to avoid incidents;
- Would like to receive six monthly update reports;
- The Trust actively engages its partners.

The Trust will write to each stakeholder addressing each comment made following publication of the Quality Account 2017/18 and use the feedback as part of an annual lessons learnt exercise in preparation for the Quality Account 2018/19.

In response to many stakeholders' requests, the Trust has agreed to continue providing all stakeholders with a half-year update in November 2018 on the Trust's progress with delivering its quality priorities and metrics for 2018/19.

APPENDICES

APPENDIX 1: 2017/18 STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Accounts/Reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support the data quality for the preparation of the Quality Account/Report.

In preparing the Quality Account/Report, Directors are required to take steps to satisfy themselves that:

- the content of the Quality Account/Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 and supporting guidance;

- the content of the Quality Account is not inconsistent with internal and external sources of information including:

  - Board minutes and papers for the period April 2017 to May 2018;
  - Papers relating to quality reported to the Board over the period April 2017 to May 2018;
  - Feedback from the Commissioners dated 23 April, 13 May and 17 May 2018;
  - Feedback from Governors dated 8 March and 13 April 2018;
  - Feedback from Local Healthwatch organisations two undated with one received on 3 May 2018 and one received on 9 May 2018;
  - Feedback from Overview and Scrutiny Committees two dated 11 May 2018, one undated but received on 11 May 2018 and one dated 17 May 2018;
  - Feedback from Health and Wellbeing Board dated 10 May 2018;
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, received 9th May 2018;
  - The latest national patient survey published 1 August 2017 and 15 November 2017;
  - The latest national staff survey published March 2018;
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2018;
  - CQC inspection reports dated 11 May 2017 and September 2017.

- the Quality Account/Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;

- the performance information reported in the Quality Account/Report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account/Report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review;

- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account/Report.

By order of the Board.

..22 May 2018...Date.....Chairman

..22 May 2018...Date.....Chief Executive

APPENDIX 2: 2017/18 LIMITED ASSURANCE REPORT ON THE CONTENT OF THE QUALITY ACCOUNTS AND MANDATED PERFORMANCE INDICATORS

To be included within final version.

APPENDIX 3: GLOSSARY

Academic Health Science Network (AHSN): There are 15 AHSNs across England; they focus on two main areas: improving population health and generating economic growth. AHSNs have also been established to deliver a 'step-change' in the way healthcare providers identify, develop, adopt and spread new technologies.

Accountable Care Partnership (ACP): are alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs. Social care and independent and third sector providers may also be involved.

Acute Trust: provide physical healthcare services within hospitals, with some providing services within the community.

Adult Mental Health Service (AMH): Services provided for people aged between 18 and 64 – known in some other parts of the country as "working-age services". These services included inpatient and community mental health services. In practice, some patients younger than 64 may be treated in older people's services if they are physically frail or if they have Early Onset Dementia. Early Intervention in Psychosis teams (EIP) may treat patients younger than 18 years old as well as those over that age.

Allied Health Professional (AHP): is the term used for a range of professional roles such as Dietitians, Occupational Therapists, Physiotherapists and Speech and Language Therapists.

Audit: is an official inspection of records. This can be conducted either by an independent body or an internal audit department.

Audit Commission: This was the national body responsible for appointing external auditors to many public bodies. It also ran counter-fraud work and produced national value for money studies. Government re-assigned its roles to other bodies and the Commission was closed on 31 March 2015.

Autism Services / Autistic Spectrum Disorders: describes a range of conditions including autism, asperger syndrome, pervasive developmental disorder not otherwise specified (PDD-NOS), childhood disintegrative disorder, and Rett syndrome, although usually only the first three conditions are considered part of the autism spectrum. These disorders are typically characterised by social deficits, communication difficulties, stereotyped or repetitive behaviours and interests, and in some cases, cognitive delays.

Bank Staff: This is a pool of staff that can be called upon to cover vacant shifts on inpatient wards. These staff are employed by the Trust.

Benefits: This term is often used when describing and measuring the positive and negative (dis-benefits) elements of a project or programme.

Board / Board of Directors: The Trust is run by the Board of Directors made up of the Chairman, Chief Executive, Executive and Non-Executive Directors. The Board is

responsible for ensuring accountability to the public for the services it manages. It also:

- Ensures effective dialogue between the Trust and the communities it serves;
- Monitors and ensures high quality services;
- Is responsible for the Trust's financial viability;
- Sets general policy direction;
- Appoints and appraises the Trust's executive management team. It is overseen by a Council of Governors and regulated by NHS Improvement.

Business as usual: This is a way of describing day to day business.

CAMHS: Children and Young People's Mental Health services (together with Child Learning Disability services, this is part of Children and Young People's Services - CYPS).

Care Planning: see Care Programme Approach (CPA).

Care Programme Approach (CPA): describes the approach used in specialist mental health care to assess, plan, review and co-ordinate the range of treatment care and support needs for people in contact with secondary mental health services who have complex characteristics. It is a called "an approach" rather than just a system because the way that these elements are carried out is as important as the actual tasks themselves. The approach is routinely audited.

Care Quality Commission (CQC): the independent regulator of health and social care in England who regulate the quality of care provided in hospitals, care homes and people's own homes by the NHS, local authorities, private companies and voluntary organisations, including protecting the interests of people whose rights are restricted under the Mental Health Act.

Children and Young People Service (CYPS): Services for people under 18 years old. These include community mental health services and inpatient services. In Durham, Darlington, Teesside and York TEWV also provides services to children and young people with learning disability related mental health needs.

Clinical Commissioning Groups (CCGs): NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. CCGs are clinically led groups that include all of the GP groups in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients. CCGs are overseen by NHS England.

College Centre for Quality Improvement (CCQI): works with the majority of mental health Trusts in the UK focusing on quality networks, accreditation, national clinical audits and research.

Clinical pathway: is a multidisciplinary management tool based on evidence-based practice for a specific group of patients with a predictable clinical course, in which the different tasks (interventions) by the professionals involved in the patient care are defined, optimised and sequenced.

CLiP (Clinical Link Pathway): Completed on the Trust's electronic patient record (Paris) for Falls allowing them to be monitored effectively.

Commissioners: The organisations that have responsibility for buying health services on behalf of the population of the area work for.

Commissioning for Quality and Innovation (CQUIN): is a payment framework such that a proportion of NHS providers' income is conditional on quality and innovation. Its aim is to support the vision set out in High Quality Care for All of an NHS where quality is the organising principle.

Community Mental Health Survey: is conducted every year by the CQC. It represents the experiences of over 13,000 people who received specialist care or treatment for a mental health condition in 55 NHS Trusts in England during a specified time each year.

Confidential Inquiry: A national scheme that interviews clinicians anonymously to find out ways of improving care by gathering information about which factors contributed to the inability of the NHS to prevent each suicide of a patient within its care. National reports and recommendations are then produced.

Co-production / co-produced: This is an approach where a policy, and approach or other initiative / action is designed jointly by TEWV and a patient / carer.

Council of Governors: the Council of Governors is made up of elected public and staff members, and also includes non-elected members, such as the Prison Service, Voluntary Sector, Acute Trusts, Universities and Local Authorities. The Council has an advisory, guardianship and strategic role including developing the Trust's membership, appointments and remuneration of the Non-Executive Directors including Chairman and Deputy Chairman, responding to matters of consultation from the Trust Board, and appointing the Trust's auditors.

Dashboard: A report that uses data on a number of measures to help managers build up a picture of operational (day to day) performance or long term strategic outcomes.

Data Protection Act 1998: The law that regulates storage of and access to data about individual people.

Data Quality Improvement Plans (DQIPs): A plan to improve the reliability / accuracy of data collected on a particular subject – often used where data has not been collected in the past and new systems to do this need to be set up.

Data Quality (DQ) Strategy: This is a TEWV strategy. It sets a clear direction and outlines what the Trust expects from its staff to work towards our vision of providing excellent quality data. It helps TEWV continue to improve the quality and value of our work, whilst making sure that it remains clinically and financially sustainable.

DeNDRoN: is part of the National Institute for Health Research (NIHR) Clinical Research Network (CRN). It supports the development, set-up and delivery of

clinical research in the NHS around dementia, Huntington's disease, Motor Neurone disease, Parkinson's disease, and other neurodegenerative diseases.

Department of Health: The government department responsible for Health Policy.

Directorate(s): TEWV's corporate services are organised into a number of directorates: Human Resources and Organisational Development; Finance and Information; Nursing and Governance; Planning, Performance and Communications; Estates and Facilities Management. In the past our clinical specialities were called clinical directorates. The Specialities are Adult Mental Health services, Mental Health Services for Older People, Children and Young People's Services and Adult Learning Disability Services.

Early Intervention in Psychosis (EIP): Early intervention in psychosis is a clinical approach to those experiencing symptoms of psychosis for the first time. It forms part of a new prevention paradigm for psychiatry and is leading to reform of mental health services especially in the United Kingdom. This approach centres on the early detection and treatment of early symptoms of psychosis during the formative years of the psychotic condition. The first three to five years are believed by some to be a critical period. The aim is to reduce the usual delays to treatment for those in their first episode of psychosis. The provision of optimal treatments in these early years is thought to prevent relapses and reduce the long-term impact of the condition.

Executive Management Team: A regular meeting of individuals at the senior level of management within the organisation (e.g. Directors) who are responsible for the overall management of TEWV; they are responsible for the high-level decisions within the organisation.

Expert by Experience Groups and members: Non contracted roles, managed under the involvement and engagement structures (offered honorarium) to offer story telling input into training and provide the opportunity to gain a broader range of lived experience views on a range of service developments. Experts by Experience have been trained to work alongside the recovery team to develop and deliver recovery related training in supporting staff and service development in recovery related practice. Experts by Experience work with Trust staff, they do not work with patients and carers (ie they are not acting in a peer role). These roles are managed via our Patient and Public Involvement process.

Forensic Services: Forensic Adult Mental Health and Learning Disability services work mainly with people who are mentally unwell or who have a learning disability and have been through the criminal justice system. The majority of people are transferred to a secure hospital from prison or court, where their needs can be assessed and treated. These services are intended to see that people with severe mental illness or learning disability who enter the criminal justice system get the care they need.

Formulation: This is where clinicians use information obtained from their assessment of a patient to provide an explanation or hypothesis about the cause and nature of the presenting problems. This helps in developing the most suitable treatment approach.

Freedom of Information Act 2000: A law that outlines the rights that the public have to request information from public bodies (other than personal information covered by the Data Protection Act), the timescales they can expect to receive the information, and the exemptions that can be used by public bodies to deny access to the requested information.

Friends and Family Test (FFT): A survey question put to patients, carers or staff that asks whether they would recommend a hospital / community service to a friend of family member if they needed that kind of treatment.

General Medical Practice Code: is the organisation code of the GP Practice that the patient is registered with. This is used to make sure that our patients' GP practice is recorded correctly.

Greenlight: is a framework and self-audit toolkit for improving mental health support for people with learning disabilities.

Harm Minimisation: aims to prevent and reduce the myriad harms associated with the use of psychoactive drugs in the community.

Health and Wellbeing Boards: The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system would work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way.

Health of the Nation Outcome Score (HoNOS): A way of measuring patients' health and wellbeing. It is made up of 12 simple scales on which patients with severe mental illness are rated by clinical staff. The idea is that these ratings are stored, and then repeated- say after a course of treatment or some other intervention- and then compared. If the ratings show a difference, then that might mean that the patient's health or social status has changed. They are therefore designed for repeated use, as their name implies, as clinical outcomes measures.

Health Research Authority (HRA): In accordance with the provision of the Care Act 2014, the HRA was established as an executive non-departmental public body sponsored by the Department of Health. Its purpose is to regulate different aspects of health and social care research.

Healthwatch: local bodies made up of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services. They aim to ensure that each community has services that reflect the needs and wishes of local people.

Hospital Episode Statistics (HES): is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, Government and many other organisations and individuals.

IAPT (also known as 'Talking Therapies'): IAPT stands for "Increasing Access to Psychological Therapies" and was introduced in the last.

Information Governance Toolkit & Assessment Report: is a national approach that provides a framework and assessment for assuring information quality against national definitions for all information that is entered onto computerised systems whether centrally or locally maintained.

Integrated Information Centre (IIC): TEWV's system for taking data from the patient record (Paris) and enabling it to be analysed to aid operational decision making and business planning.

inTouch: This is the Trusts internal website used for staff to access relevant information about the organisation, such as Trustwide policies and procedures.

Involvement Peer Roles: are none contracted unpaid roles which offer individuals with lived experience an opportunity to share their experiences to support other patients/ carers wellbeing and recovery. They can input into courses or groups but always work alongside paid staff, who led the sessions. Managed under involvement and engagement processes and are offered travel and honorarium.

Join Dementia Research: is a national service that enables individuals to register their interest and be matched to take part in suitable research studies.

Kaizen: is a word used as part of the QIS process, it is a Japanese word that means 'change for the better' and is known as 'continuous improvement'.

Learning Disabilities Service: Services for people with a learning disability and mental health needs. TEWV has Adult Learning Disability (ALD) service in each of its 4 Localities and also specific wards for Forensic LD patients. TEWV provides Child LD services in Durham, Darlington, Selby, Teesside and York but not in North Yorkshire.

Lived Experience: A member of the public or staff who has been treated for MH issues in the past and so has special insight into the patient perspective of having a mental illness and receiving treatment.

Local Authority Overview and Scrutiny Committee (OSC): These are statutory committees of each Local Authority which scrutinise the development and progress of strategic and operational plans of multiple agencies within the Local Authority area. All local authorities have an OSC that focused on Health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar & Cleveland Councils have a joint Tees Valley Health OSC that performs this function.

Localities: services in TEWV are organised around four Localities (i.e. County Durham & Darlington, Teesside, North Yorkshire and York & Selby). Our Forensic services are not organised as a geographical basis, but are often referred to a fifth "Locality" within TEWV.

Locality Management and Governance Board (LMGB): A monthly meeting held in each of our Localities (see above) that involves senior managers and clinical leaders who work in that Locality which takes key decisions that relate to that Locality.

Mazars: is an international, integrated and independent organisation specialising in audit, accountancy, tax, legal and advisory services.

Memorandum of understanding: is an agreement between two or more parties. It expresses a convergence of will between the parties, indicating an intended common line of action.

Managing the Business Group: is a director level group which meets monthly and manages the operational corporate business of the Trust. Similar to the Operational Management Group (OMT), however its focus is corporate services rather than clinical services. The group holds overall responsibility for the Data Quality Strategy.

Memory Services: are for people who may be experiencing memory difficulties, which includes the early onset of dementia.

Mental Health Act: The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. In most cases, when people are treated in hospital or another mental health facility they have agreed or volunteered to be there. However, there are cases when a person can be detained (also known as sectioned) under the Mental Health Act (1983) and treated without their agreement. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

Mental Health Services for Older People (MHSOP): Services provided for people over 65 years old. These can be to treat 'functional' illness, such as depression, psychosis or anxiety, or to treat 'organic' mental illness (conditions usually associated with memory loss and cognitive impairment), such as dementia. The MHSOP service sometimes treats people younger than 65 with organic conditions such as early-onset dementia.

Multi-disciplinary: this means that more than one type of professional is involved – for example: psychiatrists, psychologists, occupational therapists, behavioural therapists, nurses, pharmacist all working together in a Multi-Disciplinary Team (MDT).

National Confidential Inquiries (NCI) and National Clinical Audit: research projects funded largely by the National Patient Safety Agency (NPSA) that examine all incidents of, for example suicide and homicide by People with Mental Illness, with the aim is to improve mental health services and to help reduce the risk of these tragedies happening again in the future. This is supported by a national programme of audit.

National Institute for Clinical Excellence (NICE): NHS body that provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health. NICE works with experts from the NHS, local authorities and others in the public, private, voluntary and community

sectors - as well as patients and carers - to make independent decisions in an open, transparent way, based on the best available evidence and including input from experts and interested parties.

National Institute for Health Research (NIHR): an NHS research body aimed at supporting outstanding individuals working in world class facilities to conduct leading edge research focused on the needs of patients and the public.

National Quality Board (NQB): The purpose of the NQB is to provide coordinated leadership for quality on behalf of the Department of Health, Public Health England, NHS England, the Care Quality Commission, NHS Improvement and the National Institute for Care Excellence.

National Reporting and Learning System (NRLS): The National Reporting and Learning System (NRLS) is a central (national) database of patient safety incident reports. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.

National Research Passport Scheme: A scheme to streamline procedures associated with issuing honorary research contracts or letters of access to researchers who have no contractual arrangements with NHS organisations who host research, and who carry out research in the NHS that affects patient care, or requires access to NHS facilities.

NHS Digital: Previously known as the Health and Social Care Information Centre (HSCIC), was set up as an executive non-departmental public body in April 2013, sponsored by the Department of Health. It is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

NHS Improvement: the independent economic regulator for NHS Foundation Trusts – previously known as Monitor.

NHS Patient Survey: the annual survey of patients' experience of care and treatment received by NHS Trusts. In different years has focused both on inpatient and community patients.

NHS Staff Survey: an annual survey of staffs' experience of working within NHS Trusts.

North of England Mental Health Development Unit (NEMHDU): offers health and social care consultancy.

Operational Management Team (OMT): work on a localised level and are responsible for the day-to-day management of TEWV; they report to the Executive Management Team.

Paris: the Trust's electronic care record, product name Paris, designed with mental health professionals to ensure that the right information is available to those who need it at all times.

Patient Safety Group: The group monitors on a monthly basis the number of incidents reported, any thematic analysis and seeks assurances from operational services that we are learning from incidents. We monitor within the group any patient safety specific projects that are on-going to ensure milestones are achieved and benefits to patients are realised.

Peer Worker: someone who is trained and recruited as a paid employee within the Trust in a specifically designed job, to actively use their lived experience (as a patient or carer) to support other patients, in line with the Recovery Approach.

Positive Behavioural Support: is a person-centred approach to people who display or are at risk of displaying behaviours with challenge. It involves understanding the reasons for behaviour and considering the person as a whole including their life history, physical health and emotional needs, to implement ways of supporting the person. It focuses on creating physical and social environments that are supportive and capable of meeting people's needs and teaching people new skills to replace the behaviours which challenge.

Prescribing Observatory in Mental Health (POMH): a national agency, led by the Royal College of Psychiatrists, which aims to help specialist mental health services improve prescribing practice via clinical audit and quality improvement interventions.

Pressure Ulcer: also known as pressure sores are localised damage to the skin and / or underlying tissue that usually occur over a bony prominence as a result of pressure or pressure in combination with shear and / or friction.

Professional Revalidation: is the process that all Nurses and Midwives need to go through in order to renew their registration with the Nursing and Midwifery Council (NMC).

Programme: A set of coordinated group of projects and change management activities designed to achieve outputs and / or changes that will benefit the organisation.

Programme Board: A group of individuals established to meet and discuss a particular programme, providing input, discussions and / or approval on issues affecting the progress of the programme, setting tasks, actions and deadlines.

Project: A one-off, time limited piece of work that will produce a product (such as a new building, a change in a service or a new strategy / policy) that will bring benefits to relevant stakeholders. In TEWV projects will go through a Scoping phase, and then a Business Case phase before they are implemented, evaluated and closed down. All projects will have a project plan, and a project manager.

Psychiatric Intensive Care Unit (PICU): are units (or wards) that are designed to look after patients who cannot be managed on open (unlocked) psychiatric wards due to the level of risk they pose to themselves or others.

Purposeful Inpatient Admission (PIPA) and Treatment: This is TEWV's method for ensuring that all patients receive assessments and treatments as quickly as possible so that their length of stay is kept as short as possible.

Quality Account: A Quality Account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider.

Quality Assurance Committee (QuAC): sub-committee of the Trust Board responsible for quality and assurance.

Quality Assurance Groups (QuAG): Locality / divisional groups within the Trust responsible for quality assurance.

Quality Strategy: This is a TEWV strategy. It sets a clear direction and outlines what the Trust expects from its staff to work towards our vision of providing excellent quality care. It helps TEWV continue to improve the quality and value of our work, whilst making sure that it remains clinically and financially sustainable.

Quality Strategy Scorecard: A set of numerical indicators related to all aspects of Quality, reported to Trust Board four times per year, that helps the Board ascertain whether the actions being taken to support the Quality Strategy are having the expected positive impact.

Quarter one (Q1) / quarter two (Q2) / quarter three (Q3) / quarter four (Q4): These refer to specific points within the financial year (1st April to 31st March). Quarter one is the period of time from April until June. Quarter two is the period of time from July to September. Quarter three is the period of time from October to December. Quarter four is the period of time from January to March.

Recovery Approach: This is a new approach in mental health care that goes beyond the past focus on the medical treatment of symptoms, and getting back to a "normal" state. Personal recovery is much broader and for many people it means finding / achieving a way of living a satisfying and meaningful life within the limits of mental illness. Putting recovery into action means focusing care on what is personally important and meaningful, looking at the person's life goals beyond their symptoms. Helping someone to recover can include assisting them to find a job, getting somewhere safe to live and supporting them to develop relationships.

Recovery College: A recovery college is a learning centre, where patients, carers and staff enrol as students to attend courses based on recovery principles. Our recovery college, called *ARCH,* opened in September 2014 in Durham. This exciting resource is available to TEWV patients, carers and staff in the Durham area. Courses aim to equip students with the skills and knowledge they need to manage their recovery, have hope and gain more control over their lives. All courses are developed and delivered in co-production with people who have lived experience of mental health issues.

Recovery College Online: This is an initiative that would allow people to access recovery college materials and peer-support on-line.

Recovery focused: see Recovery Approach.

Recovery Strategy: TEWV's long term plan for moving services towards the *recovery approach* (see above).

Ridgeway: The part of Roseberry Park Hospital that houses our low and medium Forensic Secure Adult wards (also known as Forensic wards).

Royal College of Psychiatrists: is the professional body responsible for education and training, and setting and raising standards in psychiatry.

Section 17 (S17): This is a Section within the Mental Health Act (1983) which allows the Responsible Clinician (RC) to grant a detained patient leave of absence from hospital. It is the only legal means by which a detained patient may leave a secure hospital site when they are detained under the Mental Health Act.

Serious Incidents (SIs): defined as an incident that occurred in relation to NHS-funded services and care, to ether patient, staff or member of the public, resulting in one of the following: unexpected / avoidable death, serious / prolonged / permanent harm, abuse, threat to the continuation of the delivery of services, absconding from secure care.

Service Development Group (SDG): A group of individuals established to review how changes can be made to improve patient care.

Single Oversight Framework: sets out how NHS Trusts and NHS Foundation Trusts are over overseen.

Specialities: The new term that TEWV uses to describe the different types of clinical services that we provide (previously known as “Directorates”). The Specialities are Adult Mental Health services, Mental Health Services for Older People, Children and Young People’s Services and Adult Learning Disability Services.

Steering Group: These are made up of experts who oversee key pieces of work to ensure that protocol is followed and provide advice / troubleshoot where necessary.

Strategic Change Oversight Board (SCOB): A meeting of members of EMT to oversee and discuss and / or approve development and improvement of the Trust’s services.

Strategic Programme: A programme that considers the ‘big picture’, overseeing how they can benefit the Trust as a whole in order to help improve services and patient experience.

Substance Misuse: A pattern of psychoactive substance use (including illegal drugs, alcohol, smoking and misuse of prescription drugs) that is causing damage to health or has adverse social consequences. Substances can be misused on a regular or intermittent basis (e.g. binge drinking).

SWEMWBS: The shortened version of *WEMWBS* (see below).

TEWV: see ‘The Trust’.

TEWV Quality Improvement System (QIS): the Trust’s framework and approach to continuous quality improvement based on Kaizen / Toyota principles.

Thematic Review: A piece of work to identify and evaluate Trustwide practice in relation to a particular theme. This may be to identify where there are problems / concerns or to identify areas of best practice that could be shared Trustwide.

The Process of Recovery Questionnaire (QPR): is a 15 item measurement tool developed from service users' accounts of recovery from psychosis in collaboration with local service users.

The Trust: Tees, Esk and Wear Valleys NHS Foundation Trust.

Tissue Viability Advice: is advice provided to healthcare professionals who are involved in the management of complex wounds such as pressure ulcers.

Transitions: For the transitions Quality Account Priority we define a transition as a purposeful and planned process of supporting young people to move from children's to adults' services.

Trauma informed care (TiC): involves understanding, recognising and responding to the effects of all types of trauma.

Trust Board: See 'Board / Board of Directors'.

Trustwide: This means across the whole geographical area served by the Trust's 4 Localities.

Unexpected Death: a death that is not expected due to a terminal medical condition or physical illness.

Visual Control Boards: a technique for improving quality within the overall TEWV Quality Improvement System (QIS).

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS): The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is a scale of 14 positively worded items, with five response categories, for assessing mental wellbeing. There is also a "short" version of this scale – where this is used it is called *SWEMWBS.*

Workstreams: is the progressive completion of tasks completed by different groups which are required to complete a single project or programme.

Years 2015/16 / 2016/17 / 2017/18 / 2018/19 / 2019/20 / 2020/21: These are financial years, which start on the 1st April of the first part of the year and end on the 31st March on the second part of the year on each of the years shown.

APPENDIX 4: KEY THEMES FROM 163 LOCAL CLINICAL AUDITS REVIEWED IN 2017/18

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
1. Infection Prevention and Control (IPC)	• All Infection Prevention and Control Audits are continuously monitored by the IPC team and any required actions are rectified collaboratively with the IPC team and ward staff. Assurance of implementation of actions is monitored by the Clinical Audit and Effectiveness team via the clinical audit database. • A total of **99** IPC clinical audits were conducted during 2017/18 in inpatient areas and a sample of community areas in the Trust. **96% (95/99)** of clinical areas achieved standards between 80-100% compliance. • Clinical audits have been undertaken to assess compliance with Hand Hygiene standards and a monthly Essential Steps audit is completed in inpatient areas.
2. Supervision	• Supervisory staff and Durham County Council (DCC) employees have been provided with details of DCC training requirements and provision. Local Authority staff have been given access to and registered on ESR and IIC so all can access training information for supervision. • A Task and Finish Group is scheduled to be developed which includes Team Managers from both DCC and TEWV to work locally to develop common documentation for recording staff supervision. The goals for the team that reflect DCC and TEWV required outcomes are to be identified by a leadership team and will be incorporated into individual appraisals. • There is an ongoing specialist contract requirement which involves undertaking an audit for specialist services to establish the duration of clinical supervision which staff have achieved, with a target of a minimum of 2 hours per quarter.
3. Records management	• There have been newly established work streams to rectify documentation recording within Prison patient systems and subsequent clinical audit re-audits have identified high compliance within Offender Health services documentation showing significant improvements made. • In CYPS Tier 4 Services, there have been developments following clinical audit activities which have influenced the recording of incidents of restraint within the TEWV Datix system. The developments related to including prompts for staff to document the appropriate information as required. Additional information posters were also displayed in clinical areas. • In MHSOP Services, clinical audits have identified outdated guidance and reference to age of 65 within operational policies for Age and Discrimination. These have been updated to specify 'older people' and referenced by the RCP guidance. • Following a clinical audit investigating the Claims Management Policy, the Claims and Legal Services Manager have reviewed the process of sharing lessons learnt from the claim to relevant Heads of Services. • In CYPS new guidelines and a flowchart have been developed around the requirements for documentation in a transition plan and panel meetings.
4. NICE/ Pathway Development	• Adult Mental Health services have reviewed and updated the Positive Behaviour Support (PBS) Pathway, linking to the Force Reduction Team, and awareness sessions have taken place for staff around PBS. • The Forensic Service has developed PBS awareness sessions for carers to support their involvement when service users express a wish for their involvement during behaviour support or intervention plan development. • In CYPS services, a checklist was rolled out for assessment of low mood to support compliance with NICE Guidance for Depression and this was incorporated into the CYPS Pathway shared area to be accessible. • A Memory Clinic Initial Assessment crib sheet was included within the Dementia Care Pathway document.
5. Physical Healthcare	• A new frailty CLiP has been introduced following clinical audit activities considering Falls assessment and management in MHSOP services. • AMH Teams have been provided with additional support from the Nicotine Management Team to continue to further reduce smoking rates. A Toolkit has been developed to support implementation of the Nicotine Management policy and this has been cascaded by the Smoking Cession Project Lead during ward visits to support smokers on admission. • The Trust Rapid Tranquilisation (RT) and Early Warning Score (EWS) policies have been updated to clarify the need for EWS total scores to be

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
	transferred from the paper EWS chart to the post Rapid Tranquilisation physical health case note. The RT policy has also been updated to include instructions to complete the post-Rapid Tranquilisation paper form which has been developed to provide a single place to record incident details and debrief and to provide a prompt to record EWS as per policy. • RT clinical audit findings have influenced updates to the Health Care Assistant physiological observation training detailing more information on RT and EWS, and also influenced updates to the Trust Incident reporting system to allow reporting of RT without physical intervention and to prompt recording of EWS post RT. • Trust Nasogastric Tube Insertion training materials were updated following clinical audit findings to emphasise the correct tests to check NG tube positioning and the intended use for the Cortrak system. • Results of the National CQuIN Safety Thermometer are reported to the Clinical Effectiveness Group quarterly.
6. Medicines Management	• Covert medicine checklist was updated to include space in which to indicate who is responsible for reviewing covert administration. Covert medicines Standard Process Description was amended to include the option to make reference to covert administration instructions set out in the covert medicines plan, rather than recording instructions in the comments section in the prescription and administration chart. • The Trust's High Dose Antipsychotic Treatment (HDAT) monitoring sheet was updated to include reminders for documenting the reason for HDAT, consent/T3, and Paris medication alert. • There have been updates made to the lithium initiation proforma and lithium register recording patient weight/BMI and the requirement to inform women of childbearing age of lithium's teratogenic potential. • A monitoring information sheet has been produced for GP practices as part of the new lithium shared care guidelines.
7. Risk Assessment/ Patient Safety	• Harm Minimisation Training resources programme content have been influenced from findings from clinical audit activities. • The Clinical Audit and Effectiveness Team provided immediate feedback to clinical teams as appropriate to mitigate risks identified from clinical audit activities assessing Safety Summary documentation within patient electronic records. • Guidance notes have been developed detailing requirements for Safety Summary documentation following clinical audit findings. • Safeguarding clinical audits have resulted in points of contact for the Team published on the Trust Intranet and electronic posters shared in clinical teams. A Rapid Process Improvement Workshop (RPIW) has also been arranged with a focus on addressing improvements to the process following findings from the clinical audits. • MCA/DoLS training has been made mandatory within the Trust and bespoke briefing sessions and ward visits have been facilitated to support practice delivery following a MCA assessment audit.
8. Environment and Equipment	• The Trust Resuscitation policy has been updated following clinical audit findings to comply with new training requirements. • As part of ongoing improvement work regarding improving the state and readiness of Emergency Equipment in the Trust, a process has been developed by Nursing and Governance to implement a new monitoring process for this equipment. Modern Matrons and Service Managers will receive completed daily checklists on a 4 week basis and validation checks undertaken by these will provide assurance to the Quality Assurance Groups.

APPENDIX 5: TRUST BUSINESS PLAN ADDITIONAL QUALITY PRIORITIES

The 4 quality priorities within this Quality Account also sit within TEWV's 2018/19-2020/21 Business Plan. The Business Plan includes a further 15 priorities all of which will have a positive impact on the quality of Trust services. These are shown below.

No	Priority	To conclude by
1	Implement Phase 2 of the Trust's Recovery Strategy (years 4-6 of 10) and develop Phase 3	Q4 2020/21
2	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	Q4 2020/21
3	Improve the consistency and purposefulness of inpatient care across the Trust	Q4 2020/21
4	Ensure we have the right staffing for our services now and in the future	Q4 2018/19
5	Deliver our Digital Transformation Strategy	Q4 2020/21
6	Refresh, communicate and implement Making a Difference Together across the whole organisation	Q4 2018/19
7	Develop and implement New Care Models	Q4 2020/21
8	Evaluate and agree future collaboration with universities on research, education and training	Q4 2018/19
9	Implement the Transforming Care agenda in Learning Disability Services	Q4 2018/19
10	Develop a Trust-wide approach to enabling service users with autism to access Trust mental health services	Q4 2018/19
11	Complete the transformation of our York and Selby services	Q3 2019/20
12	Agree and implement future service delivery model for service users from Harrogate and Rural District CCG and Wetherby area	Q3 2019/20
13	Deliver the agreed new model of care for Adult Mental Health and Mental Health Services for Older People in Hambleton and Richmondshire	Q4 2018/19
14	Improve the physical environment at Roseberry Park	Q4 2020/21
15	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners	Q4 2020/21

In addition to these, many of the operational plans and the enabling priorities set out within our Business Plan underpin our quality improvement agenda.

APPENDIX 6: QUALITY PERFORMANCE INDICATOR DEFINITIONS

Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral

Data definition:
Percentage of people with a first episode of psychosis beginning treatment with a NICE-recommended care package within two weeks of referral. The clock stops at the start of the first definitive treatment for 2 different patient cohorts:

a) those experiencing first episode psychosis - when a person has been accepted onto caseload, an EIP care coordinator allocated and a NICE concordant package* of care commenced - this will need to be incorporated into the KPI when details are published. ALL THESE CONDITIONS MUST HAVE BEEN MET;

UNTIL THE NICE CARE PACKAGE DETAILS ARE KNOWN, THE CLOCK WILL STOP WHEN PATIENT HAS HAD A FIRST SUCCESSFUL FACE TO FACE CONTACT AFTER NEW REFERRAL RECEIVED DATE

b) for those possibly at risk mental state (ARMS) - when the person has been accepted onto caseload, an EIP care coordinator allocated and a specialist ARMS assessment commenced by an appropriately qualified EIP clinician - ALL THESE CONDITIONS MUST HAVE BEEN MET.

Exemptions:
The only suspected cases of first episode psychosis exempt from this KPI will be referrals of individuals who are experiencing psychotic symptoms in the context of organic illness e.g. dementia.

Accountability:
This standard applies to anyone with a suspected first episode of psychosis who is aged 14 to 65. People aged over 35 who may historically not have had access to specialist early intervention in psychosis services should not be excluded. Technical guidance is available at: www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/tech-cyped-eip.pdf.

Provider boards must be fully assured that RTT data submitted is complete, accurate and in line with published guidance. Both 'strands' of the standard must be delivered:

- performance against the RTT waiting-time element of the standard is being measured via MHSDS and UNIFY2 data submissions.
- performance against The National Institute for Health and Care Excellence concordance element of the standard is to be measured via:

    - a quality assessment and improvement network being hosted by the College Centre for Quality Improvement at the Royal College of Psychiatrists; all providers will be expected to take part in this network and submit self-assessment data, which will be validated and performance-scored on a four-point scale at the end of the year. This assessment will be used to track progress against the trajectory set out in Implementing the Five Year Forward View for Mental Health: www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf.

- submission of intervention and outcomes data using SNOMED-CT codes in line with published guidance. Provider boards must be fully assured that intervention and outcomes data submitted is complete and accurate.

Inappropriate out-of-area placements for adult mental health services

Data definition:
An out of area placement that is solely or primarily necessitated because of the unavailability of a local acute bed will not meet the criteria for being appropriate. The total number of OAP days is the number of bed days associated with open OAPs in the rolling 3 month period.

Exemptions:
All beds except for acute adult mental health care - Assessment & Treatment, Acute older adult mental health care (Organic and Functional) Assessment & Treatment and PICU. The age range excludes anyone who is under 18 years.

Number of incidents of physical intervention / restraint per 1000 occupied bed days

Data definition:
Number of incidents of physical intervention / restraint per 1000 occupied bed days

Exemptions:
There are not any exemptions for this indicator.

Accountability:
QuAC and Patient Safety Group

Numerator:
The actual number of incidents of physical intervention / restraint .

Denominator:
The total number of responsible ward / team occupied bed days divided by 1000.

APPENDIX 7: FEEDBACK FROM OUR STAKEHOLDERS

County Durham Health and Wellbeing Board

Contact: Andrea Petty
Direct Tel: 03000 267312
email: andrea.petty@durham.gov.uk
Your ref:
Our ref:

Durham County Council

Sharon Pickering
Director of Planning, Performance and Communications
Tees, Esk and Wear Valleys NHS Foundation Trust
Tarncroft
Lanchester Road Hospital
Durham
DH1 5RD

10th May 2018

Dear Sharon

Re: Tees, Esk & Wear Valleys NHS Foundation Trust Quality Account 2017/18

Thank you for the opportunity to comment on the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) Quality Account 2017/18. The County Durham Health and Wellbeing Board appreciate this transparency and would like to provide the following comments on the document.

We acknowledge your performance against your four priority areas of improvement over the last year which were:

Priority 1: Implement phase two of our Recovery Strategy
Priority 2: Ensure we have Safe Staffing in all our services
Priority 3: Improve the clinical effectiveness and patient experience in times of transition from Child to Adult services
Priority 4: Reduce the number of preventable deaths
Priority 5: Reduce the occurrences of serious harm resulting from inpatient falls.

These priorities align with the County Durham Joint Health and Wellbeing Strategy.

It was assuring to note that you have maintained your registration status with the Care Quality Commission with no conditions attached and that the Commission took no enforcement action against you during 2017/18.

/Continued…

It is positive to see that the overall performance figures during 2017/18 are improving. We further note that only 2 actions have not been delivered within the timeframe and support your determination to drive continued better performance to get nearer to achieving your established three year targets.

It is important that the Quality Account aligns, where appropriate to the County Durham Joint Health and Wellbeing Strategy, Clinical Commissioning Group Commissioning Intentions and the Better Care Fund Plan which have been agreed through the County Durham Health and Wellbeing Board.

A great deal of positive partnership working exists within County Durham between Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) and other partners, including Durham County Council, Clinical Commissioning Groups and Durham Constabulary to ensure a holistic approach is provided for users of services. This can be evidenced in the work of the Mental Health Partnership Board (a sub group of the Health and Wellbeing Board). It is important that the Quality Account continues to evidence this joint work to recognise the contributions partners make to services users with mental health needs and learning disabilities.

The Health and Wellbeing Board supports the Trust's 2018/19 priorities for improvement which align to the strategic objectives in the Joint Health and Wellbeing Strategy, as follows:

	TEWV - Priorities for improvement 2018/19	**Joint Health and Wellbeing Strategy 2016-19 – Strategic Objectives**
1	Reduce the number of preventable deaths (continued from 2017/18)	Improve the mental and physical wellbeing of the population
2	Improve the clinical effectiveness and patient experience in times of transition from Child to Adult services (continued from 2017/18)	Improve the mental and physical wellbeing of the population Protect vulnerable people from harm
3	Making Care Plans more personal (New)	Improve the quality of life, independence and care and support for people with long term conditions Improve the mental and physical wellbeing of the population Protect vulnerable people from harm
4	Develop a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services (New)	Reduce health inequalities and early deaths Improve the quality of life, independence and care and support for people with long term conditions

/Continued…

The positive progress to further reduce the number of preventable deaths is welcomed. The new intervention to strengthen your learning process is further welcomed and it is important you have recognised the role that families and carers have in this assessment.

In addition to the areas that have been identified in relation to supporting a reduction in the number of preventable deaths, it is suggested that consideration is given to how people access services, and the responses they are given when in crisis, and how this impacts on preventable deaths. The evaluation planned for Q4 will be important to share with stakeholders as it will allow better understanding for improvement opportunities.

The continuing development of the clinical effectiveness and patient experience in times of transition from Child to Adult services is supported. The progress of this work is integral to our overall integration strategy for County Durham and we who look forward to receiving and understanding the actions highlighted in the thematic review evaluation. The Health and Wellbeing Board have also been sighted on the work taking place as part of the County Durham Mental Health Implementation Plan, for example the Children and Young People Mental Health, Emotional Wellbeing and Resilience Plan, suicide and self-harm, adult mental health and crisis care.

Based on feedback consistently presented to the Mental Health Partnership Board, and as evidenced by TEWV's own survey results, further work is required to improve the transition experience for young people moving from CAMHS to Adult Mental Health services. Improving the clinical effectiveness and patient experience at times of transition is essential to ensure a seamless service for patients and the developments relating to new telephone referral arrangements in the Durham and Darlington CAMHS service are noted as a positive step to reduce waiting times and to improve the patient experience.

The importance of improving the transition process is pleasing to note, however further work is still required to continue to embed the Safe Transition and Discharge Protocol in all CAMHS teams to ensure effective movement to Adult Mental Health services.

The Health and Wellbeing Board welcomes a new priority that looks to focus Care Plans to individuals and co-production will be a key area within this work.

The Health and Wellbeing Board recognise the continued importance of workforce development to ensure that the workforce has the right skills to enable them to undertake their roles safely and effectively.

The Health and Wellbeing Board welcome the new intention to focus on a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services. Joint work with new Drug and Alcohol Treatment Service provider will be important in this respect.

/Continued…

A key focus of this service will be to tackle the intergenerational cycle of substance misuse by utilising a holistic approach to family support, regardless of the entry point into health and social care services. Key priorities for the new contract include; Integration, Family Focus, Outreach support and reinvigoration of the prevention agenda to include wider health and well-being interventions. A key area of development is understanding the hospital and primary care referrals and involvement and we therefore welcome your action on engagement to agree a future approach and produce a delivery framework.

In addition, the Health and Wellbeing Board commends the Trust in relation to tobacco control within a mental health setting, the increase in front line clinical flu vaccinations and the work on falls prevention which are all areas the Board are keen to see positive improvements.

If you require further information, please contact Andrea Petty, Strategic Manager – Partnerships, on 03000 267312 or by email at andrea.petty@durham.gov.uk.

Yours sincerely

Cllr Lucy Hovvels M.B.E
Chair of the County Durham Health and Wellbeing Board
Cabinet Portfolio Holder for Adult and Health Services

Darlington Borough Council Health and Partnerships Scrutiny Committee

DARLINGTON
BOROUGH COUNCIL

Tees, Esk and Wear Valleys NHS Foundation Trust – Draft Quality Account 2017/18

The Health and Partnerships Scrutiny Committee remit covers the Governance arrangements of the Trust and has the responsibility to comment on the Quality Accounts, in line with its Health Scrutiny Powers. The Adults and Housing Scrutiny Committee remit scrutinises the delivery and provision of mental health and learning disability services.

Members of the Health and Partnerships Scrutiny Committee have considered the draft Quality Account 2017/18 for Tees, Esk and Wear Valleys NHS Foundation Trust and attended Stakeholder events over the past year. Members would like to acknowledge that the Stakeholder events are always well attended and informally structured to enable meaningful audience participation, with the opportunity for a free exchange of views.

Members agreed that the presentation of the document was user friendly and readable.

In respect of the five Quality Improvement Priorities for 2017/18, Members noted that two out of the 37 actions within those five priorities had not been completed by 31 March. The first red action related to the training element of Preventable Deaths. It was reported that although the training had been completed data system issues had prevented real time compliance figures being made available.

The second red action related to completion of an evaluation report within the Transitions Monitoring. It was reported that the Trust's target of 31 March had not been met because the other actions needed to be completed before the evaluation took place.

Members have the following comments to make:

Implementation of Phase 2 of the Recovery Strategy – Members recognised the continuation of this Priority, identified in 2014/15, as service users wanted the service to go beyond reducing symptoms of mental health and required support to live meaningful and fulfilling lives whether or not there was improvement in symptoms.

Members welcomed the substantial progress made whilst noting that both internal and external stakeholders had identified further work was required to embed a recovery and wellbeing approach within all its services.

Scrutiny Members were pleased to see the key actions in relation to continued expansion of the number of paid lived experience/peer roles and newly registered involvement peer roles within the Trust; expansion of Recovery College Online; and the increased number of staff receiving trauma informed care training.

Members are delighted that the Trust has once again included this as a Priority Action for 2018/19 and in doing so committed to large scale change, ensuring all systems and processes are reviewed from a recovery perspective and as described within its Recovery and Wellbeing Strategy for 2017-2020.

Ensure Safe Staffing in All Service Areas – Members recognised essential safe staffing for the delivery of safe, high quality, evidence-based patient care ensuring not just sufficient staff for all services but that all staff have the right skills and competencies to deliver excellent care for people with mental health needs and/or a learning disability.

Members accepted the difficulties and challenges faced by The Trust due to the national shortage of qualified nurses and other clinical professions such as psychologists, allied health professionals and doctors making it more important that the Trust focus on developing its future workforce so that new models of care and new ways of working can continue to be safely delivered.

Members noted the key actions of established governance structures; an agreed Programme Plan including benefits and work streams; and introduction of a new report for Ward Managers which brings together data on staffing and other quality and safety indicators.

Improve the Clinical Effectiveness and Patient Experience at Times of Transition from Child to Adult Services – Members welcomed continuation of this Priority, identified in 2015, providing support for young people with ongoing or long-term health or social care needs to transition into Adult Mental Health Services, other service provision or back to their GP. A loss of continuity in care can be a disruptive experience, particularly during adolescence, when young people are at an enhanced risk of psychosocial problems.

Members were pleased to note the benefits and outcomes of this priority which aims to deliver a more positive experience for young people at points of transition and place that young person at the centre of their transition plan development and implementation to ensure the continuity of care.

Members welcomed the success of the new transitions protocol implemented across the CAMHS Teams.

Members are pleased that this is a continued Priority for 2018/19.

Reduce the Number of Preventable Deaths - Members recognised the importance of this Priority following the recommendations for improvement within the 2016 CQC report, Learning, Candour and Accountability.

It was noted that the Trust had systems in place to review and investigate deaths, in line with national guidance, and believed it important to continue to reinforce how to identify the need for investigations into the care provided and the way those investigations were undertaken.

Whilst recognising that people with a mental health problem or learning disability were likely to experience an earlier death than the general population, the Trust had an increased focus on the mortality review processes for this group of people.

Members welcomed the actions put in place to address the number of preventable deaths undertaken whilst inpatients were on leave and also accepted the importance of involving family and carers in reviews and investigations.

Scrutiny Committee welcomed the actions the Trust had undertaken during 2017/18 to reduce the number of preventable deaths and are pleased that this is a continued Priority for 2018/19.

Reduce the occurrences of serious harm resulting from inpatient falls - Members support this Priority as falls can affect a patient's quality of life and impact on family members and carers.

It was noted that regardless of the work of the Trust to implement best practice and NICE guidance, the number of falls had risen although the severity had reduced. Members welcomed the further work undertaken by the Trust and the continued work of the Trust during 2018/19 to address inpatient falls.

Statement of Assurances from the Board 2016/17

Members noted that the Department of Health and NHS Improvement required the Trust to include its position against a number of mandated statements to provide assurance, from the Board of Directors, on progress made on key areas of quality during 2017/18. This included review of services; participation in clinical audits; participation in clinical research; goals agreed with commissioners; registration with the Care Quality Commission and periodic/special reviews; quality of data; and learning from deaths.

Members noted the data in relation to the mandatory quality indicators of Care Programme Approach 7 Day follow up; Crisis Resolution Home Treatment Team acted as a gatekeeper; Patients' experience of contact with a health or social care worker; and Patient safety incidents including incidents resulting in severe harm or death and welcomed the actions the Trust had taken to improve the quality of those services.

Quality Metrics – Missed Targets – Members were informed that of ten Quality Metrics, six were reported as red at the end of March 2018. Unfortunately the number of patients who felt safe on the ward was 25.67 percentage points below the Trusts target of 88 per cent although Members noted that this was mainly due to

'other patients'. Physical interventions/restraints was 8.492 out of 277,030 bed days although it was recognised that some restraints were relatively minor such as a guiding hand to a particular place. The length of stay for patients in Mental Health Services for Older People in Assessment and Treatment Wards was 69.47 days which is 17.47 worse than the target of <52 but an improvement compared to the position reported in 2016/17. The percentage of patients who reported their overall experience as excellent or good for the period April 2017 to the end of March 2018 was 90.50 per cent, 3.95 percentage points below the Trust's target of 94 per cent. Patients that reported that staff had treated them with dignity and respect for the period April 2017 to the end of March 2018 was 85.94 per cent, 8.06 per cent below the Trust target of 94 per cent. Percentage of patients that would recommend the service to friends and family if they needed similar care or treatment for the period April 2017 to the end of March 2018 was 87.22 per cent, 6.78 per cent below the Trust's target of 94.00 per cent.

Members received a full explanation for these missed targets and the actions being taken by the Trust to address the situations.

Members have the following comments to make on the four Quality Improvement Priorities for 2018/19 –

Reduce the number of preventable deaths – Members welcomed the continuation of this priority following the recommendations for improvement within the CQC report, Learning, Candour and Accountability.

Improving the Clinical Effectiveness and Patient Experience in Times of Transition from Child to Adult Services – Members supported the continuation of this Priority as a planned process of supporting young people to move from children's to adults' services. Members look forward to receiving six monthly updates at Stakeholder Events and an updated position at a future Quality Account Stakeholder Event.

Making Care Plans More Personal – Members recognised the importance of this priority to ensure patients were recognised as individuals with their own strengths and preferences. This personalised approach will involve enabling people to identify their own needs and make choices about how and when they are supported to live their lives.

Develop a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services – Members welcomed the benefits of this priority which included service users with mental health and co-existing substance misuse receiving the same level of care as people without substance mis-use ensuring that staff worked collaboratively across organisations with a creative, flexible and assertive approach.

Overall, Health and Partnerships Scrutiny Committee welcomed the opportunity to comment on the Trust's Quality Accounts and are pleased with the Trusts progress against the chosen priorities, in a challenging year for all NHS organisations.

Members would like to receive six monthly reports on the progress being made, to enable them to provide a more detailed and valuable contribution to the Quality

Accounts in the future. They would also like to continue to be invited to Stakeholders events.

Members acknowledged that the Trust was only in the first year of a three year Quality Strategy and that some red metrics were to be expected.

Councillor Wendy Newall
Chair, Health and Partnerships Scrutiny Committee

Durham County Council Adults Wellbeing and Health Overview and Scrutiny Committee

Contact: Cllr John Robinson
Direct Tel: 03000 268140
e-mail:
Your ref:
Our ref:

Colin Martin
Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust,
West Park Hospital
Edward Pease Way
Darlington
DL2 2TS

11 May 2018

Dear Mr Martin,

County Durham and Darlington Foundation Trust – Quality Accounts 2017/18

Following a special meeting of Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee on 9 May 2018 please find attached the Committee's response to your draft Quality Accounts for 2017/18.

The response provides commentary on the Trust's performance for 2017/18 as well as the identified priorities for 2018/19.

I would like to thank the Trust for providing the opportunity for continued engagement of the Adults Wellbeing and Health Overview and Scrutiny Committee in the aforementioned process.

Yours sincerely,

Cllr John Robinson
Chair of the Adults, Wellbeing and Health Overview and Scrutiny Committee

DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON TEES ESK AND WEAR VALLEYS NHS FOUNDATION TRUST QUALITY ACCOUNT FOR 2017/18

The Committee welcomes Tees, Esk and Wear Valleys NHS Foundation Trust's Quality Account 2017/18 and the opportunity to provide comment on it. The Committee are mindful of their statutory health scrutiny role and the need to demonstrate a robust mechanism for providing assurance to the residents of County Durham that health service provision is efficient and effective. The quality account process provides the Committee with one such mechanism.

The Committee has engaged with the Trust on a number of issues during the course of 2017/18 including undertaking a post implementation review of changes to inpatient dementia wards serving County Durham and Darlington and associated mitigation plans for the reimbursement of additional travelling costs; the service reconfigurations arising from structural issues at Roseberry Park, Middlesbrough; the development of an Accountable Care Partnership and the merger of mental health rehabilitation services for adults into Willow Ward, West Park, Darlington.

The Committee considers that the Quality Account is clearly set out and that progress made against 2017/18 priorities is clearly identified. The Trust has made significant progress against these priorities and the Committee welcome the completion of 35 of the 37 actions identified by the Trust under the 5 priorities. Of the 2 actions that are reported as having been missed, the Committee acknowledge that:-

(i) In respect of the preventable deaths priority and training carried out in relation to patients taking leave and time away from the ward, the action has not been achieved because real time data for compliance is not yet available from the Trust's IT systems. However, the Committee are assured that this will be addressed during 2018/19;
(ii) In respect of the transitions priority, the production of an evaluation report of the implementation of the new transitions protocol has been delayed and will not now be completed until the end of June 2018.

In considering those quality metrics where the Trust has missed its target, the Committee note that the percentage of patients who reported "yes-always" to the question "do you feel safe on the ward" for the Durham and Darlington locality whilst below the Trust-wide target is the closest to target at 69.5%. The Committee is however concerned that there appears to be a contradiction between this safety metric and the percentage of patients who reported their overall experience as excellent or good (90.38%).

The Committee is satisfied that whilst Trust-wide there are delayed transfers of care which mean patients have lengthy stays in older peoples' assessment and treatment wards this is not the case across County Durham.

The Committee acknowledges all of the 2018/19 priorities identified within the draft Quality Account and agrees that from the information received from the Trust, they are a fair reflection of healthcare services provided by the Trust. The Committee are particularly pleased to see that the Trust is to develop a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services. The move to more personalised care plans is also supported by the Committee.

During consideration of the progress made against the Trust's 2017/18 Quality Account priorities and performance metrics, the Committee have sought assurances that robust improvement action plans are in place to improve those below target metrics and would welcome sight of these plans in due course.

Finally, in order to ensure that it continues to provide a robust Health scrutiny function and assurances in this respect to the residents of County Durham, the Committee would request a six monthly progress report on delivery of 2018/19 priorities and performance targets in November 2018.

Healthwatch Darlington

Healthwatch Darlington

Comments on Tees, Esk and Wear Valley Foundation Trusts Quality Account for 2017-18 from Healthwatch Darlington.

Healthwatch Darlington have welcomed and enjoyed the opportunity to be involved with the Quality Accounts over the last twelve months and benefit from partnership working with Tees, Esk and Wear Valley NHS Foundation Trust. The Trust actively involves and engages with Healthwatch Darlington and we believe fully embraces the patient voice. Healthwatch Darlington feel the Trust have meaningfully involved a wide and varied section of stakeholders and members of the public and have been regularly updated on patient engagement activity throughout the year. Healthwatch Darlington are satisfied with the progress that Tees, Esk and Wear Valley Foundation Trust are making to achieve their set priorities.

Priorities 2017/2018

- **Implement Phase 2 of the Recovery Strategy.**
- **Ensure Safe Staffing in all services.**
- **Improve the clinical effectiveness and patient experience in times of transition from Child to Adult service.**
- **Reduce the number of preventable deaths**.
- **Reduce the occurrence of serious harm resulting from inpatient falls.**

Healthwatch Darlington have been pleased to see the progress of work carried out and the results that have been achieved over the last year around the above priorities.

Quality Indicators

We are pleased to see that many of the Quality Indicators have been met, but acknowledge along with the Trust that there are areas still to be improved. Healthwatch participants are pleased to see that the trust continues to push for quality improvements especially around patient experience and patient safety.

Future Priorities 2018/2019

Priority 1: Care Planning

Priority 2: Dual Diagnosis.

Priority 3: Improve the clinical effectiveness and patient experience in times of transition from Child to Adult service.

Priority 4: Reduce the number of preventable deaths

Healthwatch Darlington agree with the priorities set for 2018/2019 as all 4 are essential to patient experience and care.

Healthwatch Darlington have enjoyed attending Quality Account meetings and hope the two meetings a year continue.

Healthwatch Darlington would like to thank Tees, Esk and Wear Valleys NHS Foundation Trust for their continued engagement and support, we look forward to further partnership working over the next year.

Healthwatch South Tees

Healthwatch South Tees
St Marys Centre
82-90 Corporation Road
Middlesbrough
TS1 2RW

Telephone: 0800 989 0080
Email:general@healthwatchsouthtess.org.uk

Dear Phillip,

Here is the Healthwatch South Tees response to the:

Tees Esk and Wear Valleys NHS Foundation Trust draft quality account 2017/18

The TEWV's 2017 community mental health survey results response rate (page 4) may have been above the national rate but at 29% is still low enough to be likely to introduce a fair degree of bias in the results.

The decline in overall rating on care experience is a cause for concern and is something that needs to be monitored.

Why did only 52% of staff take the trouble to respond in the 2017 NHS national staff survey (page 5)? To what extent Is this a reflection of staff interest in their work?

From the information given in this draft report, the occupancy rates of assessment and treatment beds must be in excess of 86%. Is this therefore impacting on the quality of care?

South Tees Healthwatch looks forward to receiving data on the percentage of patients who have transitioned from CYPS to AMH who indicate that they have met their personal goals as agreed in the TEWV transition plan (page 23).

Does the TEWV have or are there plans to introduce Kaizen systems into Trust areas as a way of minimising falls due to environmental factors (page 29)?

In view of the report in the BMJ (21st April 2018) on the teratogenic effects of Valproate in pregnancy, does the Trust intend to review the prescription of this drug in cases of bipolar disorder (page 33)?

South Tees Healthwatch is pleased to note the level of the Trusts active involvement in clinical research, not least because this is likely to have a positive impact on quality of care.

Despite improvements in staff uptake of influenza vaccine (page36) there is still a need to further increase staff uptake both to minimise risk of infection to patients and maintain staffing levels in all Trust areas.

Priority 2 for improvement (page 50): There is a need for sufficient support to be provided to young people to ensure that they do engage with the transition process from CYPS to AMH services and do not subsequently lose out on service provision.

Priority 4 for improvement (page 54): There is a need to provide further training and identify staff with dual diagnosis skills to ensure this particularly vulnerable group of patients get the support they need and so avoid poor outcomes. The stigma sometimes attached to substance abuse patients should not be an issue in a mental health Trust.

The Trust's performance against quality metrics needs to improve in several areas, particularly metric 8 (page 59) which covers the percentage of patients reporting that staff treat them with dignity and respect.

There is no mention in this report of provision of respite care to enable carers of patients with long term conditions obtain short term relief. What involvement, if any, does the Trust have in provision of such care?

Yours sincerely

Natasha Judge

Healthwatch South Tees Development & Delivery Manager

01642 955 606

Joint Durham, Darlington and Teesside CCGs

NHS
Darlington
Clinical Commissioning Group

Darlington CCG
Billingham Health Centre
Queensway
Billingham
TS23 2LA

23 April 2018

Elizabeth Moody
Director of Nursing and Governance
Tees Esk and Wear Valleys NHS Foundation Trust
Trust Headquarters
West Park Hospital
Edward Pease Way
Darlington
DL2 2TS

Dear Elizabeth

RE: Tees, Esk and Wear Valleys NHS Foundation Trust (TEWVFT) Quality Account 2017/18

Corroborative statement from NHS Darlington Clinical Commissioning Group (CCG, NHS North Durham CCG, NHS South Tees CCG, NHS Hartlepool and Stockton on Tees CCG and NHS Durham Dales, Easington and Sedgefield CCG

The Clinical Commissioning Groups (CCGs) welcome the opportunity to review and comment on the Quality Account for Tees Esk and Wear Valleys NHS Foundation Trust for 2017/18 and would like to offer the following commentary:

As commissioners, the CCGs are committed to commissioning high quality services from Tees Esk and Wear Valleys NHS Foundation Trust and take seriously the responsibility to ensure that patients' needs are met by the provision of safe, high quality services and that the views and expectations of patients and the public are listened to and acted upon. We have remained sighted on the Trust's priorities for improving the quality of its services for its patients, and have continued to provide robust challenge and scrutiny through the Clinical Quality Review Group (CQRG) meetings with the monitoring, review and discussion of quality issues. The amalgamation of the two CQRGs across the Trust's Teesside and County Durham and Darlington localities during 2017/18 has strengthened this assurance process.

The CCGs have also continued throughout 2017/18 to conduct regular commissioner led inspection visits to TEWVFT sites to gain assurances and an insight into the quality of care delivered. Therefore the CCGs feel that the quality account is an accurate representation of the services provided during 2017/18 within the Trust.

The report provides a comprehensive description of the quality priorities which the Trust has focused on during 2017/18. The report provides an open account of where improvements have been made.

It is pleasing that the Chief Executive's overview to the Quality Account emphasises the achievements made during 2017/18 and the intentions of their Quality Strategy to further meet the

needs of the services users and their families over the next two years. The CCGs would like to commend the trust on all their external achievements won by trust staff for their contributions to service improvements and patient care and congratulate TEWVFT on the positive results from both the 2017 NHS staff survey and the NHS community mental health services survey.

The CCGs would like to commend the Trust for the improvements that are demonstrated in the report, particularly the achievement of its goals relating to reducing the number of preventable deaths. It is hoped that the ongoing work to address the quality priorities not achieved in year will yield the desired results in 2018/19.

It is pleasing to note the work being undertaken by the Trust to promote a safety culture in the organisation where the reporting of incidents, errors and near misses is encouraged. However it has been disappointing to note during 2017/18 that many of the Trust's Serious Incident reports do not identify root causes or contributory factors and it is hoped that the work underway by TEWVFT in reviewing the learning from incidents and the Serious Incident review processes will support this further during 2018/19.

We are encouraged by the Trust's approach and commitment to implementing continued development of the Recovery focussed services. This work has had a harm minimisation focus and the CCGs look forward to these developments being further embedded and enhanced with additional recovery leads and peer support recruitments during the next phase of the project in 2018/19.

The CCGs welcome the specific quality priorities for 2018/19 highlighted in the report and feel that they are appropriate areas to target for continued improvement.

The CCGs can confirm that to the best of their ability, the information provided within the Annual Quality Account is an accurate and fair reflection of the trust's performance for 2017/18. It is clearly presented in the format required and the information it contains accurately represents the Trust's quality profile and is reflective of quality activity and aspirations across the organisation for the forthcoming year.

The CCGs look forward to continuing to work in partnership with the trust to assure the quality of services commissioned in 2018/19.

Yours sincerely

Diane Murphy

Diane Murphy
Director of Nursing and Quality
NHS Darlington Clinical Commissioning Group
(Signed on behalf of NHS North Durham Clinical Commissioning Group)

Mrs Amanda Hume
Chief Officer
NHS South Tees Clinical Commissioning Group

Signed in consultation with:
NHS North Durham CCG
NHS South Tees CCG
NHS Durham Dales, Easington and Sedgefield CCG
NHS Hartlepool and Stockton on Tees CCG
NHS Darlington CCG

Joint North Yorkshire CCGs

NHS
Harrogate and Rural District
Clinical Commissioning Group

Email: j.crewe@nhs.net
Direct Tel: 01423 799334
Reference: HaRD.047-18

Harrogate and Rural District
Clinical Commissioning Group
1 Grimbald Crag Court
St James Business Park
Knaresborough
HG5 8QB

LETTER SENT VIA EMAIL

Sharon Pickering
Director of Planning, Performance and Communications
Tees, Esk and Wear Valleys NHS Foundation Trust

Tel: 01423 799300
Fax: 01423 799301
Email: hardccg.enquiries@nhs.net
Web: www.harrogateandruraldistrictccg.nhs.uk

17 May 2018

Dear Sharon

Quality Account for Tees, Esk and Wear Valley Trust for 2017-18.

Harrogate and Rural District Clinical Commissioning Group (HaRDCCG) welcomes the opportunity to review and provide a statement for the Trust's Quality Account for 2017/18. This Quality Account has been reviewed in accordance with the Department of Health and Social Care (Quality Accounts) Amendment Regulations 2017.

This report has been shared with key individuals across HaRDCCG and other CCGs in North Yorkshire and their views have been collated into my response.

The CCGs in North Yorkshire remain committed to ensuring, with its partner organisations, that the services it commissions provide the highest of standards in respect to clinical quality, safety and patient experience.

It is recognised by Commissioners that the Trust and its staff, demonstrate resilience and dedication to ensure they deliver safe and effective services, as referenced throughout the Quality Account and we congratulate the Trust in consistently maintaining improvements in:

- Its priority to reduce the number of preventable deaths, and continuing to build on the lessons learnt from the reviews of deaths. It would be helpful, to describe how learning from all deaths and those falling into the LeDeR process is captured.

- Participation in research with an increase in the total number

recruited to clinical trials, along with the commitment to establish a strong patient perspective to research. It would be helpful to see some examples of how the research project findings link to quality improvements, and what benefit is anticipated from the 15 new Involvement Peer roles.

- The review of existing Children and Young People's Services (CYPS) as a pilot in Durham and Redcar, to make them more Learning Disability compatible. It would be helpful, to see learning and interventions from the pilot being introduced into the services provided in North Yorkshire.

- The Trusts strategic approach to recovery and wellbeing which will ensure all systems and processes remain recovery focused.

- The number of national and local audits being carried out in the Trust is commendable, and it would be helpful to see more information with a focus on the measurable improvement as a result of the audit recommendations and actions.

We recognise the work undertaken by the Trust, to improve the quality of patient care and patient experience through the 2017/18 CQUIN schemes, and it is helpful to see the results and the expected impact of these schemes in the quality account.

The Trust reported the progress on improving learning from incidents, and we were pleased to read about the number of measures which have been put in place to improve reporting of incidents. We would have expected more emphasis and progress on learning the lessons from incidents or complaints, and how these have informed changes in practice and how actions will be monitored across the Trust.

The Trust reported a similar number of serious incidents causing severe harm or death as reported in 2016/17. We would have liked to see more reference to timeliness of completed incident investigation, and the learning from these included in the narrative of the Quality Account.

The Trust has experienced some challenges as referenced in their Quality Account, due to specialist inpatient care demand and therefore performance against the 'Inappropriate out of area placements for adult mental health services' indicator. The CCG has agreed a trajectory to improve performance, and we will, work with the Trust to support achievement of its actions and improve performance.

Alongside improving performance, on out of area placements, the CCGs would also like to see the Trusts continued commitment and involvement in the system wide workstreams to support reducing delayed transfers of care. Whilst we recognise the complexity of needs of many patients, and potential delays in accessing suitable placements as a contributing factor, we would wish to see significant progress in reducing inpatient length of stay for those patients who are medically fit for discharge.

Partnership working is evident throughout the report, and some good examples of where improvements have been made to support patients, and their carers. Of

particular note, should be the work in improving the clinical effectiveness and patient experience in times of transition from Child to Adult services. This work demonstrates the improvement in information sharing, with family and carers. It will have a further positive impact on the patient and relatives' experience, and we recognise this remains a quality priority for 2018/19.

The Trust appears to have a real commitment through this report to patient/service user involvement. This is really evident in how the Trust are implementing their overarching strategy, around hearing the voice of service users, this will be further strengthened by the 2018/19 priority of Making our Care Plans more personal - where there will be a refreshed approach to 'Personalisation' and therefore a positive and sustainable impact on improving the experience of service users and carers.

On another positive note, the Trust should be congratulated on their results from the National Community Services Survey 2017. We look forward to the Trust's continued progress during 2018/19 particularly in the areas set by the Trust as priority areas for improvement.

We acknowledge the work undertaken by the Trust to improve safe staffing as a priority for 2017/18. We also note reference to the expected outcomes for improvement; however we would have expected to see evidence of the impact, and more detail about the differences made by the interventions, described or reference to the plan, developed by the Trust to support this ongoing work as this remains a key national area of concern.

The North Yorkshire CCGs were pleased to read about the Trusts refreshed quality strategy, and quality performance metrics, and would like to see these and the regular reporting of progress against the Trusts 2018/19 quality priorities, as a clear focus within the CCG/TEWV monthly Quality and Safety meetings.

The key successes of the 2017/18 quality priorities are clearly reflected in the Quality Account. We welcome the opportunity to review progress on the Trust's quality improvements, and hope that our feedback is accepted as a fair reflection of the report, and look forward to working alongside the Trust to achieve the objectives of the 2018/19 priorities.

Yours sincerely

Joanne Crewe
Director of Quality and Governance/Executive Nurse
Harrogate and Rural District Clinical Commissioning Group

Cc: Colin Martin, Chief Executive, TEWV
Elizabeth Moody, Director of Nursing & Governance, TEWV
Phillip Darvill, Planning and Business Development Manager, TEWV

North Yorkshire Scrutiny of Health Committee

County Councillor Jim Clark (Chairman)
North Yorkshire Scrutiny of Health Committee
c/o Overview and Scrutiny
North Yorkshire County Council
Room 39, Brierley Block
County Hall, Northallerton
North Yorkshire, DL7 8AD
17 May 2018

Dear Sir/Madam

Re: Quality Account 2017/18

Over the past 12 months, the North Yorkshire Scrutiny of Health Committee has continued to liaise with the Tees, Esk and Wear Valleys NHS Foundation Trust to better understand some of the pressures that they face.

Throughout 2017/18 the Scrutiny of Health Committee has been heavily involved in the formal scrutiny of proposed changes to mental health commissioning and provision in the county, particularly in-patient treatment and the development of community services in rural areas of the county. The committee has also looked into what breadth and depth of services it is reasonable to expect to have in place in the county, when compared to similar areas. The trust has been highly supportive of this scrutiny work. The information, data and analysis provided has helped the committee to appreciate the issues across the whole system and the support of the trust has been much appreciated.

It is recognised that the rural nature of the county and the length of time that it can take to travel to and from appointments can have an impact upon how services are planned and delivered. The committee, however, remains committed to ensuring that people are not excluded from services based upon where they live. The presumption is that you should be able to access the same type and quality of care no matter where you live in North Yorkshire.

The current financial pressures within the health system in North Yorkshire are of great concern. Whilst there are doubts as to whether the funding formula for health and mental health is fair and concerns that it disadvantages rural areas, we need to work together to find a way to make the money that we have work the hardest and result in good outcomes across the health and social care system.

The Scrutiny of Health Committee remains committed to a system-wide view of services that helps to ensure that decisions on the commissioning, planning and

delivery of mental health care are not made in isolation and that the key role that a broad base of community services have to play is not overlooked. This will not be easy going forward as the health commissioners and providers in the county are pulled in three different directions as the new NHS integrated systems for planning and delivery in the West, South and North of the county are put in place.

Yours faithfully

County Councillor Jim Clark
Chairman of the North Yorkshire Scrutiny of Health Committee

Tees Valley Joint Health Scrutiny Committee

Sharon Pickering
Director of Planning, Performance and Communications
Tees Esk and Wear Valleys NHS Foundation Trust
Tarncroft
Lanchester Road Hospital
Durham
DH1 5RD

sharon.pickering1@nhs.net

11 May 2018

Dear Sharon

The Tees Valley Joint Health Scrutiny has prepared the following statement for inclusion within the Quality Account 2017/18 for the Tees, Esk and Wear Valley (TEWV) NHS Foundation Trust

Progress Against Quality Priorities 2017/18

Representatives from TEWV attended a meeting of the Tees Valley Health Joint Scrutiny Committee on 18 April 2018. The Committee was advised that TEWV had produced a Quality Account which covered Mental Health and Learning Disability Services for County Durham, York and most of North Yorkshire, as well as the five Tees Valley Boroughs. Locally specific data had been drawn from the full report for the benefit of the Joint Committee.

Within the 2016/17 Quality Account the Trust had agreed the following five Quality Priorities for 2017/18:-

(a) Implementation of Phase Two of the Recovery Strategy;

(b) Ensure safe staffing in all services;

(c) Improve clinical effectiveness and patient experience in times of transition from Child to Adult Services;

(d) Reduce the number of preventable deaths; and

(e) Reduce the occurrences of serious harm resulting from inpatient falls

The Committee was advised two out of the 37 actions within those five priorities had not been completed by 31 March. The first red action related to the training element of Preventable Deaths. It was reported that although the training had been completed data system issues had prevented real time compliance figures being made available.

The second red action related to completion of an evaluation report within the Transitions Monitoring. It was reported that the Trust's target of 31 March had not been met because the other actions needed to be completed before the evaluation took place.

Hartlepool Borough Council's Audit and Governance Committee were of the view that learning from deaths was a significant issue particularly around men's mental health and Hartlepool's suicides statistics were poor, both of which were areas that required continued improvement.

In terms of the Quality Metrics six of the ten were reported as red and three green at the end of March 2018 (full year). The six red Quality Metrics were as follows:-

1. Percentage of Patients reported 'yes always' to the question, 'do you feel safe on the ward'

It was advised that TEWV's position for the period April 2017 to the end of March 2018 was 62.13 per cent, which related to 2290 out of 3,7674 surveyed. This was 25.67 percentage points below the Trust target of 88 per cent. All localities underperformed this year with Durham and Darlington being closest to the target. It was emphasised that one of the most frequently cited reasons for not feeling safe was 'other patients' and that the Trust's Patient Safety Group was undertaking a 'deep dive' to better understand the data and develop an Action Plan to resolve the issues highlighted.

2. Number of Incidents of Physical Intervention/restraint per 1000 occupied bed days

TEWV's end of year position was 30.65 which related to 8,492 incidents out of 277,030 occupied bed days resulting in 11.40 above the target of 19.25. Scrutiny was advised that a small number of patients account for a high proportion of the restraints recorded and that some of the recorded instances of restraint were relatively minor – for example a hand on a shoulder or a guiding hand towards a dining area is classed as a restraint.

3. Average length of stay for patients in both Adult Mental Health and Mental Health Services for Older People Assessment and Treatment Wards

TEWV's position for the period April 2017 to the end of March 2018 in Mental Health Services for Older People was 69.47 days which is 17.47 worse than the target of <52 but an improvement compared to the position reported in 2016/17. The median

length of stay was 54 days. Scrutiny was informed that a number of factors impacted on achieving this target including complexity of patient's needs and delays in accessing suitable placement for patients subsequent to discharge. Members acknowledged that MHSOP were reliant on Social Care provision and Care Home Capacity, both Residential and Nursing Home, which could slow the process down and that there were some difficulties around several providers.

4. Percentage of patients who reported their overall experience as excellent or good

The end of year position for the period April 2017 to the end of March 2018 was 90.50 per cent which related to 13,772 out of 15,218 surveyed. Although it was reported that nine out of ten patients had a good experience this was 3.95 percentage points below the Trust's target of 94.00 per cent.

5. Percentage of patients that report that staff had treated them with dignity and respect

The end of year position for the period April 2017 to the end of March 2018 was 85.94 per cent which related to 14,567 out of 16,950 surveyed. It was reported that this figure equated to 17 out of 20 people which was 8.06 per cent below the Trust target of 94 per cent. Members noted that the Trust were striving to improve on this target.

6. Percentage of patients that would recommend the service to friends and family if they needed similar care or treatment

The end of year position for the period April 2017 to the end of March 2018 was 87.22 per cent which related to 12,424 out of 14,244 surveyed. It was reported that this was 6.78 per cent below the Trust's target of 94.00 per cent and that all localities had underperformed.

Scrutiny Committee established that the current CQC rating of The Trust was good and that an inspection was due in the near future. The Trust is committed to working alongside Inspectors to demonstrate its competencies and, in doing so, hoped that it had made enough progress to ensure the CQC were now satisfied with the services of York which had received a poor rating prior to becoming under the responsibility of TEWV Foundation Trust. Members were keen to know the result of the Inspection which was expected in Autumn.

Whilst Scrutiny Committee did have concerns over staffing levels within The Trust and the impact on service provision, reassurances were provided by the TEWV representative that staff planning addressed this issue. The recruitment and retention pathways were being explored and staffing levels reported on a weekly basis to determine where the need was. Scrutiny welcomed the new medical school due to open in Sunderland and hoped it would encourage students from the north east to remain in the area post-graduation. Due to more people seeking help there was increased demand on mental health services in some areas. Scrutiny Committee welcomed the increased staff training whilst recognising that some staff were near retirement age and the increased demand on mental health services.

Scrutiny Committee recommended a metric for staff and staff surveys be included within the Trust's future Quality Accounts.

Whilst noting there was no financial information within the Quality Accounts, Scrutiny Committee was pleased to learn that TEWV was performing well and no deficit had been reported although each year became more challenging due to increased demand on services.

TEWV have continued to engage with the Tees Valley Joint Health Scrutiny Committee throughout the 2017/18 Municipal Year and Members have welcomed the information that is shared with them.

Yours sincerely

Councillor Wendy Newall
Chair, Tees Valley Joint Health Scrutiny Committee

Vale of York CCG

NHS
Vale of York
Clinical Commissioning Group

West Offices

Station Rise

York

YO1 6GA
Tel: 01904 555870

RNID typetalk: prefix-18001

Email: valeofyork.contactus@nhs.net

Website: www.valeofyorkccg.nhs.uk

13 May 2018

Dear Colin

On behalf of NHS Vale of York Clinical Commissioning Group (the CCG) I am pleased to provide a response to TEWV Quality Account 2017/18.

In line with your quality priorities it is particularly important to recognise the achievement in:

- The 24/7 learning disability access centre
- Increased resources for positive behavioural support and
- Good progress towards the building of the new mental health hospital in York.

Over the past year the CCG have been welcomed to undertake a variety of clinical quality visits to meet staff and patients and observe service delivery in action and continue to work with you going forward to ensure safe effective services.

NHS
Vale of York
Clinical Commissioning Group

We want to recognise key achievements in:

1. The positive improvement in preventable deaths during periods of leave
2. The significant increase in staff uptake of flu vaccination
3. The support of Consultant Psychiatrist Perinatal Mental Health (PNMH) bid and specialist placement with contribution resulting in successful bid submission to develop PNMH services
4. The reduction in inpatient falls identified as a priority and
5. Increased commissioner reengagement with Serious Incident process

It is good to see that reducing preventable deaths and improving clinical effectiveness and patient experience in times of transition from child to adult remain a priority for this coming year.

We appreciate the increased focus on improving access to services especially in Children's Mental Health (CAMHs) that you have engaged with us on and although not featured as a key priority in this Quality Account, we are working together to ensure improvements are made.

Although TEWV did not achieve all of the CQUIN for 2017/18 we have agreed to reinvest the money in key services of CAMHs and IAPT to support improvement in this area.

Performance against some other quality indicators we recognise are not yet reaching the high standard you aspire to e.g. patients treated with dignity and respect on Mental Health Older People's wards – current figure of 85.9% against a trajectory of 95% by 2021, patients who would recommend your service to family and friends – current figure 87.2% against 95% by 2021, and it is good to see a detailed plan for achievement and a governance process which supports this.

We would want to recognise the progress made and the relationships which focus around identifying with commissioners the areas of greatest risk and a focus on the action planning around these. We would wish to reiterate and support the work needed to be undertaken on the data flows around these services.

As the CCG develops its placed based plans for out of hospital provision working with all key partners, we would wish to encourage active participation and engagement with our locality developments and for TEWV to harness their relationships and clinical expertise around these for the benefit of our population.

NHS Vale of York Clinical Commissioning Group

Clinical Chair : Dr Nigel Wells **Accountable Officer** : Phil Mettam

NHS
Vale of York
Clinical Commissioning Group

NHS Vale of York CCG commend the work of the trust in 2017/18, are satisfied with the accuracy of the Quality Account and look forward to working collaboratively with you in 2018/19.

Yours sincerely

Michelle Carrington

Executive Director of Quality and Nursing

The External Auditor's Report and Opinion

To be inserted

The accounts 2017/18
(subject of audit)

The accounts are prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

Colin Martin
Chief Executive

22nd March 2018

Statement of Comprehensive Income for 12 months ended 31 March 2018

	Note	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
Revenue			
Operating income from patient care activities	2	326,538	318,450
Other operating income	2	23,811	27,438
Total operating income from continuing operations		**350,349**	**345,888**
Operating expenses of continuing operations	3	(366,629)	(318,092)
Operating Surplus / (deficit)		**(16,280)**	**27,796**
Finance costs			
Finance income	8	165	163
Finance expense - financial liabilities	9	(5,411)	(5,354)
PDC dividends payable		(2,916)	(3,368)
Net Finance Costs		**(8,162)**	**(8,559)**
Other gains/(losses)	10	4	(15)
Surplus / (Deficit) from continuing operations		**(24,438)**	**19,222**
Other comprehensive income			
Will not be reclassified to income and expenditure			
Impairments		(9,905)	(983)
Revaluations		655	1,500
Other recognised gains and losses		0	(27)
Total comprehensive income / (expense) for the year		**(33,688)**	**19,712**

Statement of Financial Position as at 31 March 2018

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	11	700	0
Property, plant and equipment	12	170,694	212,320
Investments in joint ventures and associates	16	125	125
Other investments / financial assets	20	50	420
Trade and other receivables	22	42	45
Total non-current assets		**171,611**	**212,910**
Current assets			
Inventories	21	221	205
Trade and other receivables	22	19,275	16,726
Other investments / financial assets	20	420	80
Non-current assets for sale and assets in disposal groups	18	350	0
Cash and cash equivalents	25	58,415	57,845
Total current assets		**78,681**	**74,856**
Current liabilities			
Trade and other payables	26	(25,978)	(24,612)
Borrowings	27	(5,343)	(5,469)
Provisions	30	(580)	(591)
Other liabilities	28	(660)	(225)
Total current liabilities		**(32,561)**	**(30,897)**
Total assets less current liabilities		**217,731**	**256,869**
Non-current liabilities			
Borrowings	27	(75,369)	(80,712)
Provisions	30	(2,646)	(2,753)
Total non-current liabilities		**(78,015)**	**(83,465)**
Total assets employed		**139,716**	**173,404**
Financed by taxpayers' equity			
Public dividend capital		145,053	145,053
Revaluation reserve	32	9,908	19,158
Income and expenditure reserve		(15,245)	9,193
Total taxpayers' equity		**139,716**	**173,404**

The notes 1-43 form part of these financial statements.

The financial statements were approved by the Board and signed on its behalf by:

Signed: ……(Chief Executive) Date:

Statement of Changes in Taxpayers' Equity

	Total	Public Dividend Capital (PDC)	Revaluation Reserve	Statement of Comprehensive Income Reserve
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**173,404**	**145,053**	**19,158**	**9,193**
Deficit for the year	**(24,438)**	0	0	(24,438)
Net impairments	**(9,905)**	0	(9,905)	0
Revaluations - property, plant and equipment	**655**	0	655	0
Taxpayers' Equity at 31 March 2018	**139,716**	**145,053**	**9,908**	**(15,245)**

Taxpayers' and other' equity at 1 April 2016	**153,692**	**145,053**	**18,641**	**(10,002)**
Surplus for the year	**19,222**	0	0	19,222
Net impairments	**(983)**	0	(983)	0
Revaluations - property, plant and equipment	**1,500**	0	1,500	0
Other recognised gains and losses	**(27)**	0	0	(27)
Taxpayers' Equity at 31 March 2017	**173,404**	**145,053**	**19,158**	**9,193**

Statement of Cash Flows for 12 months ended 31 March 2018

	Note	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
Cash flows from operating activities			
Operating surplus/(deficit) from continuing operations		(16,280)	27,796
Operating surplus/(deficit)		**(16,280)**	**27,796**
Non-cash income and expense:			
Depreciation and amortisation	3	3,489	3,873
Impairments and reversals	3	41,238	3,184
Increase in trade and other receivables		(1,563)	(9,733)
Increase in other assets		0	(500)
Increase in inventories		(16)	(24)
Increase/(decrease) in trade and other payables		(342)	1,331
Increase/(decrease) in other liabilities		435	(74)
Increase/(decrease) in provisions		(121)	1,583
Net cash generated from operations		**26,840**	**27,436**
Cash flows from investing activities			
Interest received		165	163
Purchase of financial assets		(50)	0
Proceeds from settlements of financial assets		80	0
Purchase of property, plant and equipment and investment property		(11,795)	(9,592)
Proceeds from sales of property, plant and equipment and investment property		6	85
Cash movement from acquisitions of business units and subsidiaries		0	(45)
Net cash used in investing activities		**(11,594)**	**(9,389)**
Cash flows from financing activities			
Movement in loans from the Department of Health and Social Care		(3,000)	(3,000)
Capital element of PFI, LIFT and other service concession payments		(2,469)	(2,429)
Interest paid		(111)	(152)
Interest element of PFI, LIFT and other service concession obligations		(5,308)	(5,222)
PDC dividend (paid)		(3,788)	(3,547)
Net cash used in financing activities		**(14,676)**	**(14,350)**
Increase in cash and cash equivalents	25	**570**	**3,697**
Cash and cash equivalents at 1 April - Brought Forward	25	**57,845**	**54,148**
Cash and cash equivalents at 31 March	25	**58,415**	**57,845**

Notes to the Accounts

Note 1. Accounting Policies

NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the DH Group Accounting Manual, which has been agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2017-18 DH Group Accounting Manual issued by NHS Improvement. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

The financial statements have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Accounting standards issued that have been adopted early

The following standards and updates have been published by the International Accounting Standards Board as adopted but are not required to be followed until after the current reporting period.

IFRS 9	Financial instruments
IFRS 14	Regulatory deferral accounts
IFRS 15	Revenue from contracts with customers
IFRS 16	Leases
IFRS 17	Insurance Contracts
IFRIC 22	Foreign Currency Transactions and Advance Consideration
IFRIC 23	Uncertainty over Income Tax Treatments

The Trust does not anticipate these changes in accounting standards to have a material impact on the 2018/19 accounts.

Critical accounting judgements and key sources of estimation uncertainty

These are methods adopted by the Trust to arrive at monetary amounts, corresponding to the measurement basis selected for assets, liabilities, gains, losses and charges to the Reserves. Where the basis of measurement for the amount to be recognised under Accounting Policies is uncertain, an estimation technique is applied.

The Trust has identified the valuation of the Trust estate and the valuation of Provisions as critical accounting judgements and key sources of uncertainty. Cushman and Wakefield Inc. provide third party assurance of the value of the estate completing a full modern equivalent valuation exercise every 3 years. Provisions are, in the main, injury benefits provisions which are valued using actuarial tables.

The Trust has not consolidated its charitable fund within the main accounts on the grounds of materiality as per guidance within the group accounting manual. The Trust has not consolidated its subsidiaries for the provision of Positive Individual Proactive Support (PIPS) services, and TEWV Estates and Facilities Management (TEWV EFM) services within the main accounts on the grounds of materiality as per guidance within the group accounting manual. The Trust has not consolidated its joint venture for the provision of North East Transformation System services (NETS) within the main accounts on the grounds of materiality as per guidance within the group accounting manual.

Income recognition

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. Main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Notes to the Accounts

Note 1. Accounting Policies (continued)

Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- an item has a cost of at least £5,000; or
- it forms part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost;
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably.
- the Trust does not capitalise grouped assets.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Depreciated replacement cost has been applied for assets with a short life and/or low values.

Each piece of new equipment has its useful economic life assessed prior to capitalisation; however, the range of useful lives is shown below:

- IT Equipment is depreciated over 5 years
- Furniture and Equipment and other Equipment are depreciated between 5 and 10 years
- Plant aligned to buildings is depreciated between 15 and 30 years

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being fair value at the date of revaluation less subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised Buildings – Depreciated Replacement Cost

In line with HM Treasury guidance with effect from 31 March 2010, Trust owned assets have been valued on modern equivalent asset (MEA) valuations, based on an alternative site valuation where the location meets the requirements of service provision. Owned assets lives were assessed as part of the MEA valuation exercise at 31 March 2010. The MEA value and assessed asset life are the basis for the depreciation charge. The depreciation charge for non-owned assets is based on the capital expenditure being depreciated over the remaining lease license life of the asset.

A full MEA valuation was carried out on the Trusts land and buildings on 31 March 2016, and the assets have been treated as prescribed in the Group Accounting Manual. Accumulated depreciation on these assets has been written to zero, and the cost or valuation at 31 March 2016 amended to the MEA values to reflect this. All of the Trusts MEA valuations have been completed by Cushman and Wakefield Inc. (independent qualified valuer).

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

A non current asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IFRS 5.

All fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Notes to the Accounts

Note 1. Accounting Policies (continued)

Intangible assets

Intangible assets are capitalised when they are capable of being used in a Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis, except capitalised research and development which is revalued using an appropriate index figure. The carrying value of the intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Depreciation, amortisation and impairments

Freehold land and properties under construction are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Donated assets

Donated property, plant and equipment assets are capitalised at their fair value on receipt. The donation is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. The donated assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Legacy Transfers

For property, plant and equipment assets that have been transferred to the Trust from another NHS body, the assets transferred are recognised in the accounts as at the date of transfer. The cost and accumulated depreciation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

Government grants

Government grants are grants from government bodies other than revenue from NHS bodies for the provision of services. Where a grant has been used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Grant income relating to assets is recognised within income when the foundation trust becomes entitled to it, unless the grantor imposes a condition that the future economic benefits embodied in the grant are to be consumed as specified by the grantor and if it is not, the grant must be returned to the grantor, e.g. a grant that is conditional on the construction of an asset.

Non-current assets held for sale

Non-current assets are classified as held for sale when the following conditions are met:

1. The asset is available for immediate sale in its present condition
2. The sale must be highly probable i.e.:
   - -management are committed to a plan to sell the asset
   - -an active programme has begun to find a buyer and to complete the sale
   - -the asset is being actively marketed at a reasonable price
   - -the sale is expected to be completed within 12 months of the date of classification as "Held for Sale"
   - -the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to the statement of comprehensive income reserve. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then transferred to the statement of comprehensive income reserve.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

Notes to the Accounts

Note 1. Accounting Policies (continued)

Private finance initiative (PFI)

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

Notes to the Accounts

Note 1. Accounting Policies (continued)

Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate. The discount rate has changed as follows, resulting in changes to the amount of provision made:

	2017/18	2016/17
Short term (<5 years)	-2.42%	-2.70%
Medium term (5-10 years)	-1.85%	-1.95%
Long term	-1.56%	-0.80%
Pensions rate	0.10%	0.24%

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 30.3.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through income and expenditure; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly/through a provision for impairment of receivables.

A provision for impairment of receivables is recognised upon notification that a debt is unlikely to be settled. The provision reflects amounts that are unlikely to be settled, where this is part of a larger debt only that which is uncertain is provided for.

Financial liabilities

Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Leases

Operating leases are lease agreements where the Trust is not exposed to the risks and rewards of ownership of a leased asset. Rentals are charged to operating expenses on a straight-line basis over the term of the lease.

Corporation tax

Foundation Trusts are exempt from corporation tax on their principle health care income under section 519A Income and Corporation Taxes Act 1988. In determining whether other income may be taxable, a full review of the Trust's activities has been carried out in accordance with guidance published by HM Revenue and Customs to establish any activities that are subject to Corporation Tax. Based on this review there is no corporation tax liability in the period ended 31st March 2018.

Notes to the Accounts

Note 1. Accounting Policies (continued)

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March 2018. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 42 to the accounts.

Public Dividend Capital (PDC) and PDC dividend

Public Dividend Capital represents taxpayers' equity in the NHS Foundation Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as PDC dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and daily average cash balances with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. The dividend payable is based on the average relevant net assets for the year.

Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

Joint operations

Joint operations are activities undertaken by the Trust in conjunction with one or more other parties but which are not performed through a separate entity.

The Trust has entered into a joint operation with Mental Health Matters and County Durham & Darlington NHS Foundation Trust to provide services to improve access to psychological therapies (IAPT services). The Trust is the host organisation and only the Trusts share of the income and expenditure; gains and losses; assets and liabilities; and cash flows are recognised in the accounts. The Trust has not consolidated the joint operation on the grounds of materiality.

The Trust is also Trustee for the "Tees Esk and Wear Valleys NHS Trust General Charitable Fund", the balances of which are not consolidated with the Trusts accounts on the grounds of materiality.

The Trust has two wholly owned subsidiary companies "Positive Individualised Proactive Support Limited", and "TEWV Estates and Facilities Management Limited", however the Trust has not consolidated within the Trust's Accounts on the grounds of materiality.

The Trust is a shareholder in the newly established company "North East Transformational Support Ltd", however the Trust has not consolidated within the Trust's Accounts on the grounds of materiality.

Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

(a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period.

This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes.

The valuation of scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data.

In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.
The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

Notes to the Accounts

Note 1. Accounting Policies (continued)

Pension costs (continued)

(b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

NHS pension scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

Annual Pensions

From 01 April 2015 the 1995 and 2008 final salary based schemes were replaced with a career average scheme. Annual pensions are accrued at a rate of 1/54th of pensionable pay each year of membership. All employees without pension scheme protection ended their 1995 / 2008 scheme and started in the 2015 scheme. Upon retirement employees may get 2 pensions, their 2015 scheme pension and any 1995/2008 scheme pension held.

The 1995 and 2008 schemes are "final salary" schemes. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service. From 01 April 2015 only members with pension scheme protection can continue to accrue additional years in these schemes.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Pensions Indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) replaced the Retail Prices Index (RPI).

Ill-Health Retirement

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Death Benefits

A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Additional Voluntary Contributions (AVCs)

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Transfer between Funds

Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits

Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Auto-Enrolment

To comply with auto-enrolment the Trust has opened a second pension scheme, for employees not eligible to be enrolled in the NHS Pension Scheme. The NHS Scheme will always be the default selection, however employees not eligible for membership are entered into the National Employment Savings Trust (NEST) scheme. This is a defined contribution scheme, and as such the cost to the NHS Body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

Operating segments

The Trust has no elements that require segmental analysis for the period ended 31 March 2018. The chief operating decision maker has been identified as the Executive Director Chief Operating Officer post within the Trust; and on this basis the Trust has identified healthcare as the single operating segment.

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The Trust does not undertake any material income generation activities with an aim of achieving profit.

Note 2.1 Operating income (by classification) **Income from activities**	**12 months ended 31 March 2018 £000**	**12 months ended 31 March 2017 £000**
Cost and volume contract income	50,919	53,053
Block contract income	255,151	250,904
Clinical income for the secondary commissioning of mandatory services	11,388	6,971
Other clinical income from mandatory services	3,438	3,143
Other clinical income	5,642	4,379
Total income from activities	**326,538**	**318,450**
Other operating income		
Research and development	671	558
Education and training	8,483	8,077
Education and training - notional income from apprenticeship fund	49	0
Non patient care services to other bodies	4,879	3,519
Sustainability and transformation fund (STF)	6,599	9,231
Income in respect of employee benefits accounted on a gross basis	153	214
Rental revenue from operating leases	488	568
Other revenue	2,489	5,271
Total other operating income	**23,811**	**27,438**
Total operating income	**350,349**	**345,888**

Note 2.2 Operating lease income

	£000	**£000**
Rental revenue from operating leases	488	568
Future minimum lease receipts		
not later than one year;	488	564
later than one year and not later than five years;	1,164	1,279
later than five years.	9	290
Total future minimum lease receipts	**1,661**	**2,133**

Note 2.3 Non NHS income

The Trust had Non NHS income totalling £10,990k (2016-17, £11,997k).

Note 2.4 Income from Overseas Visitors

The Trust had no income relating to overseas visitors (non-reciprocal, chargeable to the patient) (2016-17 £nil).

Note 2.5 Fees and Charges

The Trust received no income from fees and charges - aggregate of all schemes that, individually, have a cost exceeding £1m (2016-17 £nil).

Note 2.6 Operating income (by type)	12 months ended 31 March 2018 £000	*Restated 12 months ended 31 March 2017 £000
Income from activities		
NHS England	59,438	55,718
Clinical Commissioning Groups	260,265	256,736
NHS Foundation Trusts	1,027	971
NHS Trusts	0	1
Local Authorities	2,936	2,331
NHS other (including Public Health England)	576	549
Non NHS: other	2,296	2,144
Total income from activities	**326,538**	**318,450**
Other operating income		
Research & Development	671	558
Education and training	8,483	8,077
Education and training - notional income from apprenticeship fund	49	0
Non-patient care services to other bodies	4,879	3,519
Sustainability and transformation fund (STF)	6,599	9,231
Income in respect of employee benefits accounted on a gross basis	153	214
Rental revenue from operating leases	488	568
Other	2,489	5,271
Total other operating income	**23,811**	**27,438**
Total operating income	**350,349**	**345,888**

* restated following additional guidance.

Analysis of income from activities - non NHS other

Other government departments and agencies	742	771
Other*	1,554	1,373
	2,296	**2,144**

*Other income is mainly from the Trusts Lifeline Project/Grow, Change, Live contract (£1,019k), (2016-17, £1,304k) and Spectrum Community Health Contract £800k (2016-17 £nil)

Analysis of other operating income - other

Catering	185	141
Other income not already covered*	2,304	5,130
	2,489	**5,271**

*Other income of £2,116k was received from commercial settlement agreements, (2016-17, £4,711k)

Revenue is mainly from the supply of services. Revenue from the sale of goods is not material.

Commissioner requested services

Income from activities from commissioner requested services	327,260	322,581
Income from activities from non-commissioner requested services	23,089	23,307
	350,349	**345,888**

Note 3 Operating expenses (by type)	12 months ended 31 March 2018	*Restated 12 months ended 31 March 2017
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,711	2,040
Purchase of healthcare from non-NHS and non-DHSC bodies	7,090	6,723
Staff and executive directors costs	252,881	242,923
Non-executive directors	158	157
Supplies and services – clinical (excluding drugs costs)	2,074	3,025
Supplies and services - general	6,432	7,494
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	4,013	3,635
Consultancy**	496	684
Establishment	3,620	4,109
Premises - business rates collected by local authorities	1,491	1,480
Premises - other	12,626	13,389
Transport (business travel only)	3,320	3,192
Transport - other (including patient travel)	1,423	1,394
Depreciation	3,489	3,873
Impairments net of (reversals)	41,238	3,184
Increase in impairment of receivables	4,393	388
Provisions arising in year	213	190
Change in provisions discount rate	91	674
Audit services - statutory audit	40	40
Other auditor remuneration (payable to external auditor only)	12	16
Internal audit - non-staff	223	220
Clinical negligence - amounts payable to NHS Resolution (premium)	1,178	1,162
Legal fees**	1,458	1,075
Insurance	36	97
Research and development - staff costs	631	509
Research and development - non-staff	74	149
Education and training - staff costs	1,503	1,476
Education and training - non-staff	1,412	1,549
Education and training - notional expenditure funded from apprenticeship fund	49	0
Operating lease expenditure (net)	8,481	8,187
Redundancy costs - non-staff	23	368
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	2,582	2,427
Car parking and security	0	143
Hospitality	121	111
Other losses and special payments - non-staff	198	1,252
Other	849	757
Total operating expenses	**366,629**	**318,092**

* restated following additional guidance.

**consultancy and legal expenditure includes expenditure related to the commercial settlement detailed in note 2.6

Analysis of operating expenses - other

Services from local authorities	23	23
Other patients' expenses	155	213
National offender health services	198	146
CQC and accreditation fees	246	166
Miscellaneous	227	209
	849	**757**

Note 4.1 Employee expenses

	12 months ended 31 March 2018			* Restated 12 months ended 31 March 2017		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	205,586	197,516	8,070	198,641	190,858	7,783
Social security costs	17,507	16,802	705	16,541	15,843	698
Apprenticeship levy	981	942	39	0	0	0
Pension cost - employer contributions to NHS pension scheme	24,416	23,375	1,041	24,170	23,192	978
Pension Cost - other contributions	17	17	0	15	15	0
Temporary staff - agency/contract staff	6,775	0	6,775	5,780	0	5,780
Gross employee expenses	**255,282**	**238,652**	**16,630**	**245,147**	**229,908**	**15,239**
Recoveries from other bodies in respect of staff cost netted off expenditure	0	0	0	(11)	(11)	0
Total employee expenses	**255,282**	**238,652**	**16,630**	**245,136**	**229,897**	**15,239**
of which:						
Costs capitalised as part of assets	267	267	0	228	228	0
Analysed into Operating Expenditure (page 14):						
Employee expenses - staff & executive directors	252,881	236,366	16,515	242,923	227,753	15,170
Research & development	631	516	115	509	440	69
Education and training	1,503	1,503	0	1,476	1,476	0
Total employee expenses excluding capitalised costs	**255,015**	**238,385**	**16,630**	**244,908**	**229,669**	**15,239**

The salary costs of the capital development team are capitalised over the full costs of the Trust's capital schemes, of which in 2017-18 the largest scheme was an inpatient unit in York.

Note 4.2 Average number of employees (WTE Basis)

	12 months ended 31 March 2018			* Restated 12 months ended 31 March 2017		
	Total Number	Permanently Employed Number	Other Number	Total Number	Permanently Employed Number	Other Number
Medical and dental	338	296	42	352	311	41
Administration and estates	1,170	1,108	63	1,204	1,095	109
Healthcare assistants and other support staff	319	307	12	308	295	13
Nursing, midwifery and health visiting staff	3,892	3,484	408	3,776	3,458	318
Scientific, therapeutic and technical staff	788	726	63	729	699	30
Healthcare science staff	2	2	0	10	10	0
Social care staff	8	0	8	24	0	24
Total	**6,517**	**5,922**	**595**	**6,403**	**5,868**	**535**
of which						
Number of Employees (WTE) engaged on capital projects	5	5	0	6	6	0

* restated following additional guidance.

Note 4.3 Early retirements due to ill health

During the period to 31 March 2018 there were 11 (2016-17, 11) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of the ill-health retirement will be £678,470 (2016-17, £927,379). The cost of this ill-health retirement will be borne by the NHS Business Services Authority - Pension Division.

Note 4.4 Analysis of termination benefits

There was 1 payment for termination benefits valuing £23,000 during the period to March 2018, relating to redundancy (2016-17, 11 payments valuing £368,000).

Note 4.5 Cost of exit packages

	12 months ended 31 March 2018			12 months ended 31 March 2017		
Exit Package Cost	Total number	Compulsory Redundancies number	Other Departures number	Total number	Compulsory Redundancies number	Other Departures number
<10,000	0	0	0	1	1	0
£10,001 - £25,000	1	1	0	4	4	0
£25,001 - £50,000	0	0	0	5	5	0
£50,001 - £100,000	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	1	1	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,001	0	0	0	0	0	0
Total number of exit packages	**1**	**1**	**0**	**11**	**11**	**0**
Total resource cost (£000's)	**23**	23	0	**368**	368	0

Note 4.6 Exit packages: other non compulsory

There were no other non compulsory exit packages between 01 April 2017 and 31 March 2018, (2016-17, nil)

Note 5.1 Operating leases	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
Minimum lease payments	8,481	8,187
Total	**8,481**	**8,187**

Note 5.2 Arrangements containing an operating lease	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
Future minimum lease payments due:		
not later than one year	7,441	7,169
later than one year and not later than five years	7,840	5,982
later than five years	8,920	5,333
Total	**24,201**	**18,484**

The Trust operating leases includes leased vehicles for staff, property rental and telephony rental.

Note 5.3 Limitation on auditor's liability

There is no specified limitation stated in the engagement letter of the Trust's auditors (no specified limitation 2016-17).

Note 5.4 The late payment of commercial debts (interest) Act 1998

The Trust did not pay any interest payable arising from claims or pay compensation to cover debt recovery costs under this legislation (2016-17, £nil).

Note 5.5 Other audit remuneration

The Trust paid it's external auditors additional remuneration totalling £12k for the period to 31 March 2018, £4k in respect of the delivery of workshops on developing approaches to learning from deaths and £8k for work on the Quality Report (31 March 2017, £16k). Auditors remuneration for statutory audit is shown in note 3.

Note 6 Discontinued operations

The Trust has no discontinued operations at 31 March 2018 (31 March 2017, £nil).

Note 7 Corporation tax

The Trust has no Corporation Tax liability or asset at 31 March 2018 (31 March 2017, £nil).

Note 8 Finance income	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
Interest on bank accounts	165	163
Total	**165**	**163**

Note 9 Finance costs	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
Interest expense:		
Interest on loans from the Department of Health and Social Care:		
- Capital loans	100	127
Finance costs in PFI obligations:		
- Main finance costs	3,763	3,884
- Contingent finance costs	1,545	1,338
Total interest expense	**5,408**	**5,349**
Unwinding of discount on provisions	3	5
Total	**5,411**	**5,354**

Note 10.1 Gains / (losses) on disposal of assets	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
Gains on disposal of property, plant and equipment	4	2
Losses on disposal of assets held for sale	0	(17)
Total other gains/(losses)	**4**	**(15)**

Note 10.2 Impairment of assets	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
Over specification of assets	0	1,930
Changes in market price	43,211	3,185
Reversal of impairments	(1,973)	(1,931)
Total impairments and (reversals) charged to operating surplus	**41,238**	**3,184**
Impairments charged to the revaluation reserve	9,905	983
Total impairments and (reversals)	**51,143**	**4,167**

The Trust realised an impairment totalling £50.8m following confirmation of rectification works required on one of its PFI sites.

Note 11 Intangible assets

The Trust's intangible assets are licenses for a software system that are to be held in perpetuity. Balance as at 31 March 2018 was £700k (31 March 2017, £nil).

Note 12.1 Property, plant and equipment 2017-18

	Total	Land	Buildings exc. Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	**216,671**	**12,658**	**196,331**	**3,732**	**818**	**84**	**1,701**	**1,347**
Additions - purchased	12,710	0	6,026	6,252	124	0	308	0
Impairments charged to operating expenses	(43,195)	(335)	(42,860)	0	0	0	0	0
Impairments charged to the revaluation reserve	(9,905)	0	(9,905)	0	0	0	0	0
Reversal of impairments credited to operating expenses	1,973	0	1,973	0	0	0	0	0
Revaluations	655	0	655	0	0	0	0	0
Reclassifications	0	0	1,007	(1,007)	0	0	0	0
Transfers to assets held for sale and assets in disposal groups	(375)	(113)	(262)	0	0	0	0	0
Disposals/derecognition	(2,318)	0	(2,301)	0	(17)	0	0	0
Cost or valuation at 31 March 2018	**176,216**	**12,210**	**150,664**	**8,977**	**925**	**84**	**2,009**	**1,347**
Accumulated depreciation at 1 April 2017	**4,351**	**0**	**1,271**	**0**	**465**	**74**	**1,194**	**1,347**
Provided during the year	3,489	0	3,232	0	73	5	179	0
Transfers to/from assets held for sale and assets in disposal groups	(9)	0	(9)	0	0	0	0	0
Disposals/derecognition	(2,309)	0	(2,301)	0	(8)	0	0	0
Accumulated depreciation at 31 March 2018	**5,522**	**0**	**2,193**	**0**	**530**	**79**	**1,373**	**1,347**

* Derecognition of valuation and accumulated depreciation of buildings is due to a modern equivalent asset valuation.

Note 12.2 Property, plant and equipment 2016-17

	Total	Land	Buildings exc. Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	**213,315**	**12,771**	**195,758**	**1,305**	**662**	**84**	**1,388**	**1,347**
Additions - purchased	8,572	0	4,758	3,345	156	0	313	0
Impairments charged to operating expenses	(5,115)	(113)	(5,002)	0	0	0	0	0
Impairments charged to the revaluation reserve	(983)	0	(983)	0	0	0	0	0
Reversal of impairments credited to operating expenses	1,931	0	1,931	0	0	0	0	0
Revaluations	1,500	0	1,500	0	0	0	0	0
Reclassifications	0	0	918	(918)	0	0	0	0
Transfers to/from assets held for sale and assets in disposal groups	(100)	0	(100)	0	0	0	0	0
Disposals/derecognition	(2,449)	0	(2,449)	0	0	0	0	0
Valuation/gross cost at 31 March 2017	**216,671**	**12,658**	**196,331**	**3,732**	**818**	**84**	**1,701**	**1,347**
Accumulated depreciation at 1 April 2016	**2,927**	**0**	**0**	**0**	**421**	**62**	**1,097**	**1,347**
Provided during the year	3,873	0	3,720	0	44	12	97	0
Disposals / derecognition*	(2,449)	0	(2,449)	0	0	0	0	0
Accumulated depreciation at 31 March 2017	**4,351**	**0**	**1,271**	**0**	**465**	**74**	**1,194**	**1,347**

* Derecognition of valuation and accumulated depreciation is due to a modern equivalent asset valuation.

Note 12.3 Property, plant and equipment financing

Net book value - 31 March 2018	Total	Land	Buildings exc. Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	129,559	12,210	107,336	8,977	395	5	636	0
On-SoFP PFI contracts and other service concession arrangements	41,135		41,135	0	0	0	0	0
Net book value total at 31 March 2018	**170,694**	**12,210**	**148,471**	**8,977**	**395**	**5**	**636**	**0**
Net book value - 31 March 2017								
Owned - purchased	125,029	12,658	107,769	3,732	353	10	507	0
On-SoFP PFI contracts and other service concession arrangements	87,291	0	87,291	0	0	0	0	0
Net book value total at 31 March 2017	**212,320**	**12,658**	**195,060**	**3,732**	**353**	**10**	**507**	**0**

Note 13 Non current assets acquired by government grant

The Trust has no assets acquired by government grant (2016-17, nil).

Note 14 Economic life of property, plant and equipment	Min Life Years	Max Life Years
Buildings excluding dwellings	1	90
Assets under Construction & POA	10	90
Plant & Machinery	1	10
Transport Equipment	1	7
Information Technology	1	5
Furniture & Fittings	1	10

Note 14.1 Economic life of property, plant and equipment

The Trust's intangible assets are licenses for a software system that are to be held in perpetuity, as such they do not have a maximum life.

Note 15.1 Land and buildings disposed previously used to provide commissioner requested services

The Trust has not disposed of any land or buildings in year.

Note 15.2 NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2018

	Total	Land	Buildings exc. Dwellings
	£000	£000	£000
as at 1 April 2017	**19,158**	1,839	17,319
movement in year	**(9,249)**	0	(9,249)
as at 31 March 2018	**9,909**	**1,839**	**8,070**

Note 15.3 NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2017

	Total	Land	Buildings exc. Dwellings
	£000	£000	£000
as at 1 April 2016	**18,639**	1,864	16,775
movement in year	**519**	(25)	544
as at 31 March 2017	**19,158**	**1,839**	**17,319**

Note 16 Investments

	12 months ended 31 March 2018	12 months ended 31 March 2017
	Total £000	Total £000
as at 1 April	125	80
additions	0	125
disposals	0	(80)
as at 31 March	**125**	**125**

Note 17 Associate and jointly controlled operations

The Trust has no investments in associates or joined controlled operations consolidated in these accounts as at 31 March 2018 (31 March 2017, £nil) on the basis of materiality (as disclosed in note 1).

Note 18.1 Non current assets for sale and assets in disposal groups 2017-18	Total	PPE: Land	Property, Plant & Equipment
	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2017	**0**	0	0
Plus assets classified as available for sale in the year	**366**	113	253
Less impairment of assets held for sale	**(16)**	0	(16)
NBV of non-current assets for sale and assets in disposal groups at 31 March 2018	**350**	**113**	**237**

Note 18.2 Non current assets for sale and assets in disposal groups 2016-17	Total	PPE: Land	Property, Plant & Equipment
	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2016	**0**	0	0
Plus assets classified as available for sale in the year	**100**	0	100
Less assets sold in year	**(100)**	0	(100)
NBV of non-current assets for sale and assets in disposal groups at 31 March 2017	**0**	**0**	**0**

Note 18.3 Liabilities disposal groups
The Trust has no liabilities in disposal groups as at 31 March 2018 (31 March 2017, £nil).

Note 19 Other assets
The Trust has no other assets as at 31 March 2018 (31 March 2017, £nil).

Note 20 Other financial assets

Other financial assets at 31 March 2018 (£470k) relate to a loan provided to Positive Individual Proactive Support (PIPS) services (31 March 2017, £500k).

Note 21.1 Inventories	12 months ended 31 March 2018	12 months ended 31 March 2017
	£000	£000
Carrying Value at 1 April	205	181
Additions	221	205
Inventories consumed (recognised in expenses)	(205)	(181)
Carrying Value at 31 March	**221**	**205**

Note 22 Trade receivables and other receivables

	31 March 2018 £000	*Restated 12 months ended 31 March 2017 £000
Current		
Trade receivables	6,515	3,424
Accrued income	5,014	8,356
Provision for impaired receivables	(4,836)	(443)
Prepayments (revenue) [non-PFI]	3,822	3,043
PFI lifecycle prepayments (capital)	735	624
PDC dividend receivable	937	65
VAT receivable	833	698
Other receivables	6,255	959
Total current trade and other receivables	**19,275**	**16,726**
*restated following additional guidance		
Non Current		
Other receivables	42	45
Total non current trade and other receivables	**42**	**45**

Note 23.1 Provision for impairment of receivables	**31 March 2018 £000**	**31 March 2017 £000**
At 1 April - brought forward	443	86
Increase in provision	4,824	436
Amounts utilised	0	(31)
Unused amounts reversed	(431)	(48)
At 31 March	**4,836**	**443**

Note 23.2 Analysis of impaired receivables	**31 March 2018 £000**	**31 March 2018 £000**	**31 March 2017 £000**	**31 March 2017 £000**
Ageing of impaired receivables	**Trade and other receivables**	**Investments & Other financial assets**	**Trade and other receivables**	**Investments & Other financial assets**
0 - 30 days	1,086	0	49	0
30-60 Days	0	0	0	0
60-90 days	3,116	0	158	0
90- 180 days	25	0	192	0
over 180 days	609	0	44	0
Total	**4,836**	**0**	**443**	**0**
Ageing of non-impaired receivables past their due date				
0 - 30 days	1,995	0	1,223	0
30-60 Days	183	0	228	0
60-90 days	1,002	0	440	0
90- 180 days	69	0	535	0
over 180 days	122	0	266	0
Total	**3,371**	**0**	**2,692**	**0**

Note 24 Finance leases

The Trust does not have any finance lease obligations other than PFI commitments (2016-17, nil).

Note 25.1 Cash and cash equivalents

	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
At 1 April	57,845	54,148
Net change in year	570	3,697
At 31 March	**58,415**	**57,845**
Broken down into:		
Commercial banks and cash in hand	196	60
Cash with Government Banking Service	58,219	57,785
Cash and cash equivalents as in SoFP	**58,415**	**57,845**
Cash and cash equivalents as in SoCF	**58,415**	**57,845**

Note 25.2 Third party assets held

	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
At 1 April	1,437	1,416
Gross inflows	3,092	3,159
Gross Outflows	(3,030)	(3,138)
At 31 March	**1,499**	**1,437**

Note 26.1 Trade and other payables

Current	31 March 2018 £000	* Restated 12 months ended 31 March 2017 £000
Trade Payables	5,299	8,154
Capital payables (including capital accruals)	2,332	606
Accruals	12,262	10,205
Social security costs	2,921	2,833
VAT payable	908	57
Other taxes payable	2,215	2,694
Accrued interest on DHSC loans	36	55
Other Payables	5	8
Total current trade and other payables	**25,978**	**24,612**

*restated following additional guidance

Non current

The Trust has no non current trade and other payables (2016-17 £nil).
The Directors consider that the carrying amount of trade payables approximates to their fair value.

Note 26.2 Early retirements detail included in NHS payables above

There were no early retirement costs in the NHS payables balance at 31 March 2018 (2016-17, £nil).

Note 27 Borrowings	31 March 2018	31 March 2017
Current	**£000**	**£000**
Loans from the Department of Health and Social Care		
Capital loans	3,000	3,000
Obligations under PFI, LIFT or other service concession contracts (excl lifecycle)	2,343	2,469
Total current borrowings	**5,343**	**5,469**
Non current		
Loans from the Department of Health and Social Care		
Capital loans	3,000	6,000
Obligations under PFI, LIFT or other service concession contracts (excl lifecycle)	72,369	74,712
Total other non-current liabilities	**75,369**	**80,712**

PFI borrowings are in relation to Lanchester Road Hospital and Roseberry Park Hospital which all operate under a standard form PFI contract i.e. unitary payments are payable from the date construction completion and are not subject to re-pricing. Inflation linked to RPI is applied annually. Final settlements are expected in May 2038 and March 2040 respectively.

During 2014-15 the Trust received a £15,000k loan repayable over 5 years from the Department of Health, which was used to support the Trust's capital programme.

Note 28 Other liabilities

	31 March 2018	31 March 2017
	£000	**£000**
Current		
Deferred income	660	225
Total other current liabilities	**660**	**225**

Note 29 Other financial liabilities

The Trust has no other financial liabilities at 31 March 2018 (31 March 2017, £nil).

Note 30.1 Provisions for liabilities and charges 2017-18	Total	Pensions- Early departure costs *	Other legal claims **	Redundancy
	£000	£000	£000	£000
At 1 April 2017	**3,344**	**2,904**	**255**	**185**
Change in discount rate	91	91	0	0
Arising during the year	363	65	275	23
Utilised during the year - accruals	(9)	0	(9)	0
Utilised during the year - cash	(416)	(153)	(99)	(164)
Reversed unused	(150)	(112)	(38)	0
Unwinding of discount rate	3	3	0	0
At 31 March 2018	**3,226**	**2,798**	**384**	**44**
Expected timing of cash flows:				
not later than one year	580	152	384	44
Current	**580**	**152**	**384**	**44**
later than one year and not later than five years	605	605	0	0
later than five years	2,041	2,041	0	0
Non Current	**2,646**	**2,646**	**0**	**0**
TOTAL	**3,226**	**2,798**	**384**	**44**

*Pensions - early departure costs relating to other staff is a provision for injury benefit pensions.

**Other legal claims relate to the following; employer / public liability claims notified by the NHS Litigation Authority £303,597 (2016-17, £209,989), and the provision for employment law £80,200 (2016-17, £45,000).

Note 30.2 Provisions for liabilities and charges 2016-17	Total	Pensions- Early departure costs	Other legal claims **	Redundancy
	£000	£000	£000	£000
At 1 April 2016	**1,756**	**1,157**	**431**	**168**
Change in discount rate	674	674	0	0
Arising during the year	1,646	1,239	222	185
Utilised during the year - cash	(520)	(171)	(181)	(168)
Reversed unused	(217)	0	(217)	0
Unwinding of discount rate	5	5	0	0
At 31 March 2017	**3,344**	**2,904**	**255**	**185**
Expected timing of cash flows:				
not later than one year	591	151	255	185
Current	**591**	**151**	**255**	**185**
later than one year and not later than five years	602	602	0	0
later than five years	2,151	2,151	0	0
Non Current	**2,753**	**2,753**	**0**	**0**
TOTAL	**3,344**	**2,904**	**255**	**185**

Note 30.3 Clinical negligence liabilities

£1,351,227 (2016-17, £1,308,490) is included in the provisions of the NHS Litigation Authority at 31 March 2018 in respect of clinical negligence liabilities of the NHS Foundation Trust.

Note 31.1 Contingent liabilities	31 March 2018	31 March 2017
	£000	£000
Gross value of contingent liabilities	(89)	(99)
Net value of contingent liabilities	**(89)**	**(99)**

The contingencies relate to employer liability legal cases, all cases relate to the NHSLA and are due within 1 year.

The Trust has contingent liabilities linked to the legal dispute detailed in note 31.2.

Note 31.2 Contingent assets

The Trust is currently involved in an ongoing contractual legal dispute which may result in future economic benefits relating to past events. Income has been recognised in the financial statements when it meets the criteria detailed in the Group Accounting Manual. The ongoing dispute may result in additional future economic benefits, however these have not been recognised in the financial statements due to uncertainty around the amount of these economic benefits, and because an appeals process is available following the outcome.

Note 32 Revaluation reserve	31 March 2018	31 March 2017
	£000	£000
Revaluation reserve at 1 April	**19,158**	**18,641**
Net impairments	(9,905)	(983)
Revaluations	655	1,500
Revaluation reserve at 31 March	**9,908**	**19,158**

Note 33.1 Related Party Transactions	Income	Expenditure
2017-2018	**£000**	**£000**
Value of transactions with other related parties in 2017-2018		
Non-consolidated subsidiaries and associates / joint ventures	113	73
Other bodies or persons outside of the whole of government accounting boundary	1,019	0
Total	**1,132**	**73**
2016-2017 Restated *		
Value of transactions with other related parties in 2016-2017 Restated *		
Non-consolidated subsidiaries and associates / joint ventures	26	0
Other bodies or persons outside of the whole of government accounting boundary	1,303	0
Total	**1,329**	**0**

Note 33.2 Related Party Balances	Receivables	Payables
2017-2018	**£000**	**£000**
Value of balances with other related parties at 31 March 2018		
Non-consolidated subsidiaries and associates / joint ventures	244	0
Other bodies or persons outside of the whole of government accounting boundary	1,154	36
Value of provisions for doubtful debts held against related parties (excludes salaries)	(255)	0
Total	**1,143**	**36**
2016-2017 Restated *		
Value of balances with other related parties at 31 March 2017		
Non-consolidated subsidiaries and associates / joint ventures	29	0
Other bodies or persons outside of the whole of government accounting boundary	65	55
Total	**94**	**55**

* restated following additional guidance.

During the period none of the Board members or members of the key management staff or parties related to them has undertaken any material transactions with Tees, Esk and Wear Valleys NHS Foundation Trust.

Note 33.3 - Related Party Organisations

Tees, Esk and Wear Valleys NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.

The Department of Health is regarded as a related party. During the period Tees, Esk and Wear Valleys NHS Foundation Trust has had a significant number of material transactions (total transactions greater than £1,000k) with the Department, and with other entities for which the Department is regarded as the parent department, or a related party. These entities are detailed in the table below (income and expenditure totals are for the accounting period, receivables and payables balances are at 31 March 2018):

Entity	Income £000	Expenditure £000	Receivables £000	Payables £000
NHS England - North East Specialised Commissioning Hub	50,523	0	1,982	0
NHS Durham Dales, Easington and Sedgefield CCG	46,951	0	419	0
NHS South Tees CCG	42,485	0	180	0
NHS Vale of York CCG	40,156	0	156	0
NHS North Durham CCG	38,545	0	494	0
NHS Hartlepool and Stockton-on-Tees CCG	33,943	0	5	0
NHS Hambleton, Richmondshire and Whitby CCG	15,478	0	9	0
NHS Harrogate and Rural District CCG	15,103	3	18	0
NHS Scarborough and Ryedale CCG	14,606	0	171	0
NHS Darlington CCG	13,753	0	35	15
Health Education England	8,629	25	444	187
NHS England - Core (including 1718 sustainability & transformation fund)	6,297	6	4,990	19
NHS England - Cumbria and North East Local Office	6,013	0	852	0
NHS Leeds North CCG	1,085	0	1	0
NHS Property Services	248	2,543	93	281
South Tees Hospitals NHS Foundation Trust	92	1,485	38	126
NHS Resolution (formerly NHS Litigation Authority)	0	1,178	0	9
Humber NHS Foundation Trust	0	1,175	0	441
York Teaching Hospital NHS Foundation Trust	159	1,032	34	278
Other DH Group	5,293	4,874	938	506

In addition, the Trust has had a number of material transactions (total transactions greater than £1,000k) with other Government Departments and other central and local Government bodies. These are detailed in the table below:

Entity	Income £000	Expenditure £000	Receivables £000	Payables £000
NHS Pension Scheme	0	24,416	0	3,322
HM Revenue & Customs	0	18,488	0	5,136
Other Government Bodies	4,491	1,240	1,488	1,934

Note 34 Contractual capital commitments	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	1,031	2,644
Total as at 31 March	**1,031**	**2,644**

Note 34.2 Other Financial Commitments
The Trust has no other financial commitments as at 31 March 2018 (31 March 2017, £nil).

Note 35 Finance lease obligations
The Trust has no finance lease obligations as at 31 March 2018 (31 March 2017, £nil).

Note 36.1 On SoFP PFI obligations (finance lease element)	31 March 2018 Total £000	31 March 2018 Lanchester Rd PFI £000	31 March 2018 Roseberry Park PFI £000	31 March 2017 Total £000
Gross PFI liabilities	**182,342**	**36,570**	**145,772**	**187,896**
of which liabilities are due				
not later than one year	7,697	1,356	6,341	7,777
later than one year and not later than five years	33,778	6,780	26,998	32,223
later than five years	140,867	28,434	112,433	147,896
Finance charges allocated to future periods	(107,630)	(22,375)	(85,255)	(110,715)
Net PFI liabilities	**74,712**	**14,195**	**60,517**	**77,181**
not later than one year	2,343	365	1,978	2,469
later than one year and not later than five years	11,521	2,422	9,099	10,672
later than five years	60,848	11,408	49,440	64,040
	74,712	**14,195**	**60,517**	**77,181**

Note 36.2 On SoFP PFI service concession commitments	31 March 2018 Total £000	31 March 2018 Lanchester Rd PFI £000	31 March 2018 Roseberry Park PFI £000	31 March 2017 Total £000
Commitments				
not later than one year	11,335	2,108	9,227	10,934
later than one year and not later than five years	48,252	8,973	39,279	46,552
later than five years	261,394	43,592	217,802	270,894
Total	**320,981**	**54,673**	**266,308**	**328,380**

Note 36.3 On SoFP PFI unitary payments	31 March 2018 Total £000	31 March 2018 Lanchester Rd PFI £000	31 March 2018 Roseberry Park PFI £000	31 March 2017 Total £000
Unitary payment	**10,792**	**2,008**	**8,784**	**10,393**
Consisting of:				
- Interest charge	3,763	685	3,078	3,884
- Repayment of finance lease liability	2,469	448	2,021	2,429
- Service element (and other charges to operating expenditure excluding revenu	2,582	298	2,284	2,427
- Capital lifecycle maintenance	323	51	272	307
- Contingent rent	1,545	306	1,239	1,338
- Addition to lifecycle prepayment	110	110	0	8
Total	**10,792**	**1,898**	**8,894**	**10,393**

The Trust have full control of clinical services provided from PFI funded hospitals, and full access and use of the buildings, which are maintained by the PFI project companies as part of the PFI procurement contract.

PFI project companies provide services for “hard” facilities management including building maintenance and life cycle replacement programmes. A contractual commitment exists for the PFI project companies to maintain the building at “category b” status for the contract life (30 years from commencement for Lanchester Road and 30 years from financial close for Roseberry Park).

The contract can be terminated within the 30 year contract period if contractual obligations for service delivery (maintenance) and building availability are not met. This is controlled by a points based payment deduction methodology within the standard PFI contract. The Trust have the right to cease the contract early, subject to payment of a financial penalty.

Note 37 Off-SoFP PFIs commitments
The Trust has no off-SoFP PFIs as at 31 March 2018 (31 March 2017, £nil).

Note 38 Events after the reporting period
The Trust has no events after the reporting period.

Note 39.1 Financial assets by category Assets as per SoFP 2017-18	Total £000	Loans and receivables £000
Trade and other receivables (excluding non financial assets) - with NHS and DH bodies	10,856	10,856
Trade and other receivables (excluding non financial assets) - with other bodies	2,134	2,134
Other investments / financial assets	470	470
Cash and cash equivalents	58,415	58,415
Total at 31 March 2018	**71,875**	**71,875**

2016-17	Total £000	Loans and receivables £000
Trade and other receivables excluding non financial assets	9,941	9,941
Other Investments	2,400	2,400
Other Financial Assets	500	500
Cash and cash equivalents at bank and in hand	57,845	57,845
Total at 31 March 2017	**70,686**	**70,686**

Note 39.2 Financial liabilities by category 2017-18	Total £000	Other financial liabilities £000
Borrowings excluding finance lease and PFI liabilities	6,000	6,000
Obligations under PFI, LIFT and other service concession contracts	74,712	74,712
Trade and other payables (excluding non financial liabilities) - with NHS and DH bodies	1,593	1,593
Trade and other payables (excluding non financial liabilities) - with other bodies	18,305	18,305
Provisions under contract	384	384
Total at 31 March 2018	**100,994**	**100,994**

2016-17	Total £000	Other financial liabilities £000
Borrowings excluding finance lease and PFI liabilities	9,000	9,000
Obligations under PFI, LIFT and other service concession contracts	77,181	77,181
Trade and other payables (excluding non financial liabilities) - with NHS and DH bodies	2,179	2,179
Trade and other payables (excluding non financial liabilities) - with other bodies	16,849	16,849
Provisions under contract	210	210
Total at 31 March 2017	**105,419**	**105,419**

Note 39.3 Fair values of financial assets at 31 March 2018	Book Value £000	Fair Value £000
Non current trade and other receivables	42	42
Other investments	125	125
Total	**167**	**167**

Note 39.4 Fair values of financial liabilities at 31 March 2018	Book Value £000	Fair Value £000
Loans	3,000	3,000
Total	**3,000**	**3,000**

Note 39.5 Maturity of Financial liabilities	31 March 2018 £000	31 March 2017 £000
In one year or less	25,625	24,707
In more than one year but not more than two years	5,633	5,343
In more than two years but not more than five years	8,888	11,329
In more than five years	60,848	64,040
Total	**100,994**	**105,419**

Note 40 On SoFP pension schemes

The Trust does not operate an on-statement of financial position pension scheme. Refer to note 1 for details.

Note 41 Losses and special payments

NHS Foundation Trusts are required to report to the Department of Health any losses or special payments, as the Department still retains responsibility for reporting these to Parliament.

By their very nature such payments should not arise, and they are therefore subject to special control procedures compared to payments made in the normal course of business.

These amounts are reported on an accruals basis, but exclude provisions for future losses.

A breakdown of losses and special payments recognised by the trust is below:

At 31 March 2018	Number of cases	Value £000
Losses		
Cash losses	1	0
Special payments		
Ex gratia payments	32	7
Total at 31 March 2018	**33**	**7**

At 31 March 2017	Number of cases	Value £000
Losses		
Cash losses	4	0
Special Payments		
Ex gratia payments	44	8
Total at 31 March 2017	**48**	**8**

Note 42 Third party assets and liabilities

The Trust held £901k cash at bank and in hand at 31 March 2018 (31 March 2017, £909k) which related to monies held by the NHS Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

The Trust held £598k cash at bank and in hand at 31 March 2018 (31 March 2017, £528k) which related to monies held by the Trust for a staff savings scheme. This has been excluded from the cash at bank and in hand figure reported in the accounts.

Note 43 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the NHS Foundation Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Market risk

The main potential market risk to the Trust is interest rate risk. 100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Tees, Esk and Wear Valleys NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk.

Credit risk

Credit risk exists where the Trust can suffer financial loss through default of contractual obligations by a customer or counterparty.

Trade debtors consist of high value transactions with Clinical Commissioning Groups under contractual terms that require settlement of obligation within a time frame established generally by the Department of Health. Due to this the credit risk exposure is not significant.

Credit risk exposures of monetary financial assets are managed through the Trust's treasury policy which limits the value that can be placed with each approved counterparty to minimise the risk of loss. The counterparties are limited to the approved financial institutions with high credit ratings. Limits are reviewed regularly by senior management.

Liquidity risk

The Trust's net operating costs are mainly incurred under legally binding contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. This provides a reliable source of funding stream which significantly reduces the Trust's exposure to liquidity risk.

The Trust also manages liquidity risk by maintaining banking facilities and loan facilities to meet its short and long term capital requirements through continuous monitoring of forecast and actual cash flows.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Executive Suite
West Park Hospital
Edward Pease Way
Darlington
DL2 2TS

Tel: 01325 552077
Email: colinmartin@nhs.net
www.tewv.nhs.uk

Date: 22nd May 2018

Mazars LLP
Salvus House
Aykley Heads
Durham
DH1 5TS

Dear Sirs

Tees, Esk and Wear Valleys NHS Foundation Trust - audit for year ended 31 March 2018

This representation letter is provided in connection with your audit of the financial statements of Tees, Esk and Wear Valleys NHS Foundation Trust for the year ended 31 March 2018 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with the Group Accounting Manual.

I confirm that the following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, inspection of supporting documentation) sufficient to satisfy ourselves that I can properly make each of the following representations to you.

My responsibility for the financial statements and accounting information

I believe that I have fulfilled my responsibilities for the true and fair presentation and preparation of the financial statements in accordance with the Group Accounting Manual and relevant legislation and International Financial Reporting Standards (IFRS) as adapted and adopted by HM Treasury.

My responsibility to provide and disclose relevant information

I have provided you with:

- access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other material;
- additional information that you have requested from us for the purpose of the audit; and
- unrestricted access to individuals within the Trust you determined it was necessary to contact in order to obtain audit evidence.

I confirm as Accounting Officer that I have taken all the necessary steps to make me aware of any relevant audit information and to establish that you, as auditors, are aware of this information.

As far as I am aware there is no relevant audit information of which you, as auditors, are unaware.

Accounting records

I confirm that all transactions that have a material effect on the financial statements have been recorded in the accounting records and are reflected in the financial statements. All other records and related information, including minutes of all Board and relevant committee meetings, have been made available to you.

Accounting policies

I confirm that I have reviewed the accounting policies applied during the year in accordance with Group Accounting Manual and International Accounting Standard 8 and consider these policies to faithfully represent the effects of transactions, other events or conditions on the Trust's financial position, financial performance and cash flows.

Accounting estimates, including those measured at fair value

I confirm that any significant assumptions used by the Trust in making accounting estimates, including those measured at fair value, are reasonable.

Contingencies

There are no material contingent losses including pending or potential litigation that should be accrued where:

- information presently available indicates that it is probable that an asset has been impaired or a liability had been incurred at the balance sheet date; and
- the amount of the loss can be reasonably estimated.

There are no material contingent losses that should be disclosed where, although either or both the conditions specified above are not met, there is a reasonable possibility that a loss, or a loss greater than that accrued, may have been incurred at the balance sheet date.

There are no contingent gains which should be disclosed.

All material matters, including unasserted claims, that may result in litigation against the Trust have been brought to your attention. All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to you and accounted for and disclosed in accordance with the Group Accounting Manual and relevant legislation and IFRSs as adapted and adopted by HM Treasury.

Laws and regulations

I confirm that I have disclosed to you all those events of which I am aware which involve known or suspected non-compliance with laws and regulations, together with the actual or contingent consequences which may arise therefrom.

We have complied with all aspects of contractual agreements that would have a material effect on the accounts in the event of non-compliance.

Fraud and error

I acknowledge my responsibility as Accounting Officer for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

I have disclosed to you:

- all the results of my assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- all knowledge of fraud or suspected fraud affecting the Trust involving:
    - management and those charged with governance;
    - employees who have significant roles in internal control; and
    - others where fraud could have a material effect on the financial statements.

I have disclosed to you all information in relation to any allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, analysts, regulators or others.

Related party transactions

I confirm that all related party relationships, transactions and balances, have been appropriately accounted for and disclosed in accordance with the requirements of the Group Accounting Manual and relevant legislation and IFRSs.

I have disclosed to you the identity of the Trust’s related parties and all related party relationships and transactions of which I am aware.

Impairment review

To the best of my knowledge, there is nothing to indicate that there is a permanent reduction in the recoverable amount of the property, plant and equipment below their carrying value at the balance sheet date. An impairment review is therefore not considered necessary.

Future commitments

I am not aware of any plans, intentions or commitments that may materially affect the carrying value or classification of assets and liabilities or give rise to additional liabilities.

Subsequent events

I confirm all events subsequent to the date of the financial statements and for which the Group Accounting Manual, relevant legislation and IFRSs require adjustment or disclosure have been adjusted or disclosed.

Should further material events occur after the date of this letter which may necessitate revision of the figures included in the financial statements or inclusion of a note thereto, I will advise you accordingly.

Going concern

To the best of my knowledge there is nothing to indicate that the Trust will not continue as a going concern in the foreseeable future. The period to which I have paid particular attention in assessing the appropriateness of the going concern basis is not less than twelve months from the date of approval of the accounts.

Unadjusted misstatements

I confirm that the effects of the uncorrected misstatements are immaterial, both individually and in aggregate, to the financial statements as a whole. A list of the uncorrected misstatements is attached to this letter as an Appendix.

Other representations

I confirm that all provisions required under IAS37 have been included in the financial statements.

I confirm that I do not consider that group accounts should be prepared incorporating our Subsidiaries or Charitable Funds on the grounds of materiality.

Yours faithfully

Accounting Officer

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Trust

General Charitable Fund

Fund Number: 1061486

Annual Report 2017-18

making a difference together

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Section

Appendices

Tees, Esk and Wear Valleys NHS Foundation Trust

General Charitable Trust Fund

Annual Report 2017-18

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
Mr B Kilmurray, Chief Operating Officer and Deputy Chief Executive
Mrs S Pickering, Director of Planning and Performance
Mr D Levy, Director of Human Resources and Organisational Development
Mrs L Bessant, Chairman of the Trust
Mr J Tucker, Non-Executive Director – left 31 August 2017
Mr M Hawthorn, Non-Executive Director
Mr D Jennings, Non-Executive Director
Mr P Murphy, Non-Executive Director
Mr. R. Simpson – joined 1 September 2017

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 a decrease in funds of £38k.

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 an increase in funds of £1k.

CDDPS General Fund
The purpose of this fund is to enhance patient amenities in County Durham. The fund decreased in year by £15k due to expenditure updating a garden space.

Arts Programme Millennium
The purpose of this fund is to provide entertainment to the Trust's patients. The fund decreased in year by £5k due to expenditure on music concerts.

5. Review of activities

There was 1 new fund set up during the year, and 11 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.

6. Financial activity

A full set of accounts for the financial year 2017-18 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 £79k 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 2018 was £448k.

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 2017 to 31 March 2018 total investment income was £1k which was less than the previous year, due to a reduction in funds held and reduced interest rates.

Investment income from deposit accounts 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 two bids approved by the Trustee in 2017-18, both to improve patient garden spaces within Trust properties.

The funds classed as "Others" in note 9 of the accounts are further broken down as follows:

	"Others" Balance	Number Of Funds	Average Fund Balance
Restricted	£164,985	98	£1,684
Unrestricted	£52,530	46	£1,142

6.2 Incoming resources

Total income for the year was £107k a decrease of £14k on last year. Actual figures were:

	2017-18 £000	2016-17 £000
Donations	14	12
Legacies	5	0
Other trading activities	87	106
Income from investments	1	3
Total	**107**	**121**

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

6.3 Material donations and legacies

The Charitable Fund received three legacies totalling £5k in 2017-18, and received donations of £14k to various funds.

6.4 Resources expended

Expenditure for the year was £186k, an increase of £48k when compared with £138k spent in the previous year.

Analysis of Expenditure:

	2017-18 £000	2016-17 £000
Purchasing goods for resale	88	68
Patients' welfare	77	43
Staff welfare	13	8
General / miscellaneous	0	11
Governance costs	8	8
Total	**186**	**138**

Expenditure has increased from the previous financial year, mainly due to internal promotion of funds to generate expenditure ideas.

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 4.3% 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 2017-18.

Fund	Expenditure £	Comment
Ridgeway Café and shop	14,908	Garage log cabin for patients
CDDPS General Fund	10,087	Garden development
Rowan Ward Patients	6,170	Digital reminiscence therapy software

6.7 Going concern

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

The fund has maintained its level of financial resources due to its long standing policy of only funding one-off in-year applications to the fund, and has no future commitments to discharge other than accruals and creditors as disclosed in the balance sheet which reports £6k of debt compared to £454k 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 Trust 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 Reserve

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 £102k; as this is not material in comparison with the Trust's turnover of £345,997k no minimum level target has yet been set.

8.2 Investments

8.2.1 Statement of policy on investments

The Charities' 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 charities 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 J Tucker - left 31 August 2017
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
Mr B Kilmurray
Mrs E Moody
Mr D Kendall

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

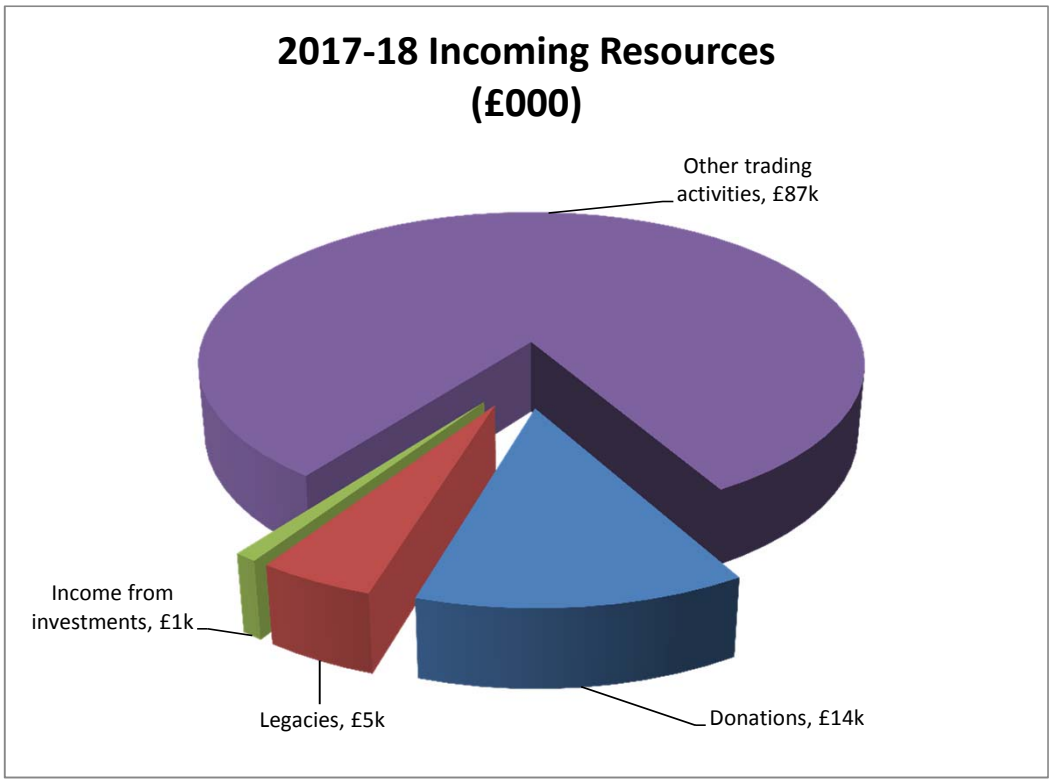
Legal advisors
Ward Hadaway
Sandgate House
102 Quayside
Newcastle upon Tyne
NE1 3DX

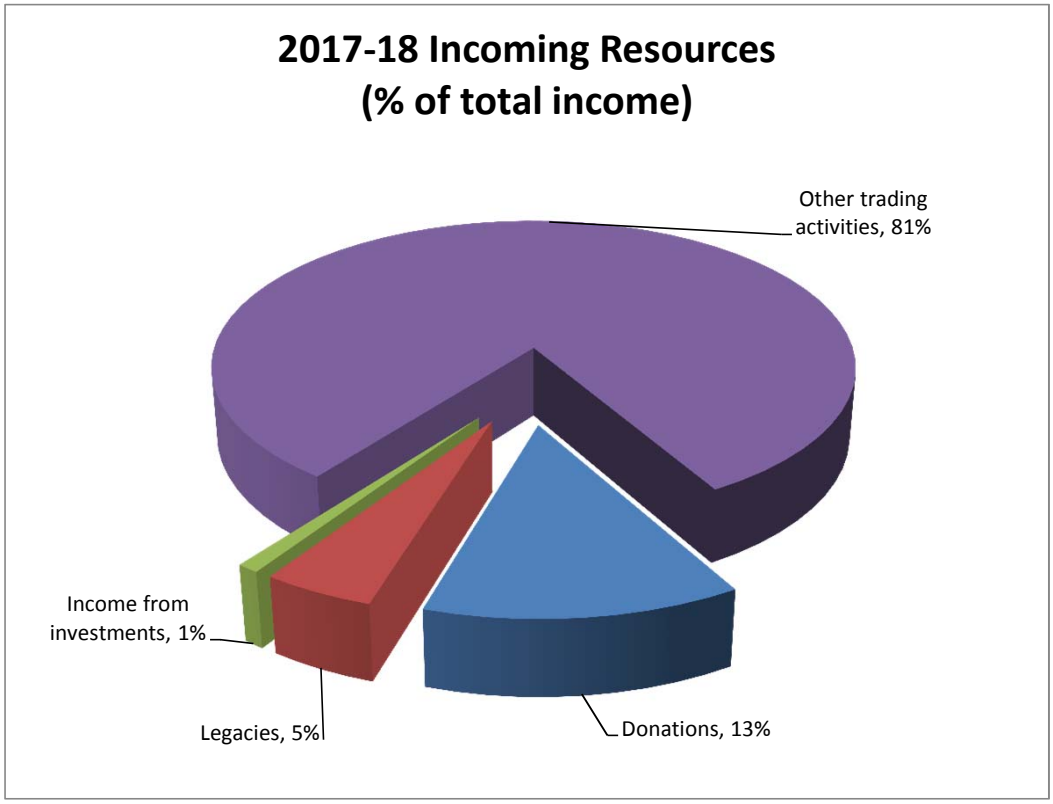
Bankers

Yorkshire Bank PLC
7 Linthorpe Road
Middlesbrough
TS1 1RF

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

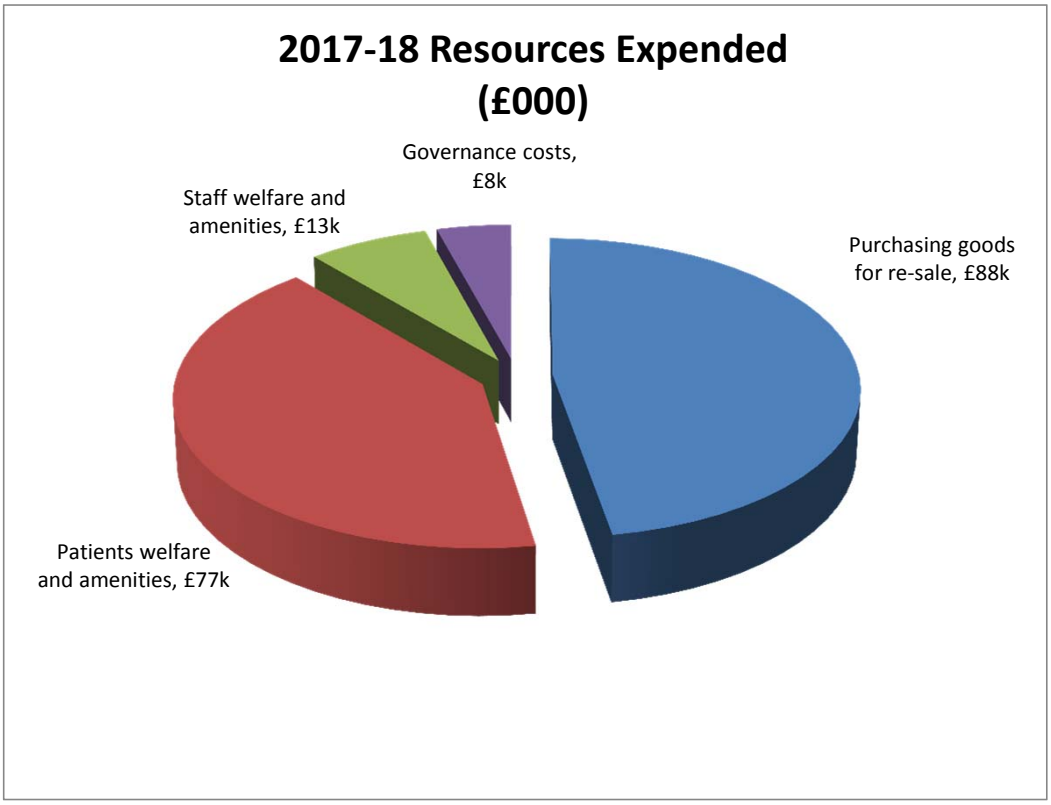
Analysis of incoming resources Appendix 1

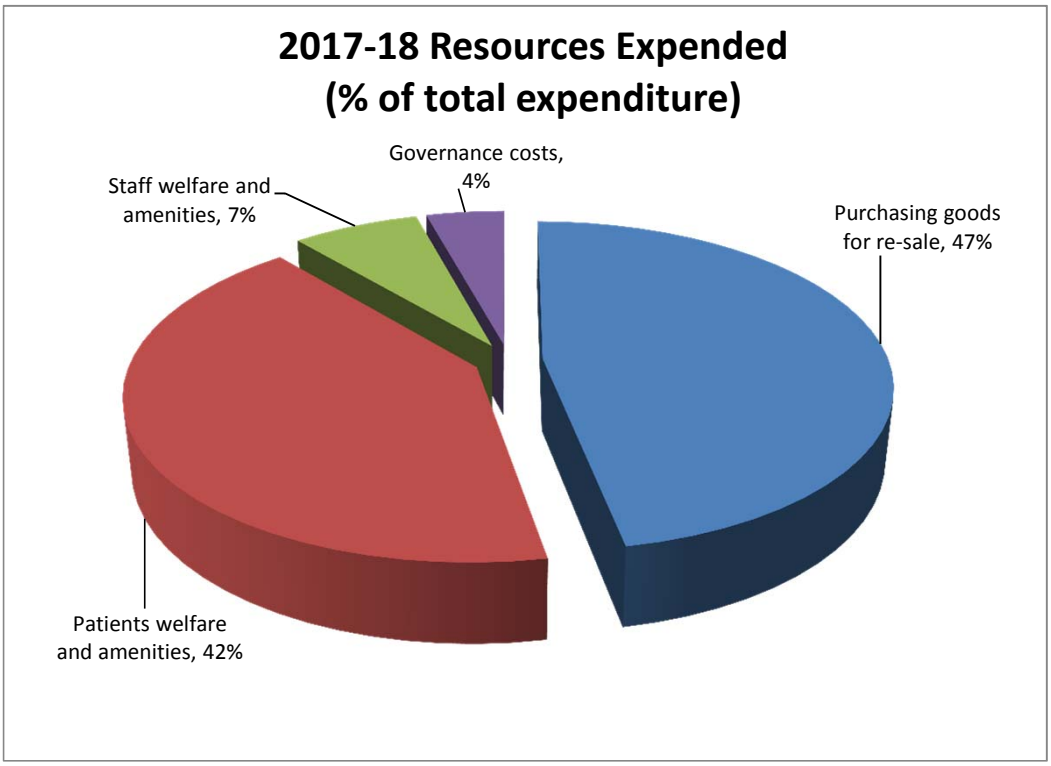




Analysis of resources expended

Appendix 2





CHARITABLE TRUST ACCOUNT - TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST - 2017-18								
Data entered below will be used throughout the workbook:								
This year	2017-18							
Last year	2016-17							
This year ended	2018							
Last year ended	2017							
This year beginning	1 April 2017							
This year name	31 March 2018							
Last year name	31 March 2017							

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 TRUSTEES OF TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST CHARITABLE FUNDS

I report on the accounts of the Charity for the year ended 31 March 2016, 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: The Rivergreen Centre, Aykley Heads, Durham DH1 5TS

Date:

Statement of Financial Activities for the year ended 31 March 2018

	Note	31 March 2018 Unrestricted Funds £000	31 March 2018 Restricted Funds £000	31 March 2018 **Total Funds £000**	31 March 2017 Total Funds £000
Incoming resources					
Incoming resources from generated funds:					
Voluntary income:					
Donations		6	8	**14**	12
Legacies		5	-	**5**	-
Sub total voluntary income		11	8	**19**	12
Income from investments	5	-	1	**1**	3
Other trading activities	5.1	-	87	**87**	106
Total income and endowments		**11**	**96**	**107**	**121**
Resources expended					
Raising funds	3.3	-	(88)	**(88)**	(68)
Charitable Activities	3.1	(30)	(68)	**(98)**	(70)
Total resources expended	4	**(30)**	**(156)**	**(186)**	**(138)**
Net outgoing resources before transfers	**6**	**(19)**	**(60)**	**(79)**	**(17)**
Internal transfers	6	-	-	-	-
Total transfers	6	**0**	**0**	**0**	**0**
Net outgoing resources before other recognised gains and losses	6	**(19)**	**(60)**	**(79)**	**(17)**
Net movement in funds		**(19)**	**(60)**	**(79)**	**(17)**
Fund balances brought forward at 31 March 2017		121	406	**527**	544
Fund balances carried forward at 31 March 2018		**102**	**346**	**448**	**527**

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

Balance Sheet as at 31 March 2018

	Notes	Unrestricted Funds £000	Restricted Funds £000	**Total at 31 March 2018 £000**	Total at 31 March 2017 £000
Current assets					
Debtors	7	-	-	**-**	-
Short Term Deposit Investment		103	351	**454**	533
Total current assets		103	351	**454**	533
Current liabilities					
Creditors: Amounts falling due within one year	8	(1)	(5)	**(6)**	(6)
Total current liabilities		(1)	(5)	**(6)**	(6)
Total current assets less current liabilities		102	346	**448**	**527**
Total net assets		**102**	**346**	**448**	**527**
Funds of the Charity					
Income Funds:					
Restricted	9.1	-	346	**346**	406
Unrestricted	9.2	102	-	**102**	121
Total funds		**102**	**346**	**448**	**527**

Notes numbered 1 to 14 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 2017-18 and throughout the comparators shown for the previous reporting year 2016-17.

1.1 Accounting convention

The financial statements have been prepared in accordance with the Statement of Recommended Accounting Practice: Accounting and Reporting by Charities (SORP FRS 102), issued in January 2015, UK Accounting Standards and the Charities Act 2011.

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.

Gifts in kind

Assets given for distribution by the Charity are included in the Statement of Financial Activities only when distributed.

Assets given for use by the Charity (e.g. property for its own occupation) are included in the Statement of Financial Activities as incoming resources when receivable.

In all cases the amount at which gifts in kind are brought into account is either a reasonable estimate of their value to the funds or the amount actually realised. The basis of the valuation is disclosed in the Annual Report.

Intangible income

Intangible income (e.g. the provision of free accommodation) is included in the accounts with an equivalent amount in outgoing resources, if there is a financial cost borne by another party. The value placed on such income is the financial cost of the third party providing the resources.

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.

Investments

Investments quoted on a recognised stock exchange are valued at market value at the year end. Other investment assets are included at trustees' best estimate of market value.

1.3 Resources expended

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.

Grants payable

Grants payable are payments, made to third parties (including NHS bodies) in the furtherance of charitable objectives. They are accounted for on an accruals basis where the conditions for their payment have been met or where a third party has a reasonable expectation that they will receive the grant. This includes grants paid to NHS bodies.

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 2017-18. These costs are apportioned across the funds using the appropriate classification of fund. During 2017-18 the classification split was:

Restricted 77%, Unrestricted 23%.

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 9.

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 Intangible fixed assets

Intangible fixed assets are included at the Trustees' best estimate of value.

1.7 Pensions contributions

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

1.8 Change in the basis of accounting

There has been no change in the basis of accounting during the year.

1.9 Prior year adjustments

There are no prior year adjustments in these accounts.

1.10 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

1.11 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 (2016-17, £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
Dr N Land - left 28 February 2018
Mr D Kendall - left 31 March 2018
Mrs E Moody
Mr B Kilmurray
Dr A Khouja - started 01 March 2018
Mr J Tucker - left 31 August 2017
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 2018**	Total 2017
	£000	£000	**£000**	£000
Patients welfare and amenities	(28)	(49)	**(77)**	(43)
Staff welfare and amenities	-	(13)	**(13)**	(8)
Governance costs (see 3.2 below)	(2)	(6)	**(8)**	(8)
Miscellaneous	-	-	**-**	(11)
	(30)	**(68)**	**(98)**	(70)

3.2 Analysis of governance costs

	Unrestricted Funds	Restricted Funds	**Total 2018**	Total 2017
	£000	£000	**£000**	£000
Establishment costs	(2)	(4)	**(6)**	(7)
Internal / External audit fee	-	(2)	**(2)**	(1)
	(2)	**(6)**	**(8)**	(8)

3.3 Details of costs incurred in raising funds

	Unrestricted Funds	Restricted Funds	**Total 2018**	Total 2017
	£000	£000	**£000**	£000
Purchasing goods for re-sale	-	(88)	**(88)**	(68)
	-	**(88)**	**(88)**	(68)

4 Analysis of total resources expended

	Costs of raising funds	Costs of activities for charitable objectives	**Total 2018**	Total 2017
	£000	£000	**£000**	£000
Internal / External audit fee	-	(2)	**(2)**	(1)
Compliance costs for Trust Funds	-	(6)	**(6)**	(7)
Charitable activities	(88)	(90)	**(178)**	(130)
	(88)	**(98)**	**(186)**	(138)

5 Analysis of income

5.1 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.

5.2 Details of other trading activities

The £87k income from other trading activities was delivered from the re-sale of goods purchased at a cost of £88k, and training provided that generated £4k income.

6 Changes in resources available for charity use

	Unrestricted Funds	Restricted Funds	**Total 2018**	Total 2017
	£000	£000	**£000**	£000
Net movement in funds for the year before transfers	(19)	(60)	**(79)**	(17)
Internal transfers	-	-	**-**	-
Net decrease in funds for the year	**(19)**	**(60)**	**(79)**	(17)

7 Analysis of receivables	Balance at 31 March 2018 £000	Balance at 31 March 2017 £000
Other debtors	-	-
Total amounts falling due within one year	**-**	-

8 Analysis of payables	Balance at 31 March 2018 £000	Balance at 31 March 2017 £000
Trade creditors	(6)	(6)
Accruals	-	-
Total amounts falling due within one year	**(6)**	(6)

9 Details of material funds

9.1 Restricted funds	Balance 1 April 2017 £000	Incoming resources £000	Resources expended £000	**Balance 31 March 2018 £000**	**Description of the nature and purpose of each fund**
Ridgeway Activity Centre Café / Shop	74	54	(92)	**36**	To provide funds for the well being of patients within Ridgeway
LD Forensic Day Services	35	28	(29)	**34**	Facilitate the Selling and Purchasing of Items with a Therapeutic Purpose
Allinson Bequest	31	0	0	**31**	To provide funds for epilepsy services in the Durham area
Acomb Garth	23	1	(1)	**23**	To provide funds for activities for patients of Acomb Garth
Learning Disabilities	16	0	(0)	**16**	To provide funds for activities for patients with Learning Disabilities in York and Selby
North of Tees MHSOP Charitable Account	11	0	(0)	**11**	To provide funds for Patient activities, comforts, diversional equipment
Epilepsy Fund, Bankfields Court	10	1	(1)	**10**	To provide funds for epilepsy services in the Middlesbrough area
Learning Disability Medical Staff	10	0	(0)	**10**	To provide additional training and development opportunities
Zomba Mental Health Link	12	0	(2)	**10**	To Support operation of NHS International Health Link between TEWV, Dept of Health Services at University of York and Zomba Mental Health Services, Zomba Malawi
Others (98 Funds)	184	12	(31)	**165**	
Total	406	96	(156)	**346**	

9.2 Unrestricted funds	Balance 1 April 2017 £000	Incoming resources £000	Resources expended £000	**Balance 31 March 2018 £000**	
CDDPS General Fund	38	4	(18)	**24**	To provide general purpose funds for the patients being cared for in the Durham area
St Mary's General Fund	15	-	-	**15**	To provide general purpose funds for the patients being cared for at St Mary's Hospital
Rowan Ward	14	4	(7)	**11**	To provide general amenities for the patients being cared for at Rowan Ward
Others (46 Funds)	54	3	(5)	**52**	
Total	**121**	**11**	**(30)**	**102**	

10 Connected organisations

	2017-18		2016-17	
	Turnover of Connected Organisation £000	Net Deficit for the Connected Organisation* £000	Turnover of Connected Organisation £000	Net Profit for the Connected Organisation £000
The charity is administered by Tees, Esk and Wear Valleys NHS FT	**350,478**	**(24,309)**	345,888	19,222

* 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 £16,929k.

11 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.

12 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.

13 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.

14 Post Balance Sheet events

There are no post balance sheet events to report.

ITEM NO. 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**22nd May 2018**
TITLE:	**Annual Self-Certifications**
REPORT OF:	**Phil Bellas, Trust Secretary/Patrick McGahon, Director of Finance and Information**
REPORT FOR:	**Decision**

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 seeks the sign off of the annual certificates required by NHS Improvement as follows:

(1) The Certificate on "Systems for Compliance with Licence Conditions" – Licence Condition G6 (3).
(2) The Corporate Governance Statement.
(3) The Certificate on the "Training of Governors".
(4) The Certificate on "The Availability of Resources" - Licence Condition CoS7 (3).

Board Members are asked to note that:

(1) Following an assurance review, the Audit Committee has recommended the confirmation of the certificates as set out in this report.
(2) In considering its response to the certificates, the Board is required to take into account the views of the Council of Governors. These are being sought at its meeting to be held on 16th May 2018 and will be reported verbally to the meeting.

Recommendations:

The Committee is asked, subject to no material issues being raised by the Council of Governors, to sign off confirmation of the annual certificates as set out in this report.

MEETING OF:	**Board of Directors**
DATE:	**22nd May 2018**
TITLE:	**Annual Self-Certifications**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to seek sign off of the annual certificates required by NHS Improvement.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Board Members will be aware that NHS Improvement requires the Boards of Foundation Trusts to self-certify, annually, the following certificates:

(a) The Certificate on "Systems for Compliance with Licence Conditions" – Licence Condition G6 (3).
(b) The Corporate Governance Statement.
(c) The Certificate on the "Training of Governors".
(d) The Certificate on "The Availability of Resources - Licence Condition CoS7 (3).

2.2 At its meeting held on 10th May 2018 the Audit Committee undertook an assurance review and its recommendations are set out in section 3 below.

(Note: The report to the Audit Committee is available on Boardpad or on request).

2.3 In determining the self-certifications the Board must have regard to the views of Governors.

2.4 The signed certificates are not required to be submitted to NHS Improvement; however, the regulator undertakes spot audits to test that Foundation Trusts have carried out the self-certification process.

3. KEY ISSUES:

3.1 The Audit Committee has recommended the confirmation and sign off of:

(a) The Certificate on Systems for Compliance with Licence Conditions in the following form:
"Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution."

(b) The Corporate Governance Statement as attached as Annex 1 to this report.

(c) The Certificate on the Training of Governors in the following form: "*The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in S.151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.*"

(d) The Certificate on the Availability of Resources as set out in Annex 2 to this report.

The Board is asked to note that a signed copy of the certificate is required to be published on the Trust's website within one month of sign off.

3.2 The views of the Council of Governors are being sought at its meeting to be held on 16th May 2018 and will be reported verbally to the meeting.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The Trust is required to be registered with the CQC under Licence Condition G7.

4.2 **Financial/Value for Money:** Under the Licence, the Trust has a duty to operate efficiently, economically and effectively.

4.3 **Legal and Constitutional (including the NHS Constitution):** The Trust is required to hold a Licence in order to provide NHS services. Failure to comply with the Licence conditions can result in enforcement action.

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

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are risks that, if following testing, NHS Improvement does not consider that the Trust's approach to self-certification is sufficiently robust it would consider this to be a breach of the Licence and take appropriate enforcement action.

6. CONCLUSIONS:

6.1 The annual self-certifications are required by NHS Improvement. The responses agreed by the Board may be used by the regulator to determine its approach to oversight of the Trust.

7. RECOMMENDATIONS

The Board is recommended, subject to no material issues being raised by the Council of Governors, to confirm and sign off:

(1) The Certificate on Systems for Compliance with Licence Conditions.
(2) The Corporate Governance Statement as set out in Annex 1 to this report.
(3) The Certificate on the "Training of Governors".
(4) The Certificate on the Availability of Resources as set out in Annex 2 to this report.

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Provider Licence

Annex 1

Draft Corporate Governance Statement (May 2018)

	Corporate Governance Statement Component	Risks & Mitigating Actions	Proposed Response (Confirmed/Not Confirmed)
1	The Board is satisfied that Tees, Esk & Wear Valleys NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	None	Confirmed
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	None	Confirmed
3	The Board is satisfied that Tees, Esk and Wear Valleys NHS Foundation Trust has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	None	Confirmed
4	The Board is satisfied that Tees, Esk and Wear Valleys NHS Foundation Trust has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health	None	Confirmed

	care professions; (d) For effective financial decision-making, management and control including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern; (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements		
5	The Board is satisfied that the systems and/or processes referred to in (4) above should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) The Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That it receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That Tees, Esk & Wear Valleys NHS Foundation Trust, including	None	Confirmed

	its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Tees, Esk & Wear Valleys NHS Foundation Trust including, but not restricted to, systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		
6	The Board is satisfied that there are systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	The Trust has recognised that difficulties in recruiting and retaining sufficient staff in all its Localities and at all times could impact on its ability to provide high quality care. This is being addressed through the Right staffing Business Plan Priority	Confirmed

Annex 2

Continuity of Services Condition 7 – Availability of Resources

After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	**Confirmed**
After making enquires the Directors of the licensee have a reasonable expectation, subject to what is explained below, that the licensee with have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the licensee to provide Commissioner Requested Services.	
In the opinion of the Directors of the Licensee, the licensee with not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

Statement of main factors taken into account in making the above declaration
In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

(e.g. key risks to deliver of CRS, assets or subcontractors required to deliver CRS, etc)

- The Trust's approved NHSI Operational Plan and Business Plan.
- The contracts agreed and signed off with all Commissioners as part of planning round.
- The approved budget, signed off by the Board, including the capital programme and CRES programme (based on quality assurance processes).
- The control total agreed with NHSI.
- The quarterly and six monthly nurse staffing reports.
- Assurances provided on the delivery of the Trust's recruitment and retention action plan.
- The findings of the initial staffing establishment reviews undertaken using the Hurst Tool and professional judgement reviews
- Significant additional investment, at a total recurring cost of over £1m, provided to increase staffing resources in the Trust's 20 bedded adult inpatient services, PICU services and to increase capacity and co-ordination of inpatient services at night

Item 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**22 May 2018**
TITLE:	**Finance Report for Period 1 April 2018 to 30 April 2018**
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 30 April 2018 is a surplus of £846k, representing 3.0% of the Trust's turnover and is £85k ahead of plan.

Identified Cash Releasing Efficiency Savings at 30 April 2018 are £4,470k behind plan for the year to date. The Trust continues to identify and develop schemes to ensure full delivery of recurrent CRES requirements.

To manage this risk and enable the Trust to achieve its 2018/19 financial plan, non-recurrent mitigations are being developed, and will include items such as expenditure reduction schemes and re-profiling of non-recurrent projects.

The Use of Resources Rating for the Trust is assessed as 3 for the period ending 30 April 2018 and is in line with plan. The 3 rating arises due to a loan repayment made during April 2018, which impacts on the Capital Service Cover score.

The rating is planned to return to a 1 by the end of quarter 1.

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:	**22 May 2018**
TITLE:	**Finance Report for Period 1 April 2018 to 30 April 2018**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2018 to 30 April 2018.

2. BACKGROUND INFORMATION

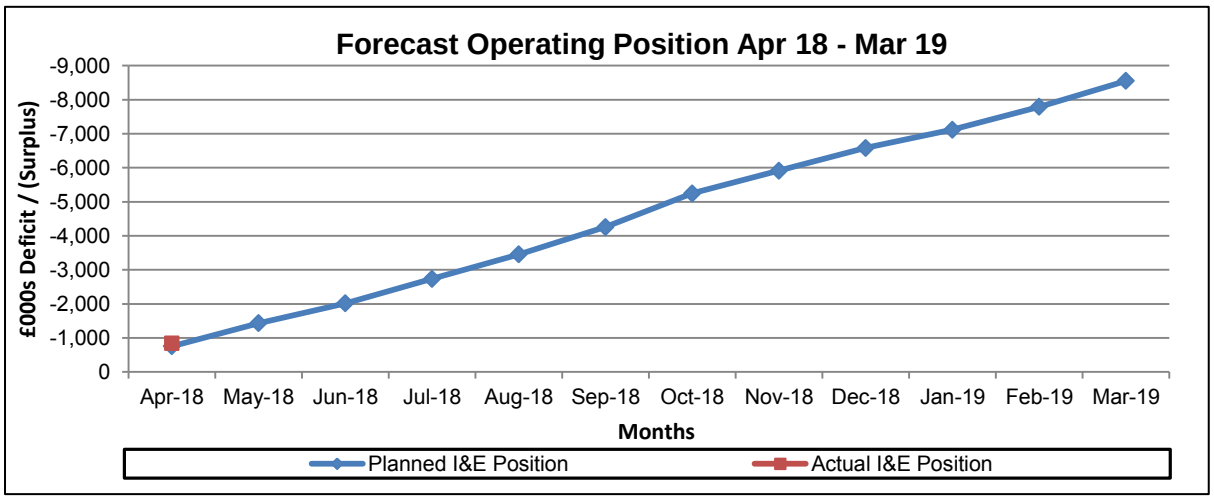
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis on a quarterly basis.

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

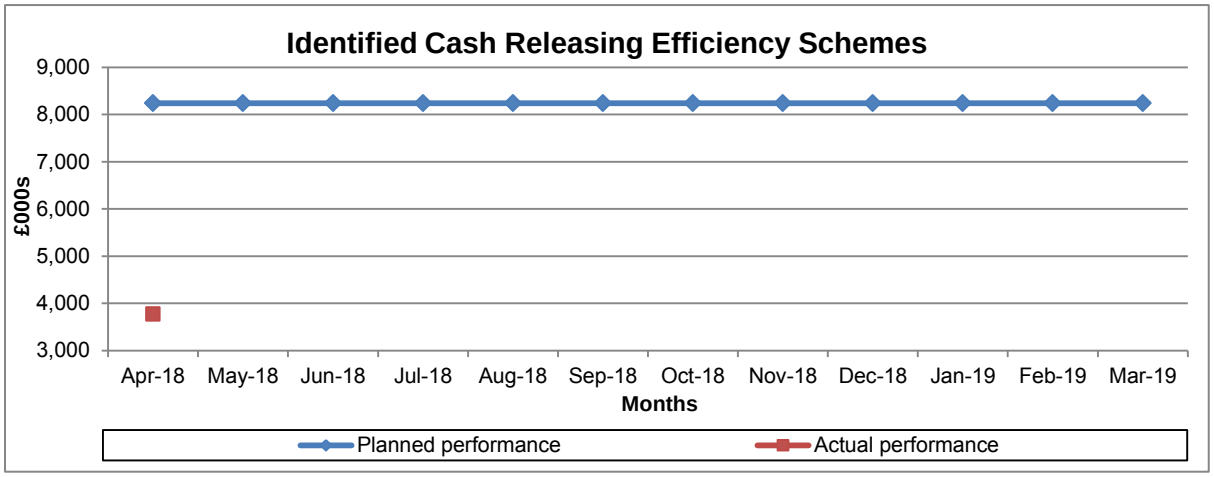
The comprehensive income outturn for the period ending 30 April 2018 is a surplus of £846k, representing 3.0% of the Trust's turnover and is £85k ahead of plan.

The graph below shows the Trust's planned operating surplus against actual performance.

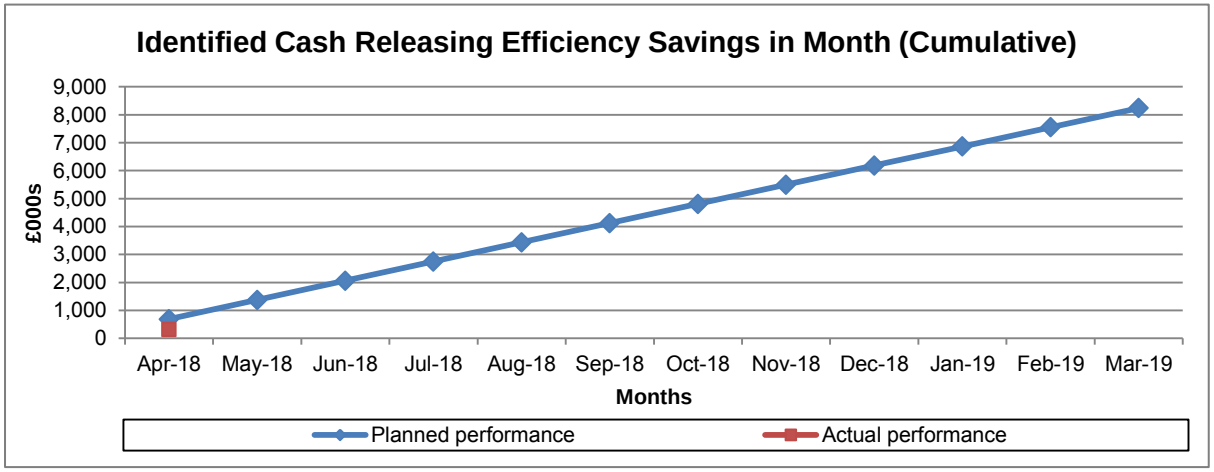


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 30 April 2018 is £3,772k and is £4,470k behind plan. Total CRES savings delivered at 30 April 2018 is £314k and is £373k behind plan. The Trust continues to identify and develop schemes to ensure full delivery of recurrent CRES requirements.

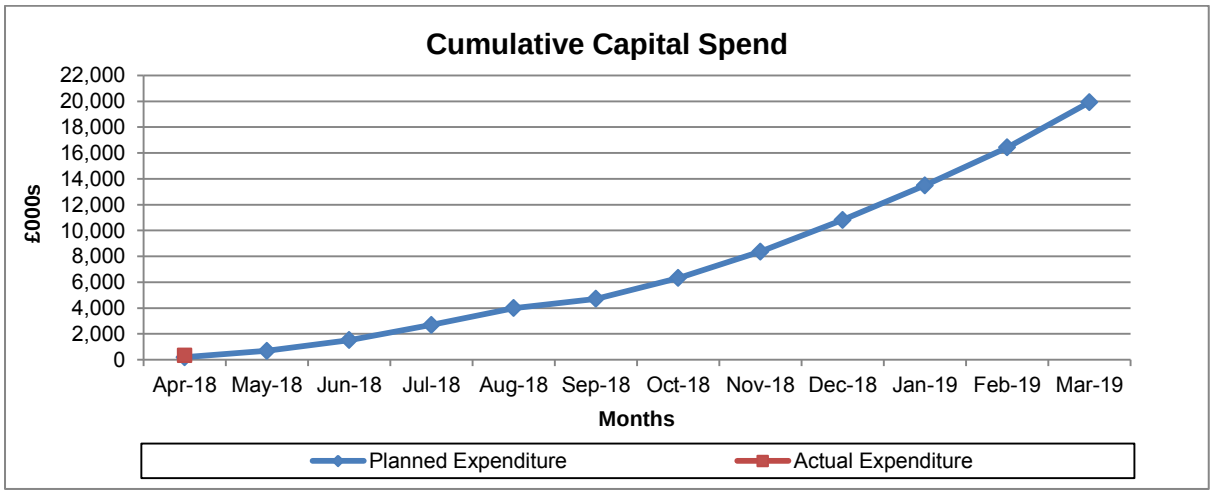


The monthly profile for CRES identified by Localities is shown below.



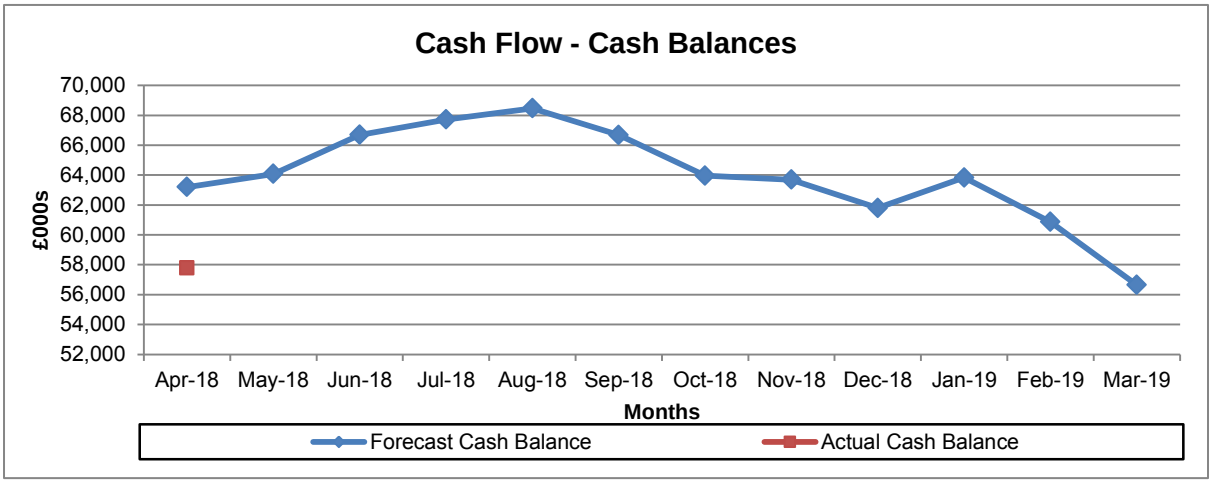
3.3 Capital Programme

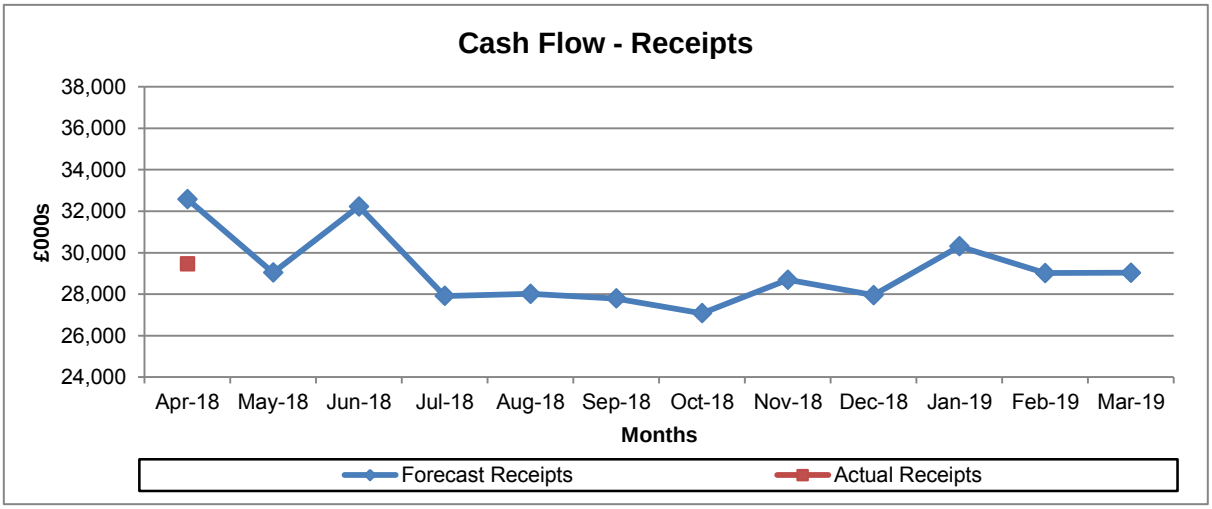
Capital expenditure to 30 April 2018 is £329k and is £129k ahead of plan due to the carry forward of a number of minor schemes that did not complete in 2017/18 financial year.

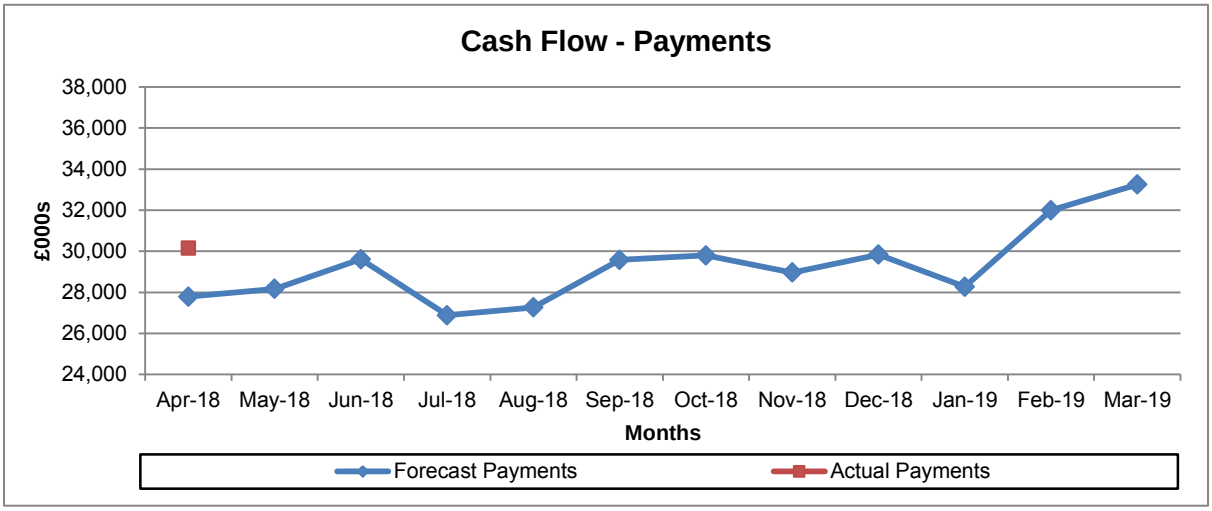


3.4 Cash Flow

Total cash at 30 April 2018 is £57,789k, and is £5,417k behind plan largely due to working capital variations, e.g. receipts from commissioner contract settlements anticipated in April, and payments for enabling expenditure accrued at the year end.



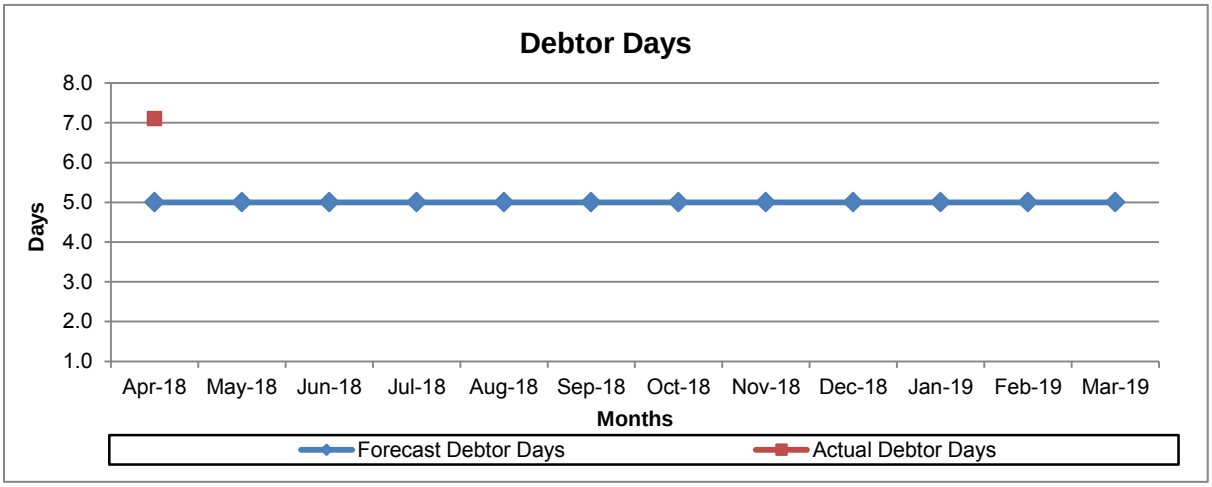




The receipts profile fluctuates over the year for Sustainability and Transformation Fund incentive scheme receipt. The payments profile fluctuates over the year for PDC dividend payments, financing repayments and capital expenditure.

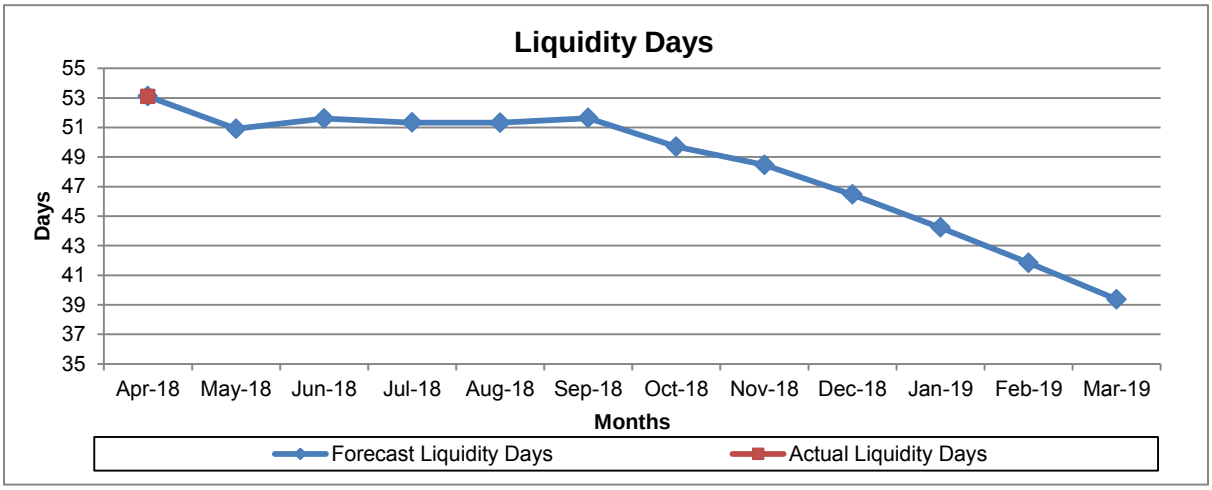
Working Capital ratios for period to 30 April 2018 are:

- Debtor Days of 7.1 days
- Liquidity of 54.7 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 73.56%
  Non NHS 30 Days – 97.76%



The Trust has a debtors' target of 5.0 days, and actual performance of 7.1 days at 30 April 2018, which is behind plan. This is due to contract variations raised in March anticipated to be settled in April.

The liquidity days graph below reflects the metric within NHS Improvement's single oversight framework. The Trust's liquidity day's ratio is ahead of plan due to higher than planned net current assets.



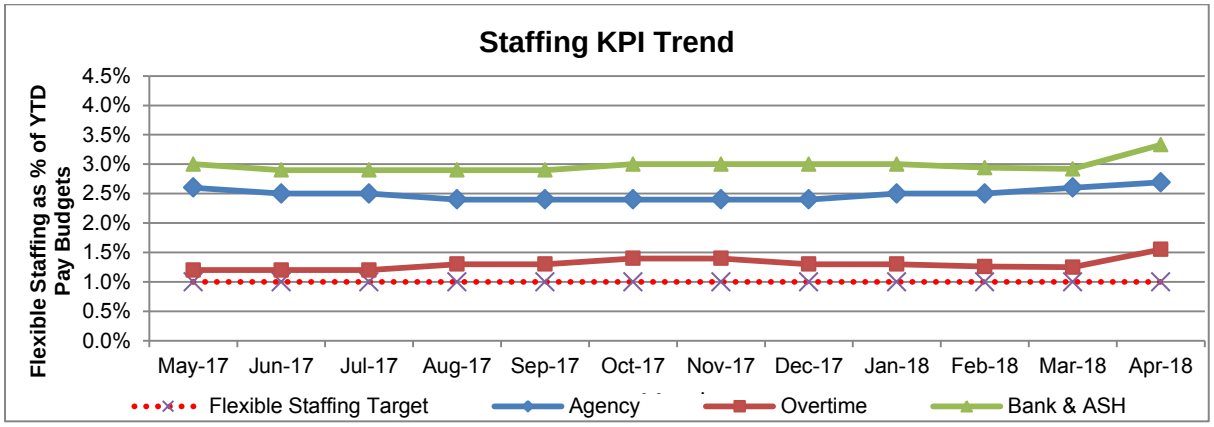
3.5 Financial Drivers

The following table and chart show the Trust's performance on some of the key financial drivers identified by the Board.

Pay Expenditure as a % of Pay Budgets						
Tolerance	Nov	Dec	Jan	Feb	Mar	Apr
Agency (1%)	2.4%	2.4%	2.5%	2.5%	2.6%	2.7%
Overtime (1%)	1.4%	1.3%	1.3%	1.3%	1.3%	1.6%
Bank & ASH (flexed against establishment)	3.0%	3.0%	2.9%	2.9%	2.9%	3.3%
Establishment (90%-95%)	94.5%	94.5%	94.2%	93.7%	93.8%	94.6%
Total	**101.3%**	**101.2%**	**100.9%**	**100.4%**	**100.6%**	**102.2%**

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 April 2018 the tolerance for Bank and ASH is 3.4% of pay budgets.

The following chart shows performance for each type of flexible staffing.



Additional staffing expenditure is 7.6% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (53%), enhanced observations (25%) and sickness (10%).

3.6 Use of Resources Rating and Indicators

3.6.1 The Use of Resources Rating for the Trust is assessed as 3 for the period ending 30 April 2018 and is in line with plan. The 3 rating arises due to a loan repayment made during April 2018, which impacts on the Capital Service Cover score.

The rating is planned to return to a 1 by the end of quarter 1.

3.6.2 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 0.77x (can cover

debt payments due 0.77 times), which is in line with plan and rated as a 4. The deterioration in this rating from March 2018 arises due to a loan repayment made during in April 2018.

3.6.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 54.7 days; this is ahead of plan and is rated as a 1.

3.6.4 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 3.0%; this is ahead of plan and is rated as a 1.

3.6.5 The I&E margin distance from plan ratio assesses the I&E Margin against plan, excluding STF income. The Trust I&E margin distance from plan is 0.3% and is ahead of plan and is rated as a 1.

3.6.6 The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is marginally higher than the cap and is rated as a 2.

The margins on Use of Resource Rating are as follows:

- Capital service cover - to improve to a 3 a surplus increase of £1,131k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £46,179k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £553k is required.
- I&E margin distance from plan – to reduce to a 2 an operating surplus decrease of £90k is required.
- Agency Cap rating – to improve to a 1 a reduction in agency expenditure of £83k is required.

Use of Resource Rating at 30 April 2018

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	0.77x	4	0.77x	4	
Liquidity	54.7 days	1	53.1 days	1	
I&E margin	3.0%	1	2.7%	1	
I&E margin distance from plan	0.3%	1	0.0%	1	
Agency expenditure	£565k	2	£482k	1	
Overall Use of Resource Rating		**3**		**3**	

3.6.7 4.0% of total receivables (£292k) are over 90 days past their due date; this is below the 5% finance risk tolerance.

3.6.8 0.4% of total payables invoices (£45k) held for payment are over 90 days past their due date. This is within the 5% finance risk tolerance.

3.6.9 The cash balance at 30 April 2018 is £57,789k and represents 68.4 days of annualised operating expenses.

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 The comprehensive income outturn for the period ending 30 April 2018 is a surplus of £846k, representing 3.0% of the Trust's turnover and is £85k ahead of plan.

6.2 Identified Cash Releasing Efficiency Savings at 30 April 2018 are £4,470k behind plan for the year to date. The Trust continues to identify and develop schemes to ensure full delivery of recurrent CRES requirements.

To manage this risk and enable the Trust to achieve its 2018/19 financial plan, non-recurrent mitigations are being developed, and will include items such as expenditure reduction schemes, and re-profiling of non-recurrent projects.

6.3 The Use of Resources Rating for the Trust is assessed as 3 for the period ending 30 April 2018 and is in line with plan. The 3 rating arises due to a loan repayment made during April 2018, which impacts on the Capital Service Cover score.

The rating is planned to return to a 1 by the end of quarter 1.

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

ITEM 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**22nd May 2018**
TITLE:	**Board Dashboard as at 30th April 2018**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance & Communication**
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 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 attached is the first Dashboard report for 2018/19. There has been significant change to the KPIs within the Dashboard and not all the KPIs agreed by the Board are included at this point within it. Work is ongoing to ensure that the outstanding KPI are included as soon as possible. Whilst the majority of KPIs reported do have targets associated with them two do not and the report includes proposals on the targets for those two KPIs for approval by the Board.

Of the 15 KPIs which have a target agreed 7 (47%) of the indicators reported are not achieving the expected levels and are red. The indicators which are rated red are spread across all 4 domains however it should be noted that there is only 1 out of the 5 KPIs red rated KPI within the workforce domain. The report contains further detail of these but key areas of risk are:

- Number of Unexpected deaths as a rate of open cases (KPI 5)
- Bed Occupancy (KPI 12)

In addition there are 4 KPIs (27%) that whilst not achieving the target are within the 'amber' tolerance levels. Those within the workforce domain particularly are very close to the target levels.

All of the Single Oversight Framework targets were delivered in April 2018 although we did not achieve the IAPT Recovery rate in Scarborough and Ryedale CCG or the EIP Waiting time target for Vale of York CCG.

Recommendations:
It is recommended that the Board: • Consider the content of this paper and raise any areas of concern/query. • Consider and approve as appropriate the proposed target for KPIs 1 and 14 as outlined in the table in Section 2.1.

MEETING OF:	**Board of Directors**
DATE:	**22nd May 2018**
TITLE:	**Board Dashboard as at 30th April 2018**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 30th April 2018 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery.

2. KEY ISSUES:

2.1 General Issues

This is the first dashboard for 2018/19 and there has been considerable changes to the KPIs within it compared to those within the 2017/18 dashboard. Some KPIs are completely new e.g. Vacancy Fill Rate and others have changes to their definitions/constructions. The attached Dashboard therefore contains all the KPIs where the extraction and reporting mechanism have been built within the IIC. Given the number of new/changed indicators Appendix B contains a list of all the KPIs agreed by the Board together with definitions for each. There are a number of indicators that have not yet been built within these IIC and these are highlighted in italics in Appendix B. Work is ongoing to complete this and these will be included within the Dashboard as they become available over the coming months.

In addition for those indicators which are not rolled over from the previous year the historical data is not able to be shown on the graphs and therefore it is not possible to include a trend arrow over the past 3 months. Clearly this will be able to be populated following the first quarter.

At its April meeting the Board approved new targets for the KPIs within the Dashboard but this was not possible for all the KPIs as the baseline data was not available for some due to the ongoing building of the KPIs in the IIC. The Board agreed to receive further proposed indicators at future meetings. Since April a further two KPIs have been built on the IIC and a baseline position obtained. Therefore the following table makes proposals as to the targets for those indicators and subject to approval by the Board these will be included within the report received in June.

No	KPI	Comments	Proposal
1	***Revised*** Percentage of patients who were seen within 4 weeks for a first appointment following an	The 17/18 target was 90% which included clock stops and starts etc. The revised baseline (excluding clock stops and starts) was 88.12% and the	To maintain the target of 90%. This is less than a 10% improvement on the baseline however given the ongoing increase in referrals and the fact that we are not stopping the clock for DNA/patient

	external referral	median 88.38%.	cancellations it is felt that it provides a balance between aiming for an improvement whilst still being achievable
14	***Revised*** Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	The revised baseline for 17/18 is 26.59% and the median is 25.49%	To set a target of 23.93%. This is a 10% improvement on the baseline and recognises the need to maintain people in the community as far as possible which is critical if we are to achieve other KPIs such as bed occupancy and Out of Area Placements.

Further proposed targets will be brought to future Board meetings as the baselines become available.

2.2 Performance Issues

The key issues in terms of the performance reported are as follows:

- As at the end of April 2018, 7 (47%) of the indicators reported are not achieving the expected levels and are red. Given the significant change to the KPIs it is not possible to make a comparison with March 2018. The indicators which are rated red are spread across all 4 domains however it should be noted that there is only 1 red rated KPI within the workforce domain.

  In addition there are 4 KPIs (27%) that whilst not achieving the target are within the 'amber' tolerance levels. Those within the workforce domain particularly are very close to the target levels.

- All of the Single Oversight Framework targets were delivered in April 2018. In terms of the IAPT recovery target this was achieved for all CCGs with the exception of Scarborough and Ryedale where the rate achieved was 44.8%. In terms of the waiting time target around EIP services this wasn't achieved within the York and Selby locality due to capacity issues within the service. The locality is taking action to address this and discussions are ongoing with the CCG.

- Appendix C includes the breakdown of the actual number of unexpected deaths by month. The Patient Safety Team now have a process in place to ensure accurate recording and reporting of coroners verdicts.

During the month of April the coroner returned 8 verdicts from deaths that took place between July 2017 and January 2018. Of these 8, the verdicts were as follows: -

- 1 was due to the patient taking their own life
- 2 were drug related deaths
- 4 were due to suicide
- 1 was an open verdict

Due to an issue with Datix it has not yet been possible to input the above onto Datix this month. Work is ongoing to resolve this.

2.3 Data Quality Assessment.

This will be completed for the new Trust Dashboard once all indicators and targets are agreed. This will be presented in this report at the July meeting.

2.4 Key Risks

- Number of unexpected deaths classed as a serious incident (KPI 5) – Whilst the rate of unexpected deaths classed as a serious incident has decreased slightly in April the actual number of deaths (9) was the same as in March. The Patient Safety Team have produced a thematic report on all the Serious Untoward Incidents (which includes unexpected deaths) which will be discussed at QuAC in June. In addition there has been a review of all the SUI reports (June to December 2017) in North Yorkshire given the higher number that have occurred in that locality and this is now being considered by the service.
- Outcome Indicators (KPIs 6 and 7) – Performance against the two outcome indicators (clinically reported (HONOS) and patient reported (SWEMWEBS)) is below target (and below the baseline for 2017/18). The PBR team are sharing reports with services to allow them to focus on the reasons for the 'breaches' and work is being undertaken in all localities on reemphasising the need to record outcome scores in order to be able to demonstrate improvement made. This is the first time these indicators have been reported and as such this is an important step forward in terms of understanding the quality of the services we are providing.
- Bed Occupancy (KPI 12) – Performance is worse than the target in April with the rate being also higher than that in March. There has been significant pressure on male adult mental health beds across the Trust during the month. This position is monitored daily in terms of managing the day to day pressure but is also discussed in depth at the Operational Management Team on a fortnightly basis in order to understand the overall bed position and what is driving that.
- Vacancy Fill Rate (KPI 16) - The performance against this indicator is significantly worse than target for April. However it should be noted that the indicator is new and that the target was based on one snap shot of performance at the end of March. In approving the target of 90% the Board agreed that we would need to monitor this indicator and if necessary revise the target when we had more information available.

- CRES Delivery (KPI 21) – the delivery of the CRES is behind plan for the month of April. The Trust has established a small team to work on identifying new potential CRES schemes using both internal knowledge and expertise but also by exploring ideas in other providers. In addition the identification and delivery of CRES is to be managed via the Programme Management Framework with the Chief Executive being the Programme Sponsor.
- Cash against plan (KPI 22) – The amount of cash held by the Trust at the end of April is below the planned level. This is due in the main to working capital variations.

3. RECOMMENDATIONS:

3.1 It is recommended that the Board:

- Consider the content of this paper and raise any areas of concern/query.
- Consider and approve as appropriate the proposed target for KPIs 1 and 14 as outlined in the table in Section 2.1.

Sharon Pickering
Director of Planning, Performance and Communications

Background Papers:

Trust Dashboard Summary for TRUST

Quality

	April 2018				April 2018 To April 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral		85.99%				85.99%		
3) The total number of inappropriate new OAPs in the reporting period	2,494.00	2,007.00				2,007.00		
4) Percentage of patients surveyed reporting their overall experience as excellent or good	92.45%	90.98%			92.45%	90.98%		92.45%
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	1.44			1.00	1.44		12.00
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	67.25%	53.66%				53.66%		
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	78.25%	54.88%				54.88%		

Activity

	April 2018				April 2018 To April 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	94.28%			85.00%	94.28%		85.00%
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	68.00	65.00			68.00	65.00		
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month		16.67%				16.67%		

Workforce

Trust Dashboard Summary for TRUST

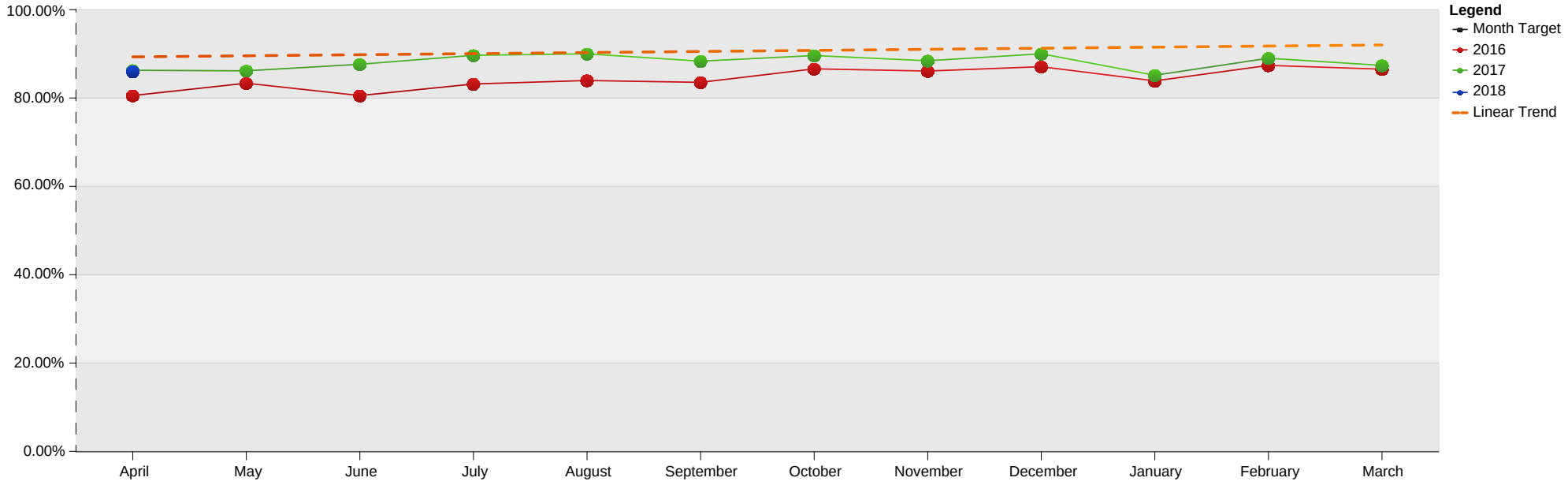
	April 2018				April 2018 To April 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
15) Actual number of workforce in month (Establishment 95%-100%)	95.00%	94.56%			95.00%	94.56%		
16) Vacancy fill rate	90.00%	67.31%				67.31%		
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	94.27%			95.00%	94.27%		
18) Percentage compliance with ALL mandatory and statutory training (snapshot)	92.00%	91.45%			92.00%	91.45%		
19) Percentage Sickness Absence Rate (month behind)	4.50%	4.37%				4.37%		

Money

	April 2018				April 2018 To April 2018			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
20) Delivery of our financial plan (I and E)	-761,000.00	-845,706.00			-761,000.00	-845,706.00		-8,556,000.00
21) CRES delivery	686,782.00	314,372.00			686,782.00	314,372.00		8,241,384.00
22) Cash against plan	63,206,000.00	57,789,000.00			63,206,000.00	57,789,000.00		56,640,000.00

Trust Dashboard Graphs for TRUST

1) % of patients who were seen within 4 weeks for a 1st appointment following an external referral

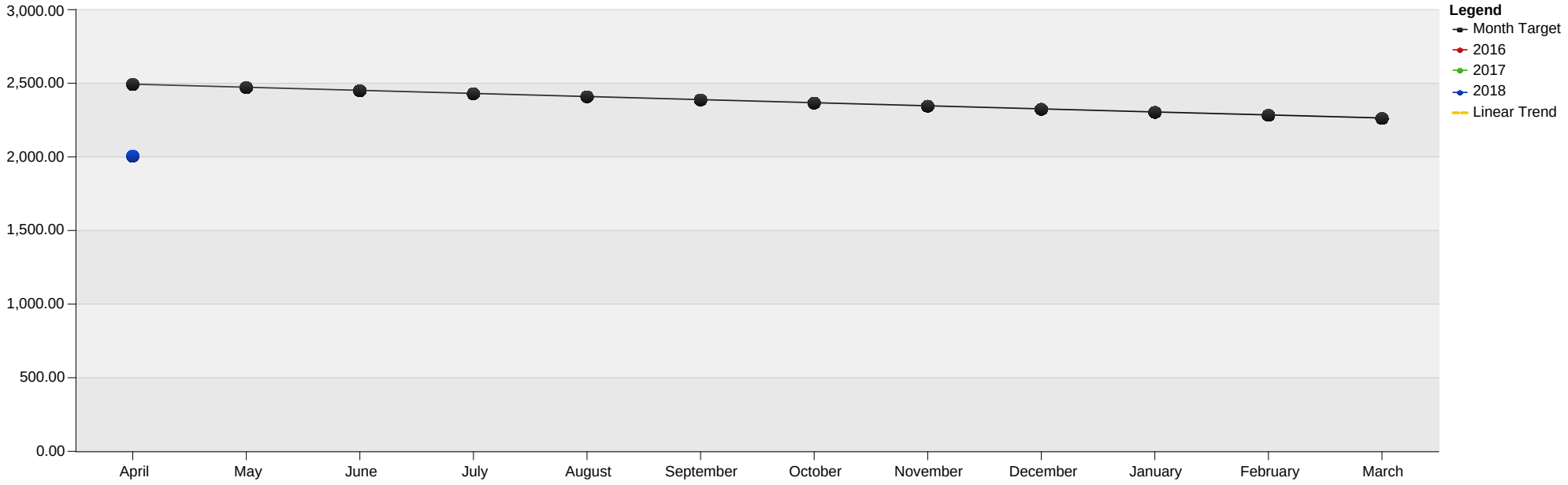


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	85.99%	85.99%	85.05%	85.05%	92.82%	92.82%	75.87%	75.87%	99.25%	99.25%	69.80%	69.80%		

Narrative
The position for April 2018 is 85.99% relating to 4977 patients out of 5788 who were seen within 4 weeks for a first appointment. There is currently no target agreed for this indicator but performance is below the baseline for 2017/18 which was 88.12%.Areas of concern:• York AMH at 47.08% (113 of 240 patients) –127 patients were not seen within 4 weeks - The Access team has a 25% DNA rate. The deterioration in this indicator is therefore impacted by the high DNA rate as this no longer stops the clock. In order to improve this, the service are continuing to seek advice from other access teams.• North Yorkshire AMH – (242 of 357 patients) -115 patients were not seen within 4 weeks – In the Primary Care team there have been some issues in the processes within the team which have led to a backlog of waiters. This has now been addressed and it is anticipated that the position should improve by the end of June. However in addition to this issue there are sickness and vacancies within the Harrogate and Ripon teams which are also having an impact.

Trust Dashboard Graphs for TRUST

3) The total number of inappropriate new OAPs in the reporting period

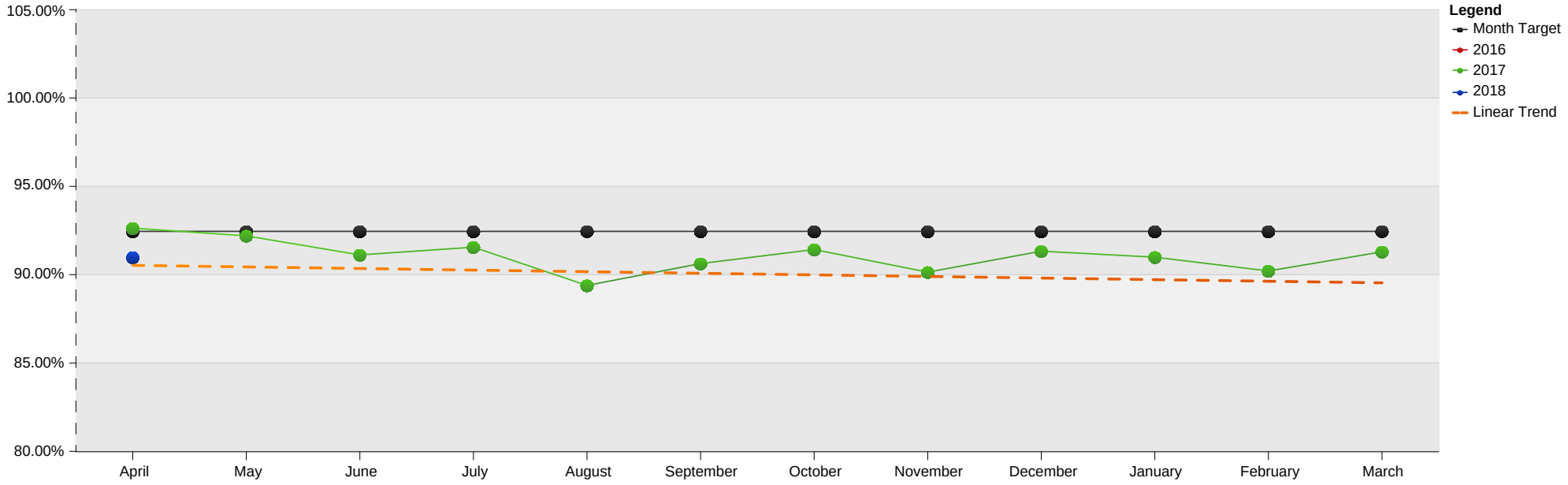


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) The total number of inappropriate new OAPs in the reporting period	2,007.00	2,007.00	517.00	517.00	236.00	236.00	986.00	986.00			268.00	268.00		

Narrative
The Trust position for April 2018 is 2,007 which is meeting the target of 2,494.The following locality is not meeting target: • Durham and Darlington– 517 occupied bed days (414 AMH and 103 MHOSP). This related to 51 patients admitted out of area. (45 AMH and 6 MHSOP)Due to the high demand in the Trust for male beds, Durham and Darlington have had a high number of patients from out of area admitted into their beds. As a result they have had to find alternative beds across the Trust for patients from the home area. All localities are monitoring this on a continual basis and actions are discussed and agreed in daily huddles.

Trust Dashboard Graphs for TRUST

4) Percentage of patients surveyed reporting their overall experience as excellent or good

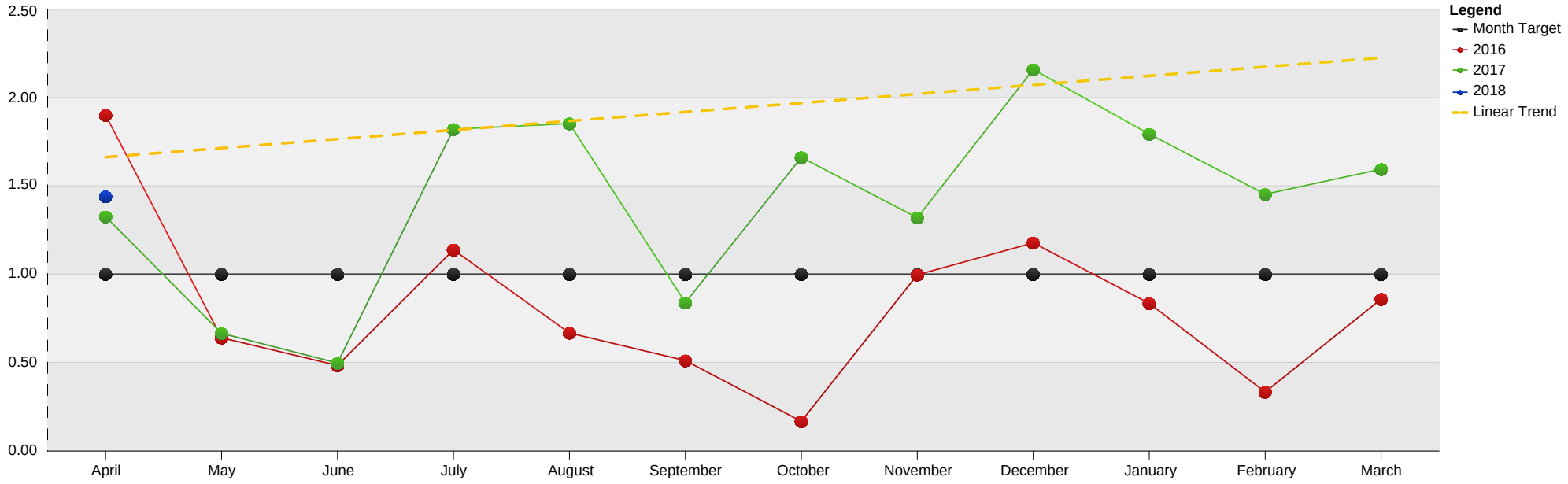


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of patients surveyed reporting their overall experience as excellent or good	90.98%	90.98%	92.10%	92.10%	93.33%	93.33%	93.12%	93.12%	80.33%	80.33%	82.84%	82.84%		

Narrative
The Trust position for April 2018 is 90.98% which is not meeting the target of 92.45% and is a deterioration on the position reported in March. Tees and North Yorkshire are meeting the target for this indicator with Forensic reporting the poorest performance at 80.33%. The two remaining localities are within 10% of the target. Work continues within each locality to review performance against this indictor and identify any areas of concern. Please note due to changes with this indicator at the end of 2016-17, 2016 data is not displayed on the graph above.

Trust Dashboard Graphs for TRUST

5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.44	1.44	0.40	0.40	0.56	0.56	5.41	5.41	0.00	0.00	1.21	1.21		

Narrative

The Trust position for April 2018 is 1.44, which is not meeting the expected number of *1.00. This rate relates to 9 unexpected deaths which is the same as the position in March 2018.

Of the 9 unexpected deaths the details below shows a breakdown by locality:

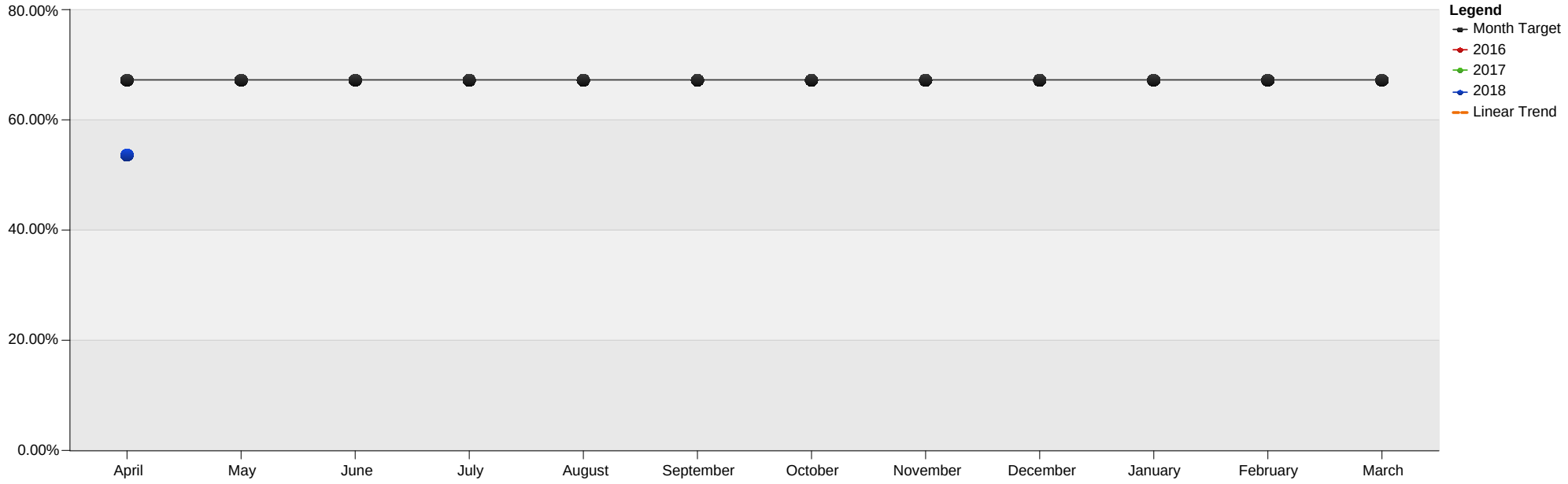
1 x Tees
1 x Durham and Darlington
6 x North Yorkshire
1 x York and Selby

Of the unexpected deaths that occurred in April 5 occurred in adult services and 4 in MHSOP services.

* Note: - This is not a target but an expected indicative level

Trust Dashboard Graphs for TRUST

6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind

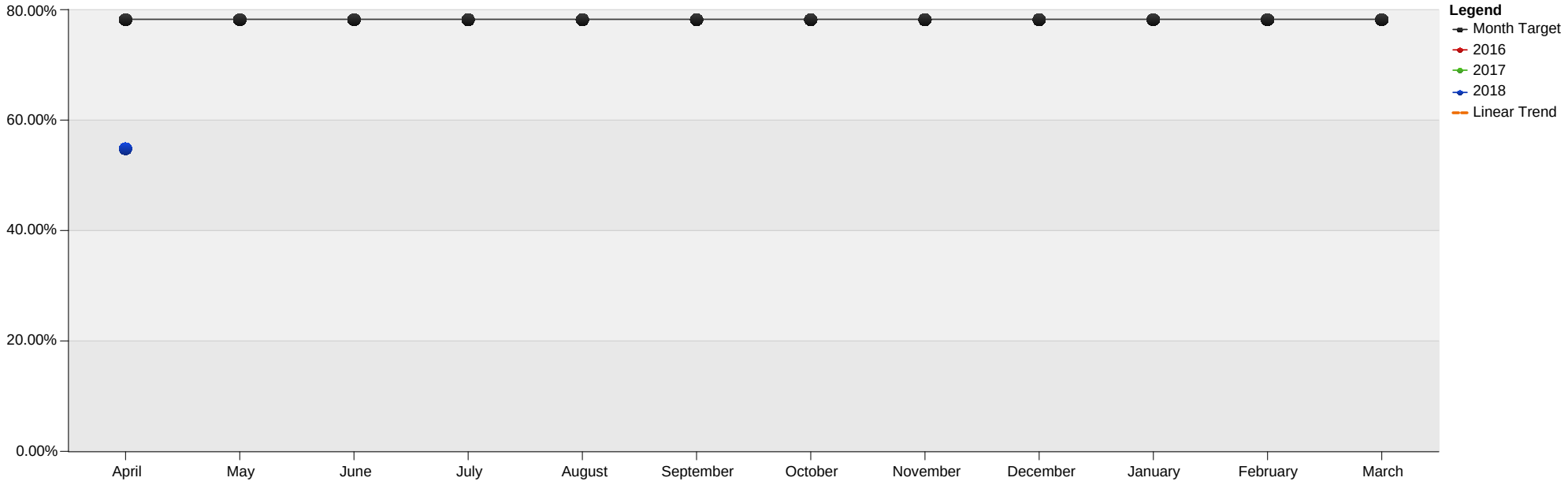


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	53.66%	53.66%	44.00%	44.00%	62.50%	62.50%	62.50%	62.50%			33.33%	33.33%		

Narrative
The Trust position for April 2018 is 53.66%, which is not meeting the target of 57.25%. Within this KPI an improvement in HONOS is shown by a decrease in the patient's actual HONOS score on PARIS. The change is identified by comparing the first HONOS score calculated on admission to TEWV, and the score on discharge.All localities are below target. The PBR team provide services with weekly breach reports to allow issues to be addressed. Work is also ongoing to improve the number of patients it is possible to report outcomes for and to report them in a timely way. Focusing on this will enable teams to improve performance against this KPI.

Trust Dashboard Graphs for TRUST

7) % of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) - month behind

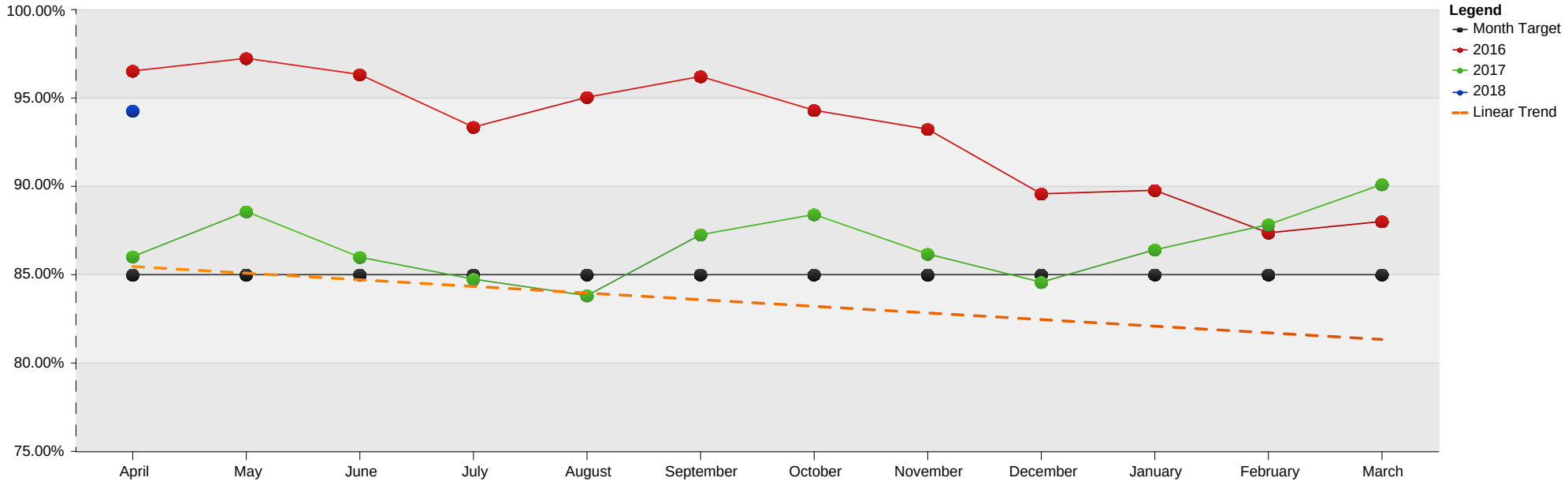


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	54.88%	54.88%	62.96%	62.96%	50.00%	50.00%	50.00%	50.00%			55.56%	55.56%		

Narrative
The Trust position for April 2018 is 54.88%, which is not meeting the target of 78.25%.Within this KPI, an improvement in SWEMWBS (which is a patient experience measure) is shown by an increase in the patients actual SWEMWBS score. The change is identified by comparing the first SWEMWBS score calculated on admission, and the score on discharge.All localities are below target. The PBR team provide services with weekly breach reports to allow issues to be addressed. Work is also ongoing to improve the number of patients it is possible to report outcomes for and to report them in a timely way. Focusing on this will enable teams to improve performance against this KPI.

Trust Dashboard Graphs for TRUST

12) Percentage of bed occupancy

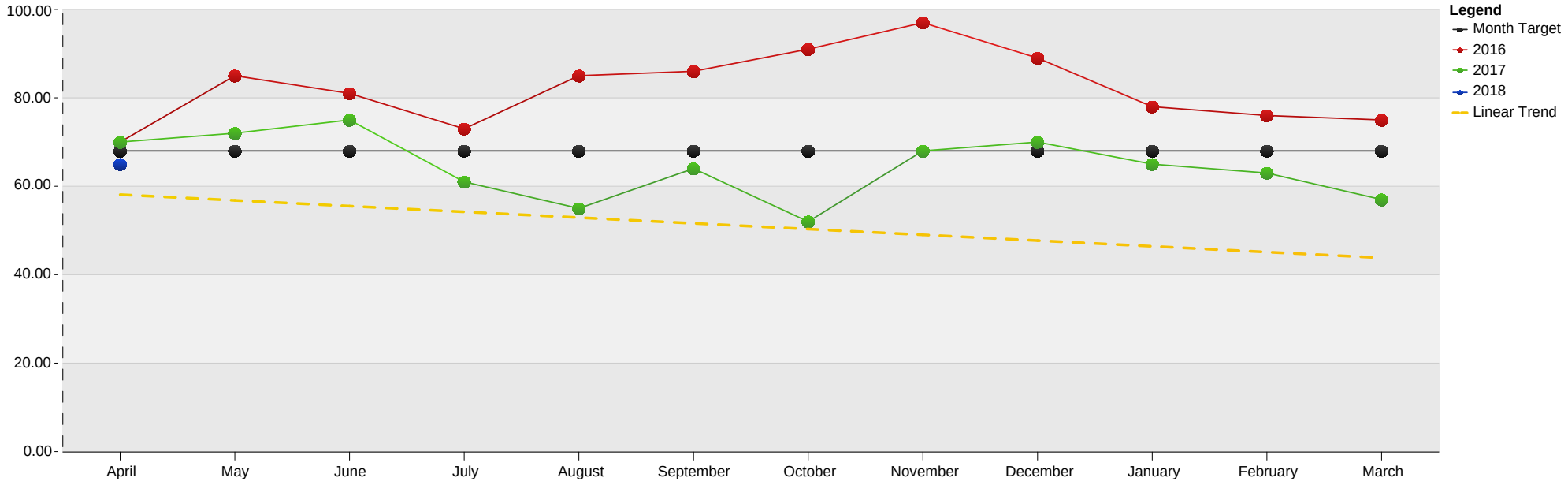


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	94.28%	94.28%	94.08%	94.08%	98.44%	98.44%	94.86%	94.86%	NA	NA	88.05%	88.05%		

Narrative
The Trust position for April 2018 is 94.28% which is worse than target and a deterioration on the position of 90.11% recorded in March 2018.Tees are reporting the highest bed occupancy at 98.44%.This is as a result of pressures on male AMH beds. Durham and Darlington are reporting a deterioration at 94.08% which is also as a result of pressures on male AMH beds. This pressure has been across all localities in the trust.. All localities are monitoring this on a continual basis and actions are discussed and agreed in daily huddles.

Trust Dashboard Graphs for TRUST

13) No. of patients occupying a bed with a LoS (from admission) > 90 days (AMH and MHSOP A&T Wards)

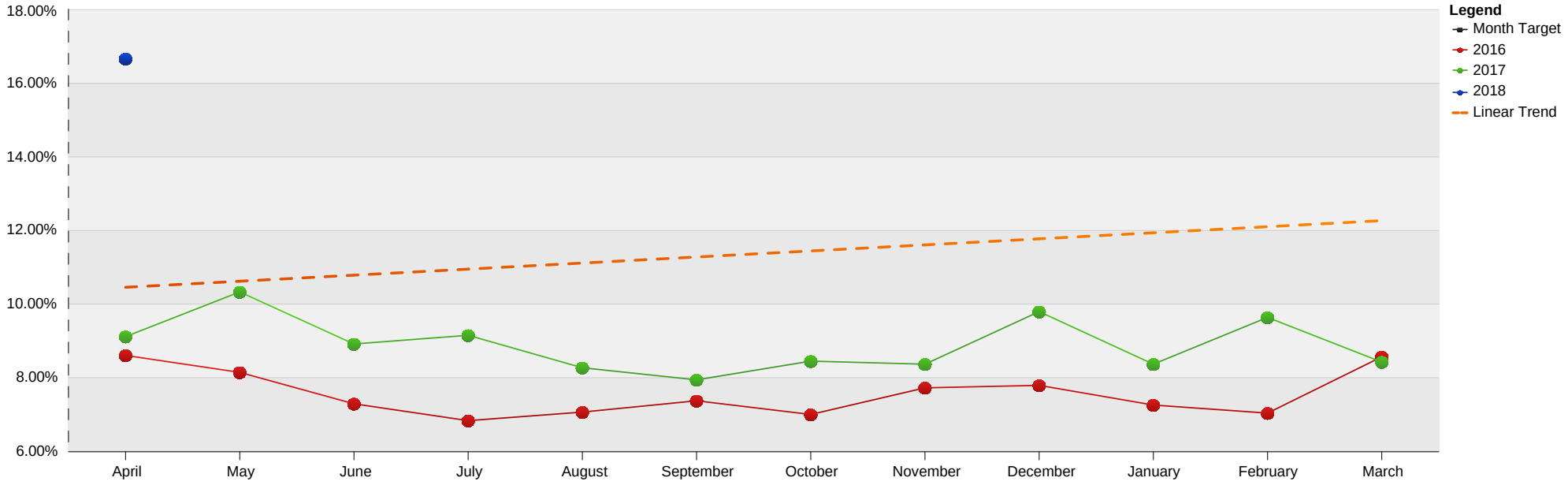


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	65.00	65.00	17.00	17.00	14.00	14.00	18.00	18.00			15.00	15.00		

Narrative
The Trust position for April 2018 is 65 which is achieving the target of 68 The following localities are not meeting target: • North Yorkshire– 18 patients (13 AMH and 5 MHOSP)• York and Selby – 15 patients (1 AMH and 14 MHOSP)North Yorkshire have the greatest number of patients with a length of stay greater than 90 days. In AMH this is mainly due to delayed transfers of care. Actions are in place to address this. Within MHSOP this is also as a result of delayed transfers of care as a result of patient complexity and the availability of appropriate placements. York and Selby are also worse than target as a result of delayed transfers of care due to problems in finding suitable placements. Actions are in place to address this and work is ongoing with partnership agencies.

Trust Dashboard Graphs for TRUST

14) % of patients re-admitted to A&T wards within 30 days (AMH & MHSOP) - in reporting month

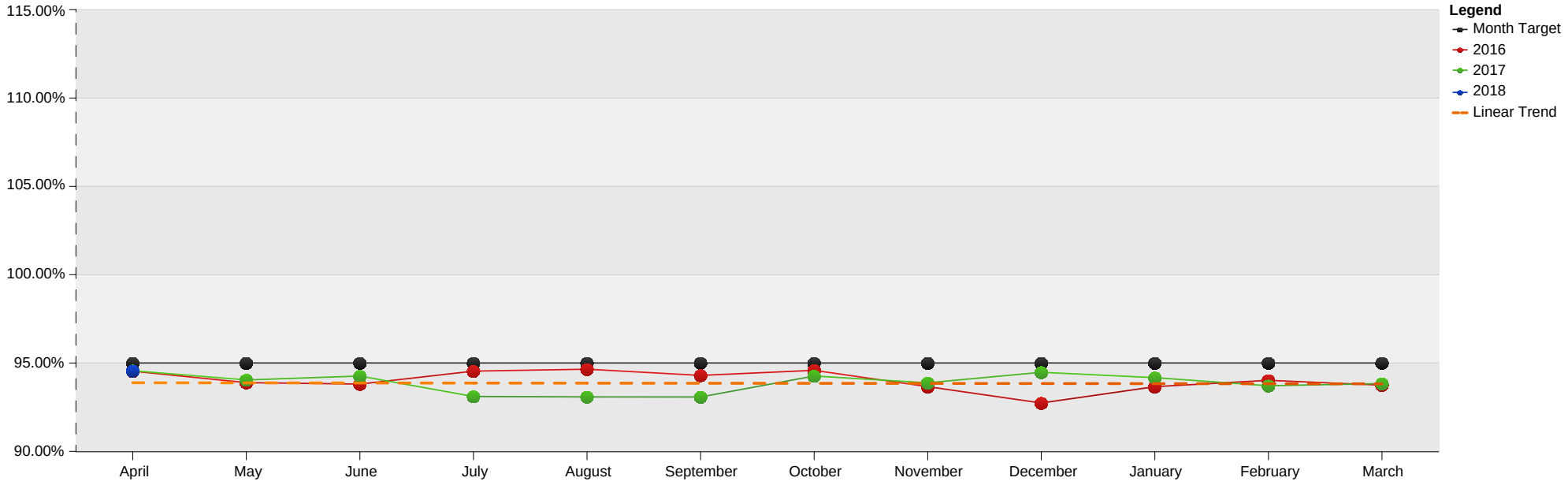


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	16.67%	16.67%	35.00%	35.00%	11.11%	11.11%	15.38%	15.38%			0.00%	0.00%		

Narrative
The Trust position ending April 2018 is 16.67%, which relates to 11 patients out of 66 that were readmitted within 30 days. This indicator has been revised from the previous year and is no longer a rolling 3 month position. A target has not yet been agreed.Durham and Darlington are on outlier at 35% (which accounts for 7 AMH patients)The service have completed focused work to improve the understanding of this issue and actions are in place to address these which were discussed at a previous board meeting.

Trust Dashboard Graphs for TRUST

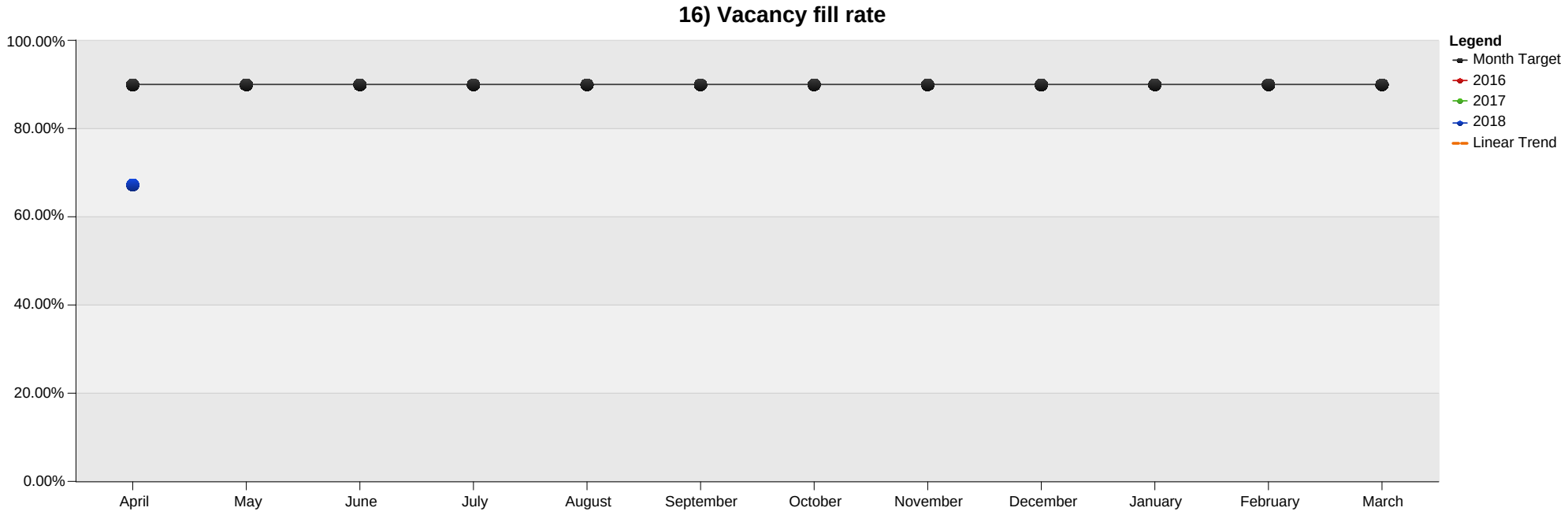
15) Actual number of workforce in month (Establishment 95%-100%)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Actual number of workforce in month (Establishment 95%-100%)	94.56%	94.56%	93.63%	93.63%	98.41%	98.41%	95.69%	95.69%	97.32%	97.32%	86.98%	86.98%		

Narrative
The Trust position for 30 April 2018 is 94.6% which is marginally worse than the targeted establishment level of 95-100%. It is expected that the establishment rate will continue to improve due to on-going recruitment events.

Trust Dashboard Graphs for TRUST

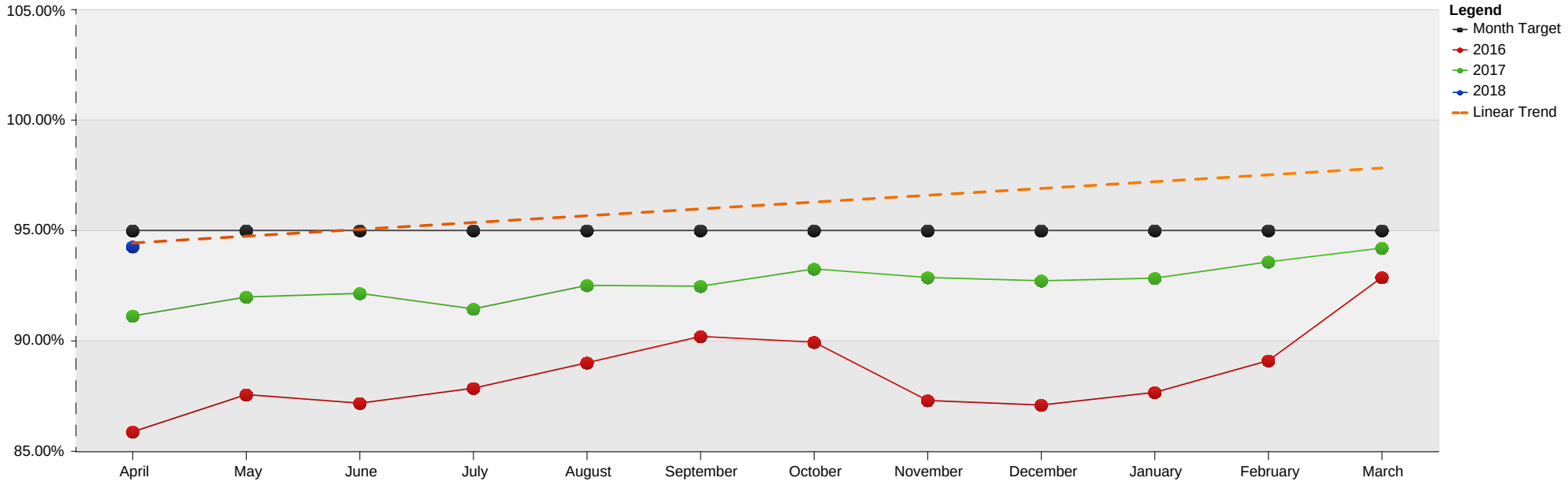


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Vacancy fill rate	67.31%	67.31%												

Narrative
The vacancy fill rate is a new key performance indicator which will report the percentage rate of health care professional vacancies band 5 and above with a conditional offer of employment made within 8 weeks of the post being advertised. The rate for April 2018 is 67.31%. This figure represents 35 vacancies with a conditional offer made out of 52. 17 vacancies are showing as waiting to be informed of interview outcome or interviews are scheduled. Due to the snapshot date in this report, in addition to the data above, during the 8 week reporting period 27 vacancies were not filled – this was due to no applicants, no applicants meeting shortlisting requirements or no applicants being appointed at interview. These vacancies do not form part of the above calculation as they are considered closed, although they were not successfully appointed to. The vacancies included a number of registered nurse posts band 5 and 6 within the Briary Unit, Harrogate, High Intensity Therapists in York and Selby and MHSOP Liaison Nurses band 6 in Durham and Darlington and Teesside.

Trust Dashboard Graphs for TRUST

17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)

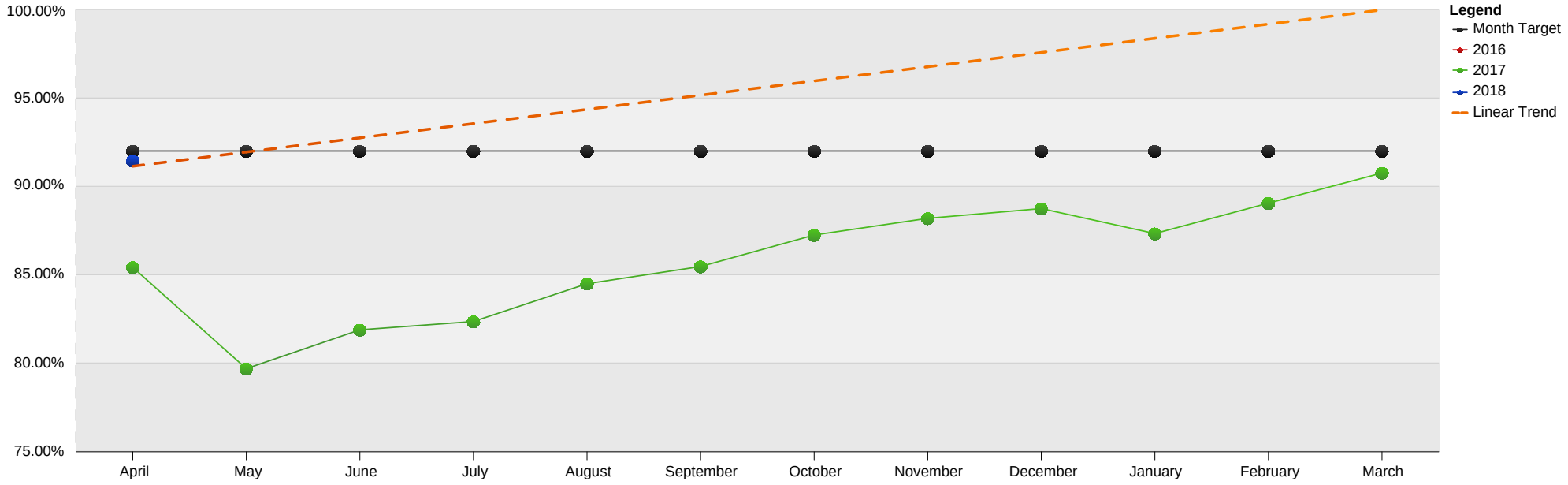


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	94.27%	94.27%	93.93%	93.93%	95.94%	95.94%	88.30%	88.30%	98.21%	98.21%	94.38%	94.38%		

Narrative
The Trust position for April 2018 is 94.27% which relates to 326 members of staff out of 5685 that do not have a current appraisal. Although this is just below the target of 95% it represents a continous improvement on the figure reported throughout 2017/18.Forensic services and Teesside are above the target of 95% with the majority of other localities reporting over 90%.The use of operational management huddles is now embedded across the Trust which includes discussions on appraisal compliance levels. When comparing the current position with 2016/17 outturn an improvement of 1.33% can be seen and this continues the increasing trend seen since 2014/15.

Trust Dashboard Graphs for TRUST

18) Percentage compliance with ALL mandatory and statutory training (snapshot)

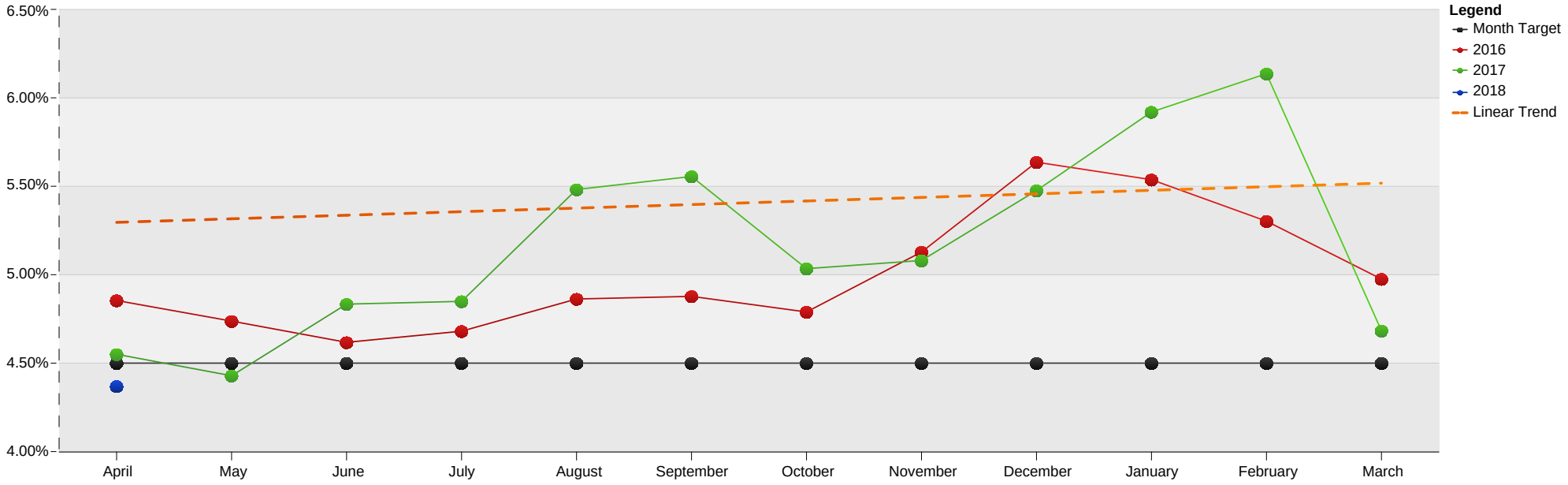


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage compliance with ALL mandatory and statutory training (snapshot)	91.45%	91.45%	89.67%	89.67%	92.06%	92.06%	89.95%	89.95%	92.18%	92.18%	93.17%	93.17%		

Narrative
The position for April 2018 continues to improve at 91.45%, which is worse than target of 92%. This figure represents a sustained increase in compliance since April 2017. The operational management huddles continue to drive improvements in performance. The improved frequency of the IIC refresh allows a timelier update of accurate performance information to managers.

Trust Dashboard Graphs for TRUST

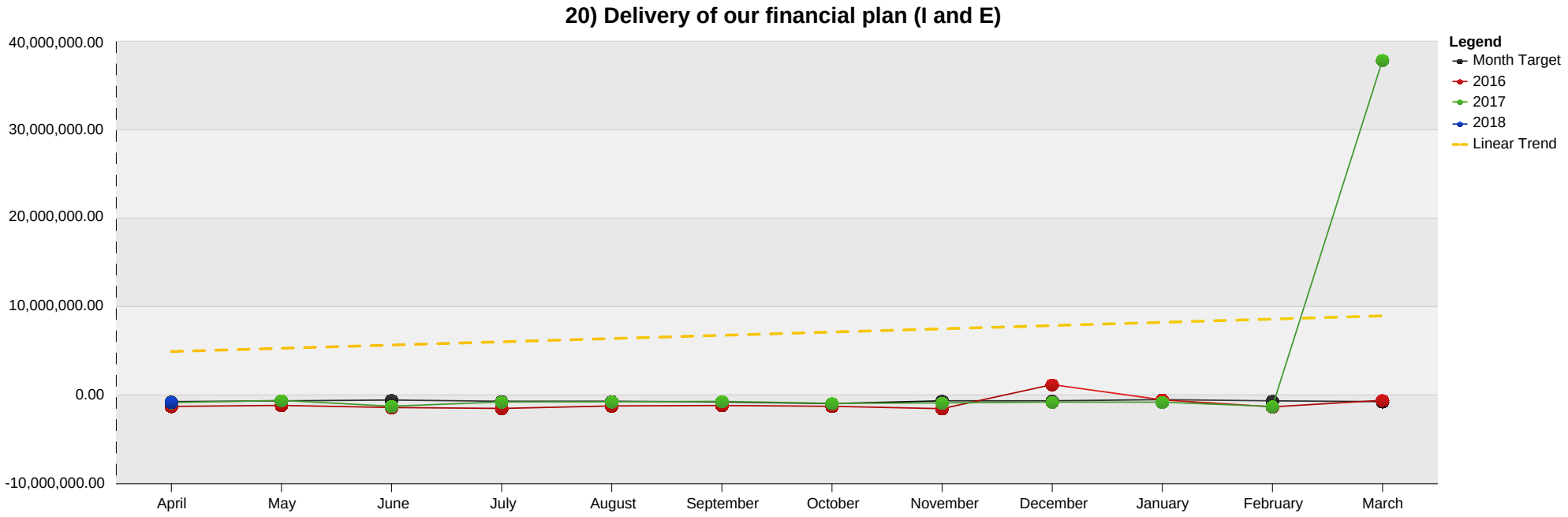
19) Percentage Sickness Absence Rate (month behind)



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Percentage Sickness Absence Rate (month behind)	4.37%	4.37%	4.99%	4.99%	4.56%	4.56%	3.11%	3.11%	4.48%	4.48%	4.65%	4.65%		

Narrative
The Trust position reported in April relates to the March sickness level. The Trust position reported in April 2018 has reduced to 4.37% which is better than the target of 4.50% and the lowest figure since May 2017. A review of the approach to managing sickness absence is currently underway and it is envisaged a new procedure will be available from September 2018. Work is also underway to review the Occupational Health provision which is due for retendering in the next 12 months.As this indicator is reported a month behind, it must be noted the financial year is calculated from March of the previous year to February within the current year (inclusive).

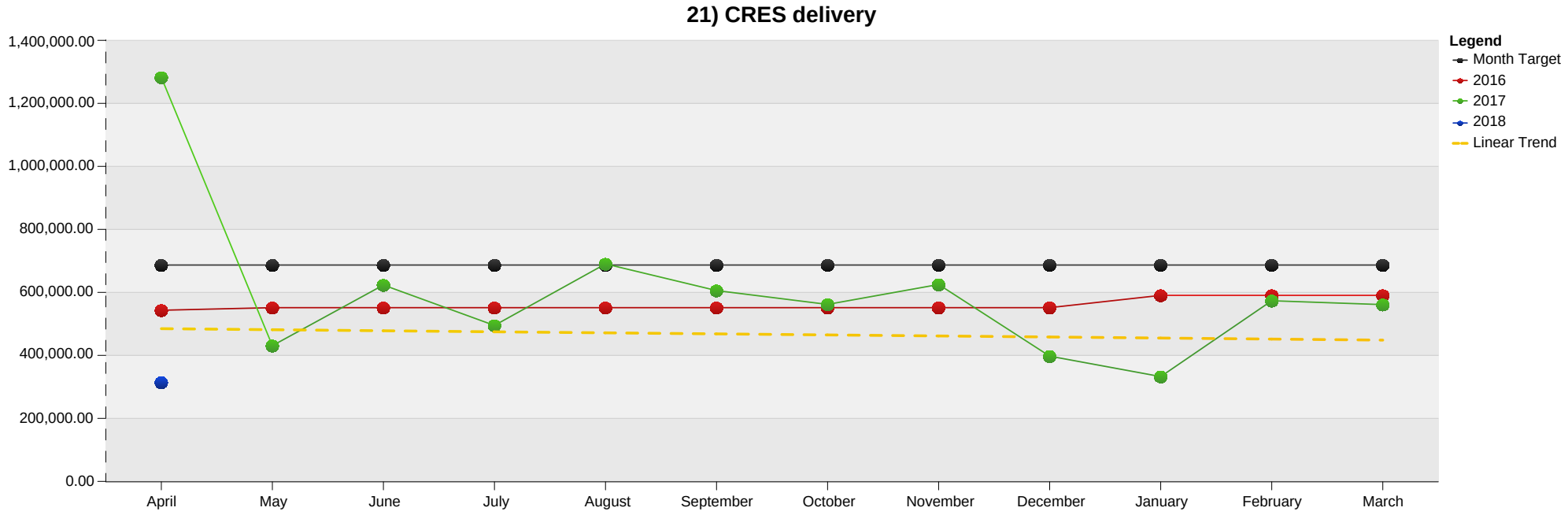
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) Delivery of our financial plan (I and E)	-845,706.00	-845,706.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
The comprehensive income outturn for the period ending 30 April 2018 is a surplus of £846k, which is £85k ahead of the planned £761k surplus and represents 3.0% of the Trust's turnover.

Trust Dashboard Graphs for TRUST

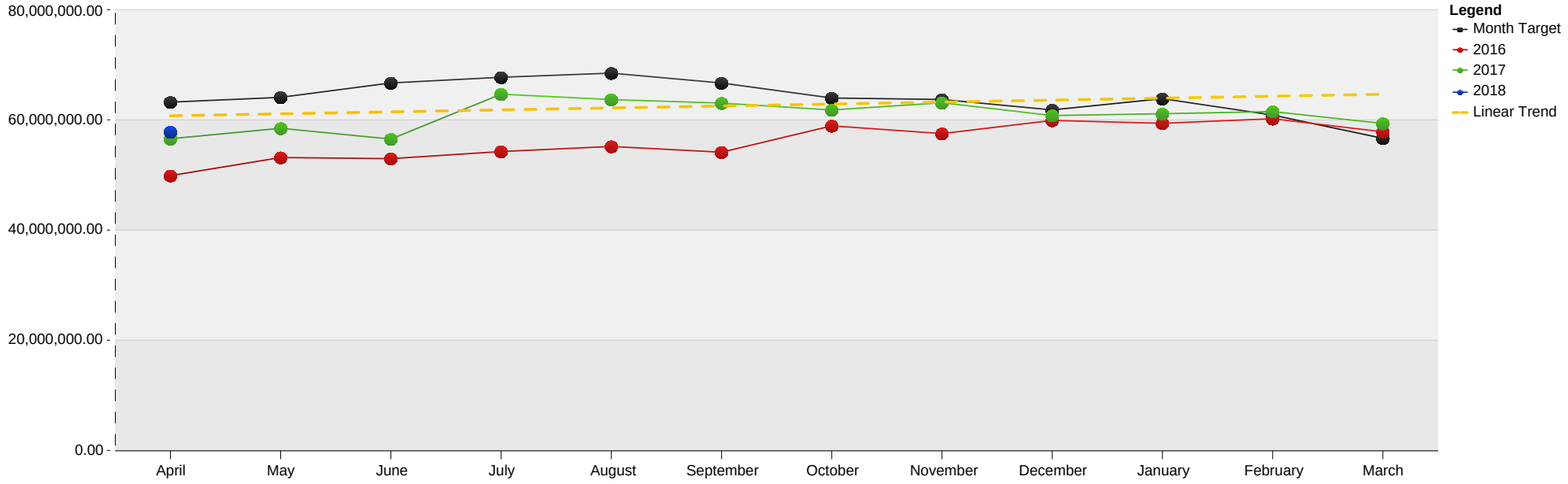


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) CRES delivery	314,372.00	314,372.00	111,977.00	111,977.00	37,486.00	37,486.00	10,264.00	10,264.00	9,132.00	9,132.00	77,528.00	77,528.00		

Narrative
Identified Cash Releasing Efficiency Savings at 30 April 2018 is £314k and is £373k behind plan for the year to date. The Trust continues to identify and develop schemes to ensure full delivery of recurrent CRES requirements.

Trust Dashboard Graphs for TRUST

22) Cash against plan



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
22) Cash against plan	57,789,000.00	57,789,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Narrative
Total cash at 30 April 2018 is £57,789k, and is £5,417k behind plan largely due to working capital variations, e.g. receipts from commissioner contract settlements anticipated in April, and payments for enabling expenditure accrued at the year end.

Trust Dashboard - Locality Breakdown for TRUST

1 - Quality

	April 2018														April 2018 To April 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral		85.99%		85.05%		92.82%		75.87%		99.25%		69.80%				85.99%		85.05%		92.82%		75.87%		99.25%		69.80%		
3) The total number of inappropriate new OAPs in the reporting period	2,494.00	2,007.00	149.00	517.00	744.00	236.00	1,215.00	986.00			387.00	268.00	2,494.00			2,007.00		517.00		236.00		986.00				268.00		
4) Percentage of patients surveyed reporting their overall experience as excellent or good	92.45%	90.98%	92.45%	92.10%	92.45%	93.33%	92.45%	93.12%	92.45%	80.33%	92.45%	82.84%			92.45%	90.98%	92.45%	92.10%	92.45%	93.33%	92.45%	93.12%	92.45%	80.33%	92.45%	82.84%		
5) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	1.44	4.00	1.61	4.00	2.25	4.00	21.65	4.00	0.00	4.00	4.83			1.00	1.44	4.00	1.61	4.00	2.25	4.00	21.65	4.00	0.00	4.00	4.83		
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	67.25%	53.66%	67.25%	44.00%	67.25%	62.50%	67.25%	62.50%				33.33%				53.66%		44.00%		62.50%		62.50%				33.33%		
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	78.25%	54.88%	78.25%	62.96%	78.25%	50.00%	78.25%	50.00%				55.56%				54.88%		62.96%		50.00%		50.00%				55.56%		

Trust Dashboard - Locality Breakdown for TRUST

2 - Activity

	April 2018														April 2018 To April 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	94.28%	85.00%	94.08%	85.00%	98.44%	85.00%	94.86%	85.00%	NA	85.00%	88.05%			85.00%	94.28%	85.00%	94.08%	85.00%	98.44%	85.00%	94.86%	85.00%	NA	85.00%	88.05%		
13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	68.00	65.00	17.00	17.00	14.00	14.00	19.00	18.00			16.00	15.00				65.00		17.00		14.00		18.00				15.00		
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month		16.67%		35.00%		11.11%		15.38%				0.00%				16.67%		35.00%		11.11%		15.38%				0.00%		

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	April 2018														April 2018 To April 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
15) Actual number of workforce in month (Establishment 95%-100%)	95.00%	94.56%	95.00%	93.63%	95.00%	98.41%	95.00%	95.69%	95.00%	97.32%		86.98%				94.56%		93.63%		98.41%		95.69%		97.32%		86.98%		
16) Vacancy fill rate	90.00%	67.31%	90.00%		90.00%		90.00%		90.00%							67.31%												
17) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	94.27%		93.93%		95.94%		88.30%		98.21%		94.38%				94.27%		93.93%		95.94%		88.30%		98.21%		94.38%		
18) Percentage compliance with ALL mandatory and statutory training (snapshot)	92.00%	91.45%		89.67%		92.06%		89.95%		92.18%		93.17%				91.45%		89.67%		92.06%		89.95%		92.18%		93.17%		
19) Percentage Sickness Absence Rate (month behind)	4.50%	4.37%		4.99%		4.56%		3.11%		4.48%		4.65%				4.37%		4.99%		4.56%		3.11%		4.48%		4.65%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	April 2018														April 2018 To April 2018											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE		FORENSIC SERVICES		YORK AND SELBY		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
20) Delivery of our financial plan (I and E)	-761,000.00	-845,706.00	0.00	NA	0.00	NA	0.00	NA	0.00	NA	0.00	NA			-761,000.00	-845,706.00	0.00	NA	0.00	NA	0.00	NA	0.00	NA	0.00	NA		
21) CRES delivery	686,782.00	314,372.00	92,714.00	111,977.00	131,481.00	37,486.00	183,271.00	10,264.00	165,920.00	9,132.00	56,518.00	77,528.00			686,782.00	314,372.00	92,714.00	111,977.00	131,481.00	37,486.00	183,271.00	10,264.00	165,920.00	9,132.00	56,518.00	77,528.00		
22) Cash against plan	63,206,000.00	57,789,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA			63,206,000.00	57,789,000.00	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		

Trust Dashboard 2018/19

KPI Guide

	KPI	***Target***	***Definition***
1	Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	TBC	This measures, the number of patients who attend their first appointment in 4 weeks of their referral date out of the total number of people who attend their first appointment following their referral. This KPI has been amended for 2018/19 and the clock will now NOT restart if the patient DNAs or the patient cancels an appointment. This looks at patients with an external referral only. This Excludes IAPT patients.
2	*Percentage of patients starting "treatment" within (x) weeks of external referral*	*TBC*	*This measures, the number of people starting treatment within X weeks of an external referral against number of people starting treatment.* *This looks at patients with an external referral only.*
3	The total number of inappropriate OAP days over the reporting period (Rolling 3 months)	2,494	This measures, the total number of days patients have spent in an out of area bed inappropriately. In line with national reporting this measures a rolling 3 months time frame
4	Percentage of patients surveyed reporting their overall experience as excellent or good	92.45%	Within all inpatient and community services, this measures: Of the number of people in the Patient Survey who answered the question: - "Overall how would you rate the care you have received?," the number of patients who have scored "excellent" or "good".
5	Number of unexpected deaths classed as a serious incident per 10,000 open cases	12	This measure looks at the number of unexpected deaths classed as a serious incident per 10,000 open cases. This mirrors the data that is reported to the National Reporting and Learning System (NRLS)
6	The % teams achieving the agreed improvement benchmarks for HoNOS total score	67.25%	This measure relates to patients discharged from TEWV In Scope services (Spells ended with a Adult or MHSOP subject to Currency & Tariff National requirements). Patients total HoNOS scores are compared from the first rating against the last. A reduction in total HoNOS score is classified as improvement. 80% of patients in the Non Psychotic and Psychotic superclass and 40% in the organic superclass are expected to achieve this reduction. Teams are subject to the measure if they discharge more than 5 patients in any of the superclasses. The measure will report against the team the patient was with at the point they are discharged entirely from TEWV not if they are transferred to a different In Scope team.

Trust Dashboard 2018/19

KPI Guide

7	The % teams achieving the agreed improvement benchmarks for SWEMWBS	78.25%	This measure relates to patients discharged from TEWV In Scope services (Spells ended with a Adult or MHSOP subject to Currency & Tariff National requirements). Patients total SWEMWBS scores are compared from the first rating against the last. An increase in SWEMWBS score is classified as improvement. 80% of patients in the Non Psychotic and Psychotic superclass and 50% in the organic superclass are expected to achieve this reduction. Teams are subject to the measure if they discharge more than 5 patients in any of the superclasses. The measure will report against the team the patient was with at the point they are discharged entirely from TEWV not if they are transferred to a different In Scope team.
8	*Number of new unique patients referred*	*TBC*	*This measures the number of new individual patients referred ie a patient is only counted once. This is when the patient is not open to any other team in the Trust.* *This Excludes IAPT patients.*
9	*The number of external referrals with an Assessment completed*	*TBC*	*This measures the number of all external referrals into Trust with an assessment completed* *This Excludes IAPT patients.*
10	*The number of external referrals which were subsequently accepted onto caseload*	*TBC*	*This measures all external referrals to all services that have been accepted onto teams caseload.* *This Excludes IAPT patients.*
11	*The number of discharges from total caseload*	*TBC*	*This measures **all discharges** excluding* • *Patients who were not appropriate to accept onto caseload* • *Patients who had a referral closed without being seen* • *Patients who were assessed but not offered treatment.* • *IAPT patients.*
12	Bed Occupancy (AMH & MHSOP A & T Wards)	85%	This measures the number of days beds that are occupied out of the number of possible bed days available. (The calculation is on the number of beds available and the days in the month). This looks at AMH and MHSOP Assessment and Treatment wards only
13	Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards (Snapshot)	68	This measures the number of patients occupying a bed with a length of stay longer than 90 days from the day they were admitted. This looks at AMH and MHSOP Assessment and Treatment wards only

Trust Dashboard 2018/19

KPI Guide

14	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	TBC	This measures the number of patients who are readmitted onto a ward within 30 days of their last discharge. This looks at AMH and MHSOP Assessment and Treatment wards only
15	Actual number of workforce in month	95%	This measures the total number of contracted staff against the number of budgeted staff.
16	Vacancy fill rate	90%	This measures the number of vacancies where an offer of employment has been made out of the number of vacancies that are being recruited to. There are vacancies that have been advertised and not filled due to no applicants or no one shortlisted, however from a recruitment vacancy perspective are closed off as an episode – These are not included in the figures as they do not go over the 8 week time frame. This looks at posts that have been vacant longer than 8 weeks. This KPI will exclude bank staff and only include professional health care posts of Band 5 and above
17	Percentage of staff in post more than 12 months with a current appraisal	95%	This measures the number of staff in post more than 12 months and of those how many have a current appraisal. For medical staff this is monitored against 13 months.
18	Percentage compliance with ALL mandatory and statutory training	92%	This measures the total number of courses completed by each member of staff for ALL mandatory and statutory training out of the number of courses due to be completed for each member of staff
19	Percentage Sickness Absence Rate	4.50%	This measures the number of days lost to sickness out of the number of days within the month
20	Delivery of our financial plan (I&E)	-8556,000	This shows the Trusts surplus or deficit position (£). The target is the planned surplus position.
21	CRES delivery	8,241,384	This shows the CRES Identified against the planned amount
22	Cash against plan	56,640	This shows the actual cash held by the Trust against the amount of cash forecasted to be held

Number of unexpected deaths and verdicts from the Coroner April 2018 - March 2019

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
9											

Number of unexpected deaths total by locality				
Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby
1	1	6	0	1

Number of unexpected deaths and verdicts from the Coroner April 2017 - March 2018

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
4	4	3	11	11	5	10	8	13	11	9	10

Number of unexpected deaths total by locality				
Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby
31	21	28	6	13

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29th May 2018**
TITLE:	**Strategic Direction Performance Report – Quarter 4 2017/18**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance & Communications**
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:

The purpose of this report is to present to the Board of Directors the Strategic Direction Performance Report as at Quarter 4 (31st March 2018).

The Trust has identified key performance indicators to monitor and report progress against its 5 year strategic direction in conjunction with the Trust Business Plan and other forms of intelligence.

Overall the scorecard position has shown an improvement when compared to quarter 3 however data is not available for all KPIs. There has been a slight increase in the number of greens reported and the quarterly position reflects that 10 metrics have improved compared to quarter 3 (irrespective of their green/red status); however there remains a number of reds at the end of quarter 4. Whilst the annual position reports an increase in the number of reds compared to 2016/17, it is positive that 15 metrics report an improvement irrespective of their green/red status.

Recommendations:

Board of Directors are asked to:

- Approve the changes to the Trust Business Plan in Appendix 1.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**29th May 2018**
TITLE:	**Strategic Direction Performance Report – Quarter 4 2017/18**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to the Board of Directors the Strategic Direction Performance Report as at Quarter 4 (31st March 2018).

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This report demonstrates progress against the Strategic Direction Scorecard and the Trust Business Plan as well as other forms of qualitative intelligence.

2.2 The 5 year targets for the Trust Strategic Direction Scorecard were agreed by the Board on the 18th August 2015, with any amendments being approved in subsequent relevant quarterly reports.

3. KEY ISSUES:

3.1 Trust Strategic Direction Scorecard

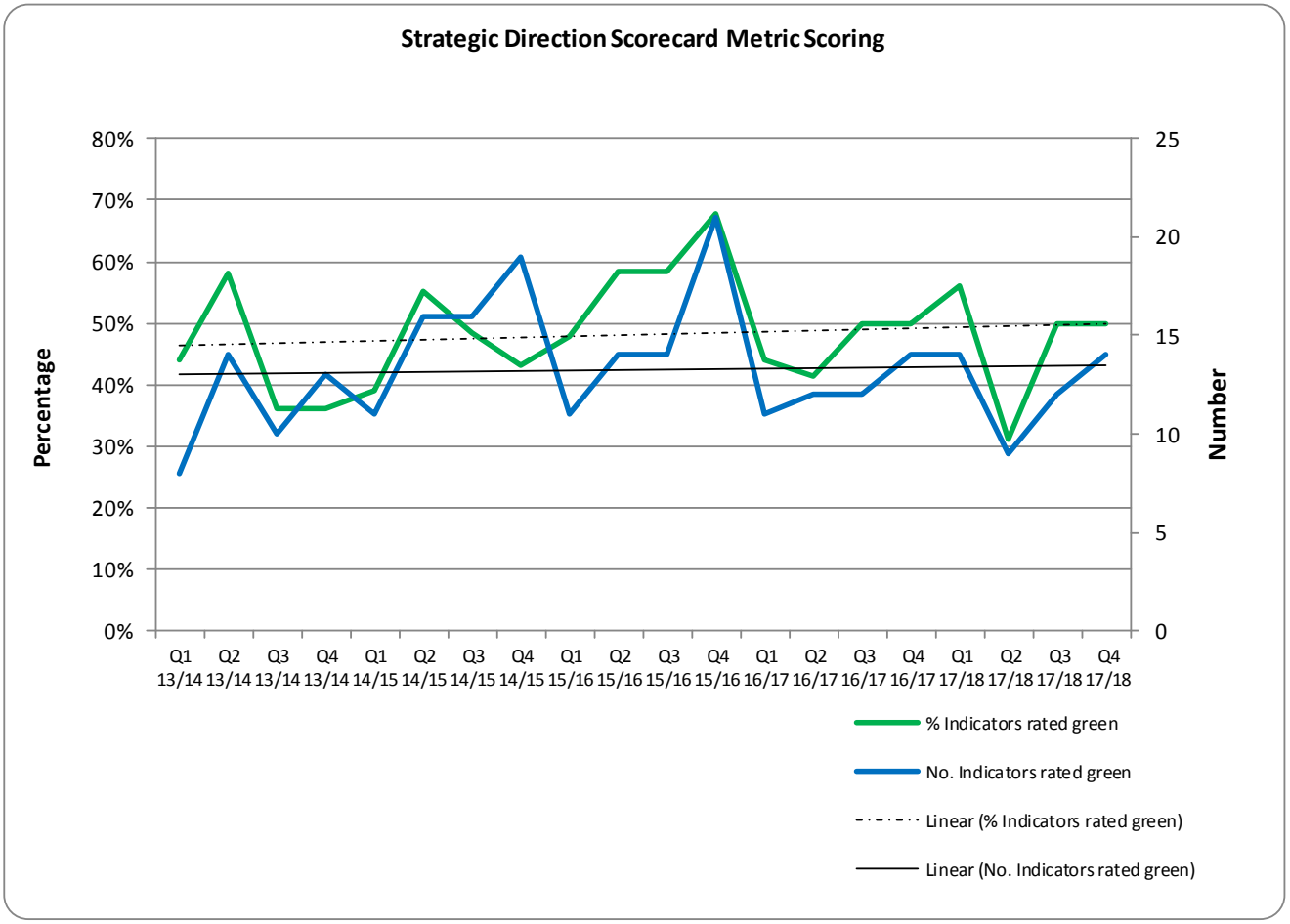
The Strategic Direction Scorecard is shown under each strategic goal with further detail, by exception, in Appendix 1.

The following table and graph provide a summary of the RAG ratings at quarter 4 compared to the position in the previous quarters and the previous financial years 2015/16 and 2016/17. The Trust is not meeting some of its high ambitions given the number of reds against stretching metrics. The actual number of those rated green has increased since last quarter and the number rated red has increased. There is a small number (6) that are not being RAG as they are not required to be reported in this quarter.

	No	%*	No	%*	No	%*	No	%*	No	%*	No	%*	No	%*
Indicators rated green	21	66%	16	55%	14	56%	9	31%	12	50%	14	48%	13	38%
Indicators rated red	11	34%	17	59%	11	44%	15	52%	12	50%	15	52%	21	62%
Indicators with no target	3		2		2		2		3		2		0	
Indicators currently under development/being finaliased	1		0		0		0		0		0		0	
Indicators where data is not yet available/not applicable in qtr	4		2		12		11		12		6		5	

The percentage is based on the number of indicators that can be RAG rated (29 for quarter 4).

The graph below shows that there has been a general slowly improving trend in the percentage of greens since 2013/14.



3.2 **Strategic Goal *1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)***

3.2.1 Trust Strategic Direction Scorecard

This strategic goal is showing 3 indicators rated red out of 6 as at quarter 4; which is the same as reported in quarter 3.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18													
	Indicator	Q4 Target 2017/18	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Quarter 4 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)													
1	Percentage of patients surveyed reporting their overall experience as excellent or good	>92.45	92.74%	91.33%	84.57%	91.35%	⇧	>92.45	90.12%	92.48%	91.37%	90.14%	>18/19 out-turn
2	Percentage of patients who have not waited longer than 4 weeks from "referral " to "assessment" for external and internal referrals	90.00%	88.22%	90.41%	90.27%	87.74%	⇩	90.00%	89.15%	84.76%	83.17%	84.50%	98.00%
3	Percentage of patients reporting "yes always" to the question "did you feel safe on the ward?"	85.00%	64.57%	62.37%	63.20%	61.17%	⇩	85.00%	62.88%	82.29%	79.96%	82.11%	85.00%
4	The Trust ranks in the top 20th percentile of all mental health Trusts for the CQC Service User Survey (annual)	Surveys: Top 20% of MH Trusts	Results due in Q2	not yet published	National scoring has changed	Results published in Q3	n/a	Surveys: Top 20% of MH Trusts	National scoring has changed	Better or About the Same as other Trusts	Yes	Survey - top 25th %ile	Surveys: Top 20% of MH Trusts
5	The Trust ranks in the top 10th percentile of all mental health Trusts for the NHS Staff Survey (annual)	Surveys: Top 10% of MH Trusts	Results due in Q4	Results due in Q4	Results due in Q4	Ranked 3rd	n/a	Surveys: Top 10% of MH Trusts	Ranked 3rd	Ranked 4th	Yes - top MH//LD trust	Survey - top 25th %ile	Surveys: Top 10% of MH Trusts
6	Percentage of service users with a recovery focused action plan (Adult Mental Health)	92.00%	90.72%	89.34%	88.97%	87.62%	⇩	92.00%	87.62%	89.73%	93.00%	93.16%	95.00%

Indicators of concern are:

- **KPI 2 Percentage of patients who have not waited longer than 4 weeks from "referral " to "assessment" for external and internal referrals –** The Trust position for quarter 4 is 87.74%, which is a deterioration on the quarter 3 position of 90.27% and worse than the Trust target by 2.26%.

  The position for the financial year is 89.15%, which is 0.85% below target but an improvement on the 2016/17 position of 84.76%.

  Only Forensic Services (99.11%) and Teesside (85.84%) are reporting above target for quarter 4, with York & Selby reporting the lowest performance at 70.72%.

  Areas of particular concern include York and Selby Adults where access continues to be the main area of concern due to a 25% DNA rate. The service has been telephoning patients prior to the appointment as a reminder but this has been unsuccessful. The impact is that patients have to be rebooked and therefore new referrals are not being seen in time. The service is seeking advice from other access teams. North Yorkshire MHSOP has seen an increase in referrals, particularly from Harrogate, which has impacted on the ability to see all patients in the required time. There continues to be staffing issues due to sickness and vacancies with teams utilising staff from other teams were possible. The Memory Service are the key area of concern with work continuing on the action plan to address issues. Following the bad weather in February/ March a number of patients did not attend appointments, the team have been trying to accommodate these rearranged sessions alongside new appointments.

- **KPI 3 – Percentage of patients reporting 'yes always' to the question 'did you feel safe on the ward?'** – The Trust position for quarter 4 is 61.17% which relates to 313 patients out of 806 patient survey responses who confirmed they always felt

safe on our wards. This is 23.83% worse than the target of 85% and a deterioration on quarter 3 when we reported 63.20%.

The position for the financial year is 62.88%, which is 22.12% below target and a significant deterioration on previous years' positions (2016/17 reported 82.29%).

All localities are reporting below target: Durham and Darlington (68.40%), York and Selby (65.56%), Teesside (55.52%), North Yorkshire (66.95%) and Forensic Services (48.53%). However, Durham and Darlington, North Yorkshire and York and Selby are all showing an improvement on quarter 3.

The table below shows a brief summary of the reasons cited by patients for feeling unsafe, not all patients provide a reason and some can give more than one.

Category	Durham & Darlington	Forensic	North Yorkshire	Tees	York &Selby
General	2	4	2	1	
Environment	2			6	
Other patients	5	3	1	11	
Personal illness	4	6	2	7	4
Staff/Staffing	5	4	1	5	2
Total	**18**	**17**	**6**	**30**	**6**

The Board received a report at its April meeting on the themes arising from responses to the question around patients reporting that they feeling safe which provided greater detail. Whilst the data shows that the main reasons for patients feeling unsafe on wards are their own illnesses or other patients, 91.35% of patients surveyed still believe their overall experience has been excellent or good (KPI 1).

- **KPI 6 - Percentage of service users with a recovery focused action plan (Adult Mental Health)** – The Trust position for quarter 4 is 87.62% which is 4.38% worse than the target of 92% and a slight deterioration on the quarter 3 position of 88.97%.

  The position for the financial year is 86.91%, which is 5.09% worse than target and a deterioration on the 2016/17 position of 89.73%. This continues a decreasing trend since 2014/15.

  Only North Yorkshire (92.68%) is achieving the target. The following should be noted:

  - The North Durham Psychosis Team is going through changes at present, staffing levels have reduced and they are dealing with a significant level of demand. In addition, cover is provided for the Access Service across 3 Teams

and staff sickness has had an impact on performance and the team's ability to complete tasks. Within the Easington Psychosis Team there have been a number of issues, including non-engagement with services, patients declining to engage in the Recovery Star and patients not being well enough to complete.

- Staffing issues have impacted on performance within all Tees psychosis teams. Team managers are to review processes to ensure patients are allocated a support worker when first referred into the service to follow the model line process. Also the possibility of integrating the recovery star within the CPA process will be explored. All breaches will be reviewed by team managers and improvements in performance are expected by June 2018.

Neither the commissioner target (90%) nor the Strategic Direction Scorecard target (92%) was achieved.

3.2.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 4 were rated green (90%) which is an increase from Quarter 3 (83%) position.

There are 3 priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

- 1 Priority (1.7h CORE 24 acute liaison service) requires additional time which moves into the next financial year 2018/19 (to be agreed by Board).
- 1 Priority (1.7s Liaison & Diversion) require removal from the business plan as there have been no external opportunities to explore Liaison and Diversion in NY and Y&S localities throughout 2017/18 (to be agreed by Board).
- 1 priority (1.2 PPCS) has identified that there is a risk to the delivery of the financial benefits due to lack of assurance on the achievement of planned financial savings. There is a planned OMT Time out on 1st May and an EMT on 2nd May. Any identified changes to the business plan and outcome/ trajectories are to be agreed through these two meetings and presented to the May PPCS Programme Board and SCOB report out and Trust Board in May 18. Within the business plan there is one action requesting removal (Product Quantity analysis) and one action requires additional time (Leadership & Development Programme) which moves into the next financial year 2018/19 (to be agreed by Board).

There are 3 metrics (CYP IHTT evaluation, Recovery - expansion of Peers roles and N&G - clinical effectiveness & patient experience evaluation) requesting approval for additional time which moves into the next financial year 2018/19 (to be agreed by Board)

There is 1 metric that requires removal from the business plan as the metrics have been revised for the 18/19 Recovery priority to include agreeing products required to support the Recovery for leaders training with a timescale of Q1 18/19 (to be agreed by Board)

Where a Board decision is required to change or remove an action, this is contained in Appendix 1 for approval.

3.2.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- Hartlepool Child and Adolescent Mental Health Services (CAMHS) has been awarded the Investing in Children Membership Award which recognises and celebrates examples of imaginative and inclusive practice with children and young people.

- The Trust's new weight management plan called 'A Weight off Your Mind' is now operating. The team are working with patients who have weight problems to help improve their physical health, quality of life and life expectancy.

- The Trust has undertaken responsibility for directly delivering mental health and learning disability services in Pocklington from 1 February 2018.

- Peer support workers within the Trust are be trained in trauma informed approaches including connecting with service users around shared experience, creating safe spaces, developing trust, being transparent about and sharing power, collaboration in the relationship and mutuality.

- Esk and Danby adult in-patient wards at Cross Lane Hospital in Scarborough have received accreditation for inpatient mental health services (AIMS) from the Royal College of Psychiatrists.

- Rollercoaster parent / carer support group, North End House, Durham were winners in the carer/parent/sibling category of the first National Children & Young People's Mental Health (CYPMH) awards.

- Stockton child and adolescent mental health service (CAMHS), Viscount House, Stockton have been awarded the Investing in Children (IiC) Membership award for their work with children, young people and their families.

- TEWV has received confirmation of its Stage One Triangle of Care award. Feedback from Carers Trust noted the "submission and progress made by the Trust over the last year has been impressive and it has been encouraging to see the renewed commitment to implementing Triangle of Care within the Trust".

3.2.4 In conclusion it can be seen for this strategic goal that that the number of KPIs rated red on the scorecard has remained the same as last quarter; however all three of those rated red show a deterioration on the previous quarter. The percentage rated green in the Business plan has improved compared to the previous quarter, but there are a number of actions which are showing some level of risk to delivery. Further work is required both around recovery star to drive up performance and with the business plan to ensure achievement. However, there is a significant amount of positive qualitative intelligence which is encouraging.

3.3 Strategic Goal 2 - *To continuously improve the quality and value of what we do*

3.3.1 Trust Strategic Direction Scorecard

This strategic goal is showing 4 indicators rated red out of 6 that can be RAG rated. Whilst this is a deterioration on quarter 3 when we reported 3 rated red, the percentage of those rated red during the quarter has decreased from 75% in quarter 3 to 66% in quarter 4.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18													
	Indicator	Q4 Target 2017/18	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Quarter 4 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 2 (To continuously improve the quality and value of what we do)													
7	Number of outstanding action points for **more than 31 days** for Level 5 SIs and action points for safeguarding serious case reviews and domestic homicide reviews	0	8	13	11	13	⇩	0	13	23	0	n/a (indicator changed)	0
8	Number of action points on action plans for complaints and clinical audit that are outstanding for **more than 31 days**	0	2	5	2	18	⇩	0	18	24	13	8	0
9	Friends & Family Test - **Patient** Survey Question: "How likely are you to recommend our ward/services to friends and family if they needed similar care or treatment?"	>86.56	87.68%	87.58%	87.00%	86.91%	⇩	>86.56	87.30%	86.56%	86.01%	89.75%	> previous year out-turn
10	Percentage of NICE Guidance where baseline assessment tool signed off by CEG within 6 months of publication	50%	14.29%	0.00%	16.67%	50.00%	⇧	50.00%	21.05%	17.14%	53.57%	34.48%	>=75%
11	Percentage of staff reporting that they can 'contribute towards improvements at work'*	>2015/16 (79%) and in top 20%ile of MH/LD trusts	Results due in Q4	Results due in Q4	Results due in Q4	75.00%	n/a	>2015/16 (79%) and in top 20%ile of MH/LD trusts	75.00%	76.00%	79% and in top 20%	77% but in top 20%	> 2018/19 and in top 20%ile for MH/LD Trusts
12	FFT - **Staff** Friends and Family scores - "How likely are you to recommend this organisation to friends and family if they need care or treatment?"	>82.58%	83.98%	80.59%	No Staff FFT in Q3	82.00%	n/a	>82.58%	82.13%	81.22%	82.58%	n/a	> previous year out-turn
13	For Trust hospital sites with over 10 beds, the trust score for each category (Cleanliness, Food, Privacy & Dignity, Condition, Appearance & Maintenance, Dementia Friendly, Learning Disability) > national average PLACE (new PEAT) assessments.	80%	Assessment due in Q2	33.33%	Assessment completed in Q2	Assessment completed in Q2	n/a	80%	33.33%	50.00%	80.00%	75.00%	80%
14	Hospitality Assured Accreditation score*	82.00%	No scoring for 2017/18	No scoring for 2017/18	No scoring for 2017/18	No scoring for 2017/18	n/a	82.00%	No scoring for 2017/18	81.10%	Assessment now due Q1 16/17 & results in Q2	80.5% (Mar 2015)	86.00%

Indicators of concern are:

- **KPI 7 - Number of outstanding action points on action plans for more than 31 days for Level 5 SI's and action points for safeguarding serious case reviews and domestic homicide reviews**– The Trust position for quarter 4 is 13 against a target of zero, which is a deterioration on quarter 3 when we reported 11. All relate to Level 5 SIs.

  The position for the financial year is 13, which is worse than target but a significant improvement on the 2016/17 position of 23.

  The 13 outstanding actions are from a total of 5 action plans. At the time of writing this report only 4 of these actions remain outstanding.

- **KPI 8 - Number of action points on action plans for complaints and clinical audit that are outstanding for more than 31 days** – The Trust position for quarter 4 is 18 outstanding action points against a target of zero, which is a significant deterioration on quarter 3 position when we reported 2.

  The position for the financial year is 18, which is worse than target but an improvement on the 2016/17 position of 24.

  All actions points relate to Clinical Audit, and in particular 4 audits. The Clinical Audit of Positive and Proactive Care: reducing the need for restrictive interventions (Positive Behavioural Support) has 1 outstanding action point relating to review and updating the AMH PBS pathway. This has now been superseded by Trust wide project work. The Clinical Audit of MHSOP Organic Wards Using the University of Stirling Dementia Design Audit Tool has 14 outstanding action points relating to specific team level environment actions and delays due to demands associated with this. All have now been received with the exception of 4 which have been extended as agreed with Project Lead and action owners. The Clinical Audit of Supervision within Durham Adult Mental Health Community Teams has 1 outstanding action relating to establishing a Task and Finish Group to include team managers of both DCC and TEWV. The Clinical Audit of Positive and Safe Practice in Forensic services has 2 actions outstanding relating to Forensic Services considering debrief process standardisation and the development of a PBS awareness session.

  Of the 18 actions, 15 are now complete, 1 has been suspended, and the action deadline has been extended for 2.

- **KPI 11 - Percentage of staff reporting that they can 'contribute towards improvements at work'** –The Trust position for 2017/18 is 75.00%, which is 4% below the target of 79% and slightly worse than the 2016/17 position of 76%.

  A Trust composite action plan will be produced and agreed by the Board, which will focus on a number of areas that have reduced in the survey.

3.3.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 4 were rated green (100%) and there were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

There is 1 action reporting grey which requires additional time which moves in to the next financial year 2018/19 (to be agreed by Board).

Where a Board decision is required to change or remove an action, this is contained in Appendix 1 for approval

3.3.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- The patient and carer experience team, Flatts Lane Centre, Middlesbrough has been shortlisted in the measuring, reporting and acting category for making best use of technology to collect, report and use feedback to improve services in the Patient Experience Network National Awards (PENNA) 2017.

- Durham and Darlington children and young people's eating disorder community service have won the 'best poster presentation' in the category of admissions and transitions, in the recent whole team training conference in London on 16 March; the team won one of four prizes across 70 teams and four categories.

3.3.4 In conclusion it can be seen for this strategic goal, that of the four KPIs that can be compared to quarter 3, two are rated red and only one has improved on the previous quarter. The 2017/18 position shows that whilst there are six metrics under-performing for the year, 5 of these have reported an improvement to 2016/17. Whilst there are no Business Plan actions at high risk, further work is required around several KPIs including the number of outstanding action points for level 5 SIs and clinical audit to achieve a more positive position in 2018/19.

3.4 **Strategic Goal 3** - ***To recruit, develop and retain a skilled, compassionate and motivated workforce***

3.4.1 Trust Strategic Direction Scorecard

This strategic goal is showing 7 indicators rated red as at quarter 4 out of a possible 11 that could be rated. Whilst this indicates a deterioration on the quarter 3 position, four of those rated in Quarter 4 could not be rated in Quarter 3. Of those that were reported in both quarters there has been a consistency in the number of red ratings; 3 within each month. Of those rated red, one has reported an improvement.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18													
	Indicator	Q4 Target 2017/18	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Quarter 4 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 3 (To recruit, develop and retain a skillled, compassionate and motivated workforce)													
15	FFT - **Staff** Friends and Family scores - "How likely are you to recommend this organisation to friends and family as a place to work?"	>70.95%	72.00%	70.33%	No Staff FFT in Q3	69.00%	n/a	>70.95%	70.44%	70.45%	70.95%	n/a	> previous year out-turn
16	Percentage of medical students and junior doctors reporting satisfaction with their placement	89.00%	90.77%	83.06%	84.72%	90.14%	⇧	89.00%	86.84%	89.97%	89.09%	87.25%	90.00%
17	Percentage of positive nursing placement evaluations received	95.00%	95.24%	97.19%	95.05%	90.78%	⇩	95.00%	94.46%	95.69%	95.17%	94.93%	95.00%
18	Excess cost of employing medical agency versus substantive	£300,000	£129,656	£102,028	£134,389	£235,477	⇧	£300,000	£601,550	£697,684	£200k	n/a	zero
19	NHS Employers Assessment of Wellbeing	100%	100.00%	100.00%	100.00%	100.00%	⇔	100%	100.00%	100.00%	100.00%	100.00%	100%
20	Percentage of Culture Metrics showing improvement at year end*	n/a	no longer reported	no longer reported	no longer reported	no longer reported	n/a	n/a	no longer reported	no longer reported	To be reported at July 16 Trust Board	16.67%	100%
21	Percentage of positive staff responses for training/development evaluations received (data is a month behind	75.00%	77.66%	82.57%	76.55%	89.51%	⇧	75.00%	80.78%	74.18%	75.30%	deferred	TBC
22	Quality of Appraisals	>4.0	Results due in Q4	Results due in Q4	Results due in Q4	3.24	n/a	>4.0	3.24	4.00	3.36	49% but in top 20%	>= 2018/19 & in top 20%
23	Percentage of medical staff successfully revalidated	100%	100.00%	N/A	100.00%	100.00%	⇔	100%	100.00%	90.00%	98.15%	100.00%	100%
24	Percentage of indicators in the NHS Staff Survey for which there was no noticeable or sufficient different in responses of those who identified themselves as disabled, compared to those who did not identify themselves as disabled	>93.75%	Results due in Q4	Results due in Q4	Results due in Q4	87.50%	n/a	>93.75%	87.50%	93.75%	n/a		TBC
25	Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above	50%	40.00%	27.78%	30.77%	11.11%	⇩	50.00%	21.21%	8.08%	32.00%	34.02%	80.00%
26	Percentage of staff reporting that they 'suffered work related stress in last 12 months'*	<2015/16 outturn (28%)	Results due in Q4	Results due in Q4	Results due in Q4	39.00%	n/a	<2015/16 outturn (28%)	39.00%	33.00%	28% and top 20% (best for MH/LD Trusts)	38% but in top 20% (DEC 14)	< previous year out-turn

Indicators of concern are:

- **KPI 17 - Percentage of positive nursing placement evaluations received** - the Trust position for quarter 4 is 90.78%, which is 4.22% worse than target and a deterioration on the 95.05% reported for quarter 3.

  The position for the financial year is 94.46%, which is slightly worse than target and a deterioration on the 2016/17 position of 95.69%. This reflects the lowest percentage of positive evaluations since 2014/15.

  The student evaluations that are influencing the reduction in satisfaction are from the short placements (short and long placements are evaluated separately, although the questions relate to the same themes), the satisfaction rates from students on a long placement remain high.

  The factor that appears to be influencing the scores is the increase in the number of students on short placements, which may influence the student satisfaction with placements. However the data presented does not give this detail. This is to be taken forward by the Nursing & Governance Teams.

- **KPI 18 - Excess cost of employing medical agency versus substantive** - the Trust position for quarter 4 is £235,477 against a target of £75,000.

The position for the financial year is £601,550, which is above target but a significant improvement on the 2016/17 position of £697,684.

As at the end of quarter 4, 14 agency staff were required to support vacancies in Durham and Darlington (3 MHSOP and 2 AMH), Teesside (1 CYPS), North Yorkshire (3 MHSOP and 1 AMH) and York and Selby (2 MHSOP, 1 AMH and 1 CYPS).

An additional 2 agency staff were required to cover sickness in York and Selby (1 AMH and 1 CYPS).

- **KPI 22 – Quality of Appraisals -** The Trust position for 2017/18 is 3.24, which is 0.76 below the target of 4, which was the baseline data for 2016/17.

  Whilst not quite achieving target, the Trust performs well against the average for mental health trusts in relation to this indicator. The number of people reporting having an appraisal has increased and the quality of appraisal is statistically equivalent in 2017 to 2016. Training for over 800 supervisors of staff in relation to the quality of appraisals took place in 2016 and integration of the talent management approach to the appraisal process was recommended in 2017 and then introduced in February 2018. A Talent management facilitator role at locality manager level is being piloted April to September 2018. The purpose of this pilot is to identify how locality managers can align business objectives through the management structure into team and individual appraisal objectives. A pre-appraisal workbook has been introduced to help staff consider how their personal values and work goals can be aligned.

- **KPI 24 - Percentage of indicators in the NHS Staff Survey for which there was no noticeable or sufficient different in responses of those who identified themselves as disabled, compared to those who did not identify themselves as disabled –** The Trust position for 2017/18 is 87.50%, which reflects 4 questions out of 32 for which there was over a 10% point difference in the response between staff who identified themselves as disabled and those who did not. This is 6.25% worse than the target of 93.75%, which reflected the 2016/17 position.

  The Trust is now certified as a Disability Confident Employer. As part of this we have undertaken and successfully completed the Disability Confident self-assessment. We have an action plan in place and are taking all of the core actions to be a Disability Confident employer which includes activity around getting the right people for our business and also how we look and develop our people. It is anticipated that this will impact on this indicator in the future.

- **KPI 25 - Percentage of recruitment processes with at least 2 internal candidates above the line for Band 7 posts and above** – The Trust position for quarter 4 is 11.11%, which reflects 16 advertised posts out of 18 that did not have at least 2 internal candidates above the line for Band 7 posts and above. This is 38.89% worse than the target of 50% and is a deterioration on the quarter 3 position of 30.77%.

The position for the financial year is 21.21%, which is worse than target but a significant improvement on the 2016/17 position of 8.08%.

An initial review of the posts advertised in the quarter does not highlight any obvious reasons for the decline in performance in quarter 4, i.e. there was a range of posts across all localities and specialisms. This unexpected decline signifies that Talent Management needs to continue to be a priority for the Trust. The new combined appraisal / talent management approach was published in February 2018 and a locality manager facilitator role is being piloted in MHSOP Teesside. The Trust is continuing to develop and refine its talent management approach.

- **KPI 26 - Percentage of staff reporting that they 'suffered work related stress in last 12 months'** – The Trust position 2017/18 is 39% which is 11% worse than the target of 28% and slightly worse than the 2016/17 position of 33%.

  A Trust composite action plan will be produced and agreed by the Board, which will focus on a number of areas that have reduced in the survey.

  Within the Trust there has been a great deal of emphasis on the 'positive action' message over the year, including the autumn health and wellbeing roadshows and detailed health and wellbeing messages in the e-bulletin and activity classes being put on for staff where possible. The Trust received a number of positive comments about the health and wellbeing support it provides to staff in the Investors in People Assessment report which it received following a full assessment by external assessors in November 2017. The Trust received a Gold award following the assessment.

3.4.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 4 were rated green (100%) and there were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

3.4.3 Other Qualitative Intelligence

- The **Trust** has achieved Investors in People (IiP) Gold accreditation for the second time in a row, demonstrating its commitment to high performance through good people management.

- **Dr Nick Rowe**, Converge Director, York, has been appointed Member of the Order of the British Empire (MBE) for services to mental health service users in Yorkshire and the North East.

- **Lorraine Ferrier**, Head of Nursing, Durham and Darlington, has received an invitation from the Master of the Household, Buckingham Palace at Her Majesty's command to attend a reception (in the presence of HRH The Prince of Wales) for those engaged in front line nursing in the UK.

- **TEWV** has been shortlisted for the NHS Employer's Flu Fighter Team of the year award.

3.4.4 In conclusion it can be seen for this strategic goal that whilst the number of red KPIs has increased by 4 since last quarter, three metrics have improved during the quarter. Nevertheless, the annual position reflects a deterioration across 6 of the metrics within this goal, when compared to 2016/17 indicating that significant progress needs to be made during 2018/19. The Trust will continue to benefit from an increased focus on talent management. The Business plan is showing a positive position, with all actions completed. Qualitative intelligence for this goal also provides a positive position.

3.5 Strategic Goal 4 - *To have effective partnerships with local, national and international organisations for the benefit of the communities we serve*

3.5.1 Trust Strategic Direction Scorecard

This strategic goal is showing no indicators rated red at quarter 4, which reflects that reported for quarter 3.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18

	Indicator	Q4 Target 2017/18	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Quarter 4 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 4 (To have effective partnerships with local, national and international organisations for the benefit of the communities we serve)													
27	Attendance rate at H&WB Boards	90%	84.21%	75.00%	92.31%	100.00%	⇧	90%	87.50%	85.71%	87.50%	97.06%	90%
28	Attendance rate at Statutory Safeguarding Boards & MAPPA Strategic Management Boards	98%	100.00%	100.00%	100.00%	88.89%	⇩	98%	97.40%	100.00%	100.00%	98.59%	98%
29	Proportion of student nursing placements provided as a % of placements requested	90%	99.86%	98.89%	99.63%	99.66%	⇧	90.00%	99.50%	100.26%	99.12%	99.77%	90.00%
30	R&D Outcomes - Annual number of recruits to National Institute of Health Research studies supported by TEWV R&D staff	n/a	539	393	153	186	⇩	498	1271	1105	412		10% increase year on year
31	R&D Outcomes - Annual external R&D income (including external grants and commercial income)	n/a	£168,674	£199,499	£154,590	£319,178	⇧	£678,014	£841,941	£585,215	£616,376	n/a	10% increase year on year
32	Corporate Governance Statement signed off annually by Board with no conditions* and Monitor Governance Risk Rating maintained at 'GREEN' each quarter	n/a	no longer reported	no longer reported	No longer reported	No longer reported	n/a	n/a	No longer reported	No longer reported	Signed & Green	Signed & Green	Signed & Green

3.5.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 4 were rated green (100%) and there were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

There is 1 action, rated grey, which requires additional time due to the NMC standard and university models external timescales which moves into the next financial year 2018/19 (to be agreed by Board).

3.5.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- **TEWV** currently has 13 interns working in a variety of roles like administration, meeting and greeting, gardening and maintenance, as part of the Project Choice supported internship programme, in partnership with Health Education England. The programme provides internships to people aged 16-24 who have a learning disability and/or autism.

- The Durham, Darlington and Tees ACP Board agreed to extend the scope of the **Accountable Care Partnership** (ACP) from Adult Learning Disabilities to all specialities. Early indications from the 62 reviews of complex Adult LD placements, is that quality has improved and some financial savings found. Evaluation work continues. Work with CCGs to agree the financial element of ringfences and the required annual uplift for CHC is behind plan and had not been completed by the end of 17/18.

- The 3 North Yorkshire CCGs have commenced exploratory discussions with TEWV about establishing an ACP, and TEWV has seconded the current Head of ALD in North Yorkshire to support this development.

3.5.4 In conclusion, performance for this strategic goal is positive. Whilst two of the five KPIs have reported a deterioration compared to the previous quarter, taking into account progress against the Business Plan and the qualitative intelligence the overall position remains positive for this strategic goal. From an annual perspective, within 2017/18, only one metric has reported below target (compared to two in 2016/17), but that reported an improvement.

3.6 Strategic Goal 5 - *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*

3.6.1 Trust Strategic Direction Scorecard

This strategic goal is showing 1 indicator rated red out of 7 as at quarter 3, which is an improvement on the position reported in quarter 3.

TRUST STRATEGIC DIRECTION SCORECARD 2017/18													
	Indicator	Q4 Target 2017/18	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Quarter 4 Actual	Change on previous quarter	YTD Target 2017/18	FYTD 17/18 Actual	2016/17 Actual	2015/16 Actual	2014/15 Actual	Final Target - March 2020 (agreed Aug 2015)
Strategic Goal 5 (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)													
33	Percentage of data quality issues reported on Data Quality Scorecard (reds on scorecard)	37.50%	71.43%	71.43%	71.43%	84.62%	⇩	37.50%	84.62%	64.29%	57.14%	75.00%	<=6.25%
34	Percentage of Information Strategy metrics on target that are reported on Information Strategy Metrics Scorecard	81.25%	85.71%	71.43%	85.71%	85.71%	⇔	81.25%	85.71%	81.25%	5 yr Strategy & metrics approved EMT March 2016	n/a	TBC
35	Percentage change in income for Trust contracted services compared to previous year	0.10%	-0.27%	-0.27%	0.43%	0.73%	⇧	0.10%	0.73%	7.42%	8.09%	0.90%	Better than deflator
36	Reference Cost Index score for in-scope PbR Services	<=95	104	N/A	100	Reported in Q3	n/a	<=95	100	100	92	n/a	TBC
37	Reference Cost Index score for out of scope PbR Services	<=95	82	N/A	88	Reported in Q3	n/a	<=95	88	88	95		TBC
38	EBITDA **	7.00%	7.70%	7.20%	7.10%	8.20%	⇧	7.70%	8.20%	7.79%	8.22%	8.73%	8.00%
39	Good Corporate Citizenship audit scores*	70.00%	Replaced by the Sustainable Development Assessment Tool				n/a	70.00%	N/A	66%	66%	51% (March 15)	75.00%

Indicators of concern are:

- **KPI 33 - Percentage of data quality issues reported on Data Quality Scorecard (reds on scorecard)** – The Trust position for quarter 4 is 84.62%, which is a deterioration on the position reported in quarter 3 of 71.43% and 47.12% more than expected and therefore an underperformance.

  The position for the financial year is 84.62%, which is worse than target and a significant deterioration on the 2016/17 position of 64.29%. This continues a decreasing trend in performance since 2015/16.

  Of the 13 metrics, only Missing Patient NHS Number and Percentage of records submitted through MHSDS with a valid NHS Number, report green. Of the 11 metrics reporting red, 3 have shown some improvement on quarter 3. The quality scorecard will continue to be monitored at the Data Quality Working group and escalated to the Managing the Business Sub group if required.

  A new Data Quality Strategy is being developed to drive this work forward.

Other points to note:

- **KPI 39 – Good Corporate Citizenship audit scores** –the Sustainable Development Unit (SDU) have replaced the Good Corporate Citizenship Assessment Tool (GCCAT). The replacement Sustainable Development Assessment Tool (SDAT) became active in February 2018 and we are currently building a score on the new assessment tool. The scoring mechanism is totally different on the new scheme; therefore proposals for a new metric will be taken forward in 2018/19.

3.6.2 Trust Business Plan

All of the business plan actions due to be completed by the end of quarter 4 were rated green (100%) and there were no priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget.

3.6.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- The Trust's comprehensive income outturn for March 2018 reflected £4,476k of incentivised and bonus sustainability and transformational funding due to financial performance exceeding the control total. Additional contract variations were received in quarter 4 relating to schemes already being delivered.

3.6.4 In conclusion performance against this strategic goal is positive. It can be seen that of the four KPIs that could be compared to the previous quarter, two have improved and one has remained the same. Progress against the Business Plan remains positive with all actions completed. Within 2017/18 two metrics have been rated red; the same as in 2016/17.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
There are no issues of compliance with the CQC fundamental standards.

4.2 **Financial/Value for Money:**
The report highlights that none of the Sustainability metrics are below target.

4.3 **Legal and Constitutional (including the NHS Constitution):**
There are no direct legal or constitutional implications from this paper.

4.4 **Equality and Diversity:**
There are no direct equality and diversity implications from this paper, however, one metric does measure the variance in the responses of staff in the NHS Staff Survey who report as 'disabled' compared to those reporting 'non-disabled'.

4.4 **Other implications:**
There are no other implications associated with this paper.

5. RISKS:
There are no identified risks associated with this paper.

6. CONCLUSIONS:

This is the final Strategic Direction Performance Report for 2017/18 and reports progress against the Strategic Direction Scorecard and the Trust Business Plan whilst also considering other forms of qualitative intelligence.

Overall the scorecard position has shown an improvement when compared to quarter 3 however data is not available for all KPIs. There has been a slight increase in the number of greens reported and the quarterly position reflects that 10 metrics have improved compared to quarter 3 (irrespective of their green/red status); however there remains a number of reds at the end of quarter 4. Whilst the annual position reports an increase in the number of reds compared to 2016/17, it is positive that 15 metrics report an improvement irrespective of their green/red status.

The report reflects that two goals still require significant improvement; quality and workforce. Whilst the Trust ranking within the Staff Survey remains in the 10th percentile and has actually improved from 4th position to 3rd position, the supporting metrics from the survey and Staff Friends and Family Test and Staff Survey have in general deteriorated and significant work is required to improve results.

7. RECOMMENDATIONS:

Board of Directors is asked to:

- Approve the changes to the Trust Business Plan in Appendix 1.

Sharon Pickering
Director of Planning, Performance & Communications

Background Papers:

Appendix 1

Board requests for changes:

Appendix D – Requests for Change to Business Plan (including priorities / service developments currently behind or at risk of failure to deliver within time, resource or quality expectations)

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Specialty	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
1.7g	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - **Intensive Home Treatment**	Tees	CAMHS	Evaluate the outcome and impact for both service users and CAMHS services	Evaluation Complete	Q4 17/18	John Barnard	**R**	Unable to pull data as IHT is absorbed within crisis figures on IIC. The service have requested for the figures to be separated out in order to evaluate appropriately Therefore the board are requested to approve an extension to 18/19 Q2
1.7h	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - **Deliver a CORE 24 acute liaison service**	Tees		Gain agreements from HaST and South Tees CCGs on how to utilise national and local funding to implement a CORE24 service in a sustainable way	HaST and South Tees CCGs submit a bid to NHSE for CORE 24 development funding.	Q4 17/18	Elaine Wells	**GY**	Core 24 Transformation Wave 2 bids anticipated October 2018. Discussions currently ongoing with South Tees CCG. This priority has been included in the 18/19 business plan Therefore the board are requested to approve an extension to Q4 18/19
1.7s	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners - **Liaison & Diversion**	Forensic	NA	Explore opportunities for provision of L&D within North Yorkshire and York & Selby Localities	Respond to opportunities within required timescales	Q4 17/18	Lisa Taylor	**GY**	There have been no external opportunities to explore Liaison and Diversion in NY and Y&S localities throughout 2017/18. Therefore Trust Board are requested to remove this Priority and metric

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
1.1	Implement Phase 2 of the Recovery Strategy	COO	NA	Development of Recovery for leaders training programme	Training programme developed	Q4 17/18	Ruth Briel	**GY**	Following discussions at Monday PMF report out it has been recognised that leadership is a strand/link across all programmes and therefore a more integrated approach should be adopted. Further discussion has taken place with Recovery lead and OD lead to progress this. Therefore Trust Board are requested to remove this action as revised actions for the Recovery priority for 18/19 Business plan is to include agreeing products required to support the Recovery for leaders training with a timescale of Q1 18/19
1.1	Implement Phase 2 of the Recovery Strategy	COO	NA	Continue to expand Involvement peer roles by at least 15 new roles per year	15 new peer roles in place	Q4 17/18	Ruth Briel	**R**	Recovery Programme Board agreed the extension of recruitment of first cohort of peers to be delayed until June 2018. The recruitment process for peer training has commenced however due to sickness absence there is some risk to the delivery of the June milestone but should not impact on the delivery of the final target in March 2020.Therefore Trust Board are requested to agree the change request to extend the timescale to end Q1 18/19

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
1.2	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	COO	NA	Introduce new leadership development programme	New leadership development programme launched	Q3 17/18	David Brown	R	There is a delay to the launch due to EMT requesting further work on the Leadership and Development Strategy which will be presented to EMT in April 18 for ratification, then Resources Committee and Trust Board. Therefore Trust Board are requested to approve the extension of timescale of this metric to Q1 18/19
1.2	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	COO	NA	PQ analysis completed to assist in identifying future workforce model	PQ analysis completed and next steps agreed in all Localities for all in-scope services	Q4 17/18	David Brown	R	Some PQ analysis has been carried out across all Specialities however this was not used to inform the future workforce modelling due to the change in direction of the PPCS programme. PPCS is a priority in the 18-20 business plan and therefore this action will be superseded. Therefore Trust Board are requested to remove this metric.
2.4	Ensure we have Safe Staffing in all our services	N&G	NA	Introduce a new report for ward managers which brings together data on staffing and other quality and recognised quality safety indicators	Report introduced	Q4 17/18	Elizabeth Moody	GY	Monthly and 6 monthly staffing reports and dashboards are in place (based on safe staffing levels). There remains to be an issue with the bespoke reporting dashboard due to the supplier not being able to provide what we require. Mitigations have been put in place locally to support local gathering of information until a technological

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Specialty	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
									solution can be found. Alternative approaches and discussions with the IT supplier continue to be explored and pursued Trust Board are requested to extend the timescale to Q2 18/19
1.10	Improve the clinical effectiveness and patient experience at times of transition	N&G	NA	Complete an evaluation report on the effectiveness of implementation of the new protocol and feedback to relevant stakeholders	Evaluation complete	Q4 17/18	Leanne McCrindle	R	An evaluation report on the effectiveness of implementation of the new protocol and feedback is being developed and will be provided to relevant stakeholders. Trust Board are requested to extend the timescale to Q1 18/19 for completion of the evaluation report.
4.8a	Develop collaboration with universities on training / R&D	Medical	NA	Work with Universities on increasing capacity of traditional nursing training programmes and developing new bespoke training programmes to "grow our own" qualified clinical staff, drawing on good practice and incorporating new roles	New models of mentorship developed	Q4 17/18	Elizabeth Moody	R	New models of mentorship are being developed with all the HEIs in preparation for the new NMC standards which will be implemented next year 2019. There is a position paper on this from Newcastle University. (the outcome to this is not fully in the trusts hands it is dependent upon NMC and University joint working on models which we are involved with) Therefore Trust Board are requested to extend the timescale to Q2 19/20 which is in line with the external timeframe linked to NMC standards and University models.

BOARD OF DIRECTORS Item No 17
FOR GENERAL RELEASE

DATE:	**22nd May 2018**
TITLE:	**To consider the publication of information on compliance with the public sector duty under the Equality Act**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Decision**

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 Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to service users and staff who share a relevant protected characteristic who are affected by its policies and practices. The attached papers contain the necessary information in relation to service users and staff. The purpose of this report is to seek ratification of this information. The paper on service users contains details of changes to the workforce equality objective (at point 3.2.6) and approval is sought for these changes. The Board are asked to note the differences in outcomes and experiences for staff from protected groups outlined in the paper on staff equality and the proposed actions at 7.2 in that paper.

The Board are asked to note that in order to comply with the requirements of the Mental Health Act code of practice around the robust monitoring of equalities it was agreed that the annual publication of equality information document includes an analysis of detentions under the Mental Health Act by gender and ethnicity. This information will not be available until July 2018 and will be presented to the Board together with the WRES. An analysis of the patient experience data by protected characteristic will be presented to the Board at the same time.

Recommendations:

- The Board is asked to ratify the publication of equality data documents and approve their publication on the trust website as required by the Equality Act.
- The Board is asked to approve the changes to the workforce equality objective (at point 3.2.6 of the paper on service user equality information).
- The Board are asked to note the differences in outcomes and experiences for staff from protected groups outlined in the paper on staff equality and the proposed actions at 7.2 and 7.3 in that paper.

MEETING OF:	**Board of Directors**
DATE:	**22nd May 2018**
TITLE:	**To consider the publication of information on compliance with the public sector duty under the Equality Act**

1.0 INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to seek ratification of the information to be published under the Trust's Equality Act duties

2.0 BACKGROUND INFORMATION AND CONTEXT:

2.1 The general equality duty of the Equality Act 2010 requires the Trust in the exercise of its functions to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

2.2 The Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to service users and staff who share a relevant protected characteristic who are affected by its policies and practices

3.0 KEY ISSUES:

3.1 The Trust needs to ensure compliance with the Equality Act 2010, by publishing information to demonstrate its compliance with the general equality duty. During 2017/18 there was a deterioration in our ability to capture information about service user ethnicity, sexual orientation and religious belief. In response to this an improvement event is to be arranged to take place with service representatives during 2018/19 as part of efforts to increase the quality of information captured that ought to then enhance understanding in respect of service users that share these particular protected characteristics.

3.2 The reports describe areas where the outcomes and experience of both staff and service users from particular protected groups are less than staff and service users who do not share those protected characteristics. There is evidence that the greater the proportion of staff from protected groups who report experiencing discrimination at work in the last 12 months the lower the levels of patient satisfaction. It is hoped that some of the interventions to improve outcomes and experience for staff will impact positively on the experience and outcomes of service users.

4.0 IMPLICATIONS:

4.1 **Compliance with the CQC fundamental Standards:**
It is a requirement of the CQC fundamental standards that the Trust meets its obligations under the Equality Act 2010.

4.2 **Financial/Value for Money:**
Financial penalties can be incurred for non- compliance with the legislative requirements of the Equality Act. This could also result in reputation loss for the Trust.

4.3 **Legal and Constitutional (including the NHS Constitution).**
The Trust is required to publish information demonstrating its compliance with the general public sector duties of the Equality Act 2010. This document will meet that legal requirement and as Equality Act compliance is a pre-requisite of Care Quality Commission registration will maintain Trust registration.

4.4 **Equality and Diversity:**
The Trust must demonstrate compliance with statutory equality requirements. Failure to do so may result in legal action and subsequent financial penalties and damage to the Trust's reputation.

4.5 **Other implications:**
None have been identified.

5.0 RISKS:

5.1 The quality of information submitted for publication continues to be subject to improvement and there may be risks related to the data quality

6.0 CONCLUSIONS:

6.1 The Trust needs to publish information demonstrating it is compliant with the general public sector duties of the Equality Act 2010 and the information in the attached document will meet that requirement.

6.2 The Trust needs to understand whether and why particular groups in the community are under or over represented in its service user population and to take action as appropriate. The Trust also needs to ensure that any differences in experience between protected groups and the service user population in general are understood and appropriate action taken to ensure high quality care is delivered for all.

6.3 The trust needs to understand the differences in experience and outcome for its staff and to take action where necessary to lessen the disparities.

6.4 Whilst actions have been undertaken for some time to address the issues described above it must be noted that considerable disparities still exist for both staff and service users from protected groups and that serious consideration is needed of both the actions needed and the resources available to lessen the differentials in experience and outcomes for these groups.

7.0 RECOMMENDATIONS:

7.1 The Board is asked to ratify the publication of equality data documents.

7.2 The Board is asked to approve the changes to the workforce equality objective (at point 3.2.6 of the paper on service user equality).

7.3 The Board are asked to note the differences in outcomes and experiences for staff from protected groups outlined in the paper on staff equality and the proposed actions at 7.2 and 7.3 in that paper

David Levy, Director of Human Resources and Organisational Development
Sarah Jay, Equality, Diversity and Human Rights Lead

Background Papers:

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

PUBLICATION OF SERVICE USER EQUALITY DATA

1 APRIL 2017– 31 MARCH 2018

Published 22nd May 2018

making a difference together

If you need this information summarised in another language or format such as Braille, talking tape or DVD please call the number below.

Polish:
Jeżeli potrzebujesz streszczenia tych informacji w innym języku lub formacie, np. w Braille'u lub w formie nagrania dźwiękowego, zadzwoń na poniższy numer.

Arabic:
إذا أردت منا تلخيص هذه المعلومات بلغة أخرى أو بصيغة مختلفة مثل لغة بريل أو شريط صوتي أو قرص DVD
يرجى الاتصال برقم الهاتف التالي.

Bengali:
যদি আপনি অন্য একটি ভাষায় এই তথ্যের সংক্ষিপ্তসার চান অথবা ব্রেইল, কথা বলা টেপ অথবা ডি.ভি.ডি. ফরম্যাট-এ এই তথ্য চান, তাহলে অনুগ্রহ করে নিচের নম্বরে টেলিফোন করুন।

Farsi:
در صورتی که مایلید خلاصه این اطلاعات را به زبان یا فرمت دیگری مانند بریل، نوار یا دی وی دی دریافت کنید، لطفا با شماره زیر تماس بگیرید.

Hindi:
यदि आप इस सूचना का सारांश किसी अन्य भाषा या स्वरूप में, जैसे ब्रेल, टाकिंग टेप या DVD में चाहते हों, तो कृपया नीचे दिए गए नंबर पर फोन करें।

Kurdish (Kurmanji):
Heke hun vê agahîyê bi kurtî bi zimanekî din an formateke din a wek Braille (ji bo kêmasîya dîtinê), teypa axaftinê yan jî DVD dixwazin, ji kerema xwe telefonî hejmara jêrîn bikin.

Punjabi:
ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਦਾ ਸਾਰ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫਾਰਮੈੱਟ ਜਿਵੇਂ ਬ੍ਰੇਲ, ਟਾਕਿੰਗ ਟੇਪ ਜਾਂ DVD ਵਿੱਚ ਚਾਹੀਦਾ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।

Simplified Chinese:
如果您需要该条信息用其他语言或格式概述，例如盲文，录音磁带或 DVD。请联系以下号码：

Urdu:
اگر آپ کو ان معلومات کے خلاصہ کی کسی دیگر زبان یا شکل مثلاً بریل، ٹاکنگ ٹیپ یا ڈی وی ڈی میں ضرورت ہو تو برائے مہربانی درج ذیل نمبر پر کال کریں۔

Telephone 0191 3336267

PUBLICATION OF EQUALITY DATA

1. INTRODUCTION

1.1 The general equality duty of the Equality Act 2010 requires the Trust in the exercise of its functions to have due regard to the need to :

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

1.2 The Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to service users who share a relevant protected characteristic who are affected by its policies and practices. The protected characteristics are gender, race, sexual orientation, gender reassignment, disability, religion and belief, marriage and civil partnership, age and pregnancy and maternity.

1.3 The Trust has published information to meet its public sector duties for the last six years. During this time the quality of the data has steadily improved however the Trust recognises that there are still qualifications around the quality and validity of the data, particularly as in some areas the numbers are relatively low. The Trust wants to be transparent in demonstrating its compliance with its Equality Act duties and has decided to publish raw data. The information published must therefore be viewed as descriptive and any interpretations of it must be conservative.

1.4 The information in this report includes:

- An analysis of service users who were referred to Trust services between 1st April 2017 and 31st March 2018 by race and ethnicity, gender, disability, religion, sexual orientation, age, marriage and civil partnership. The data is taken from information given by service users some of whom at times can refuse to provide information requested, leading to incomplete data. In the data a blank is recorded as null, refuse to disclose means that the service user preferred not to give the trust that information and not known means that the clinician has recorded that they do not know that information.
- An analysis of the length of waiting time from referral to first contact by ethnicity and an analysis of length of hospital stay by ethnicity.

Where possible the Trust's data has been compared to that of the 2011 Census produced by the Office of National Statistics. Copyright is acknowledged as adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0.

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2. ACCESS TO SERVICES

2.1 The following data is for the year 1st April 2017 to 31st March 2018 and is the information contained on the Trust's electronic clinical record system. Some of the fields are incomplete for some service users and some service users have preferred not to give the Trust certain information. The level of missing values and non-disclosure is indicated in each section.

2.3 Where it is available the makeup of the Trust's service user population has been compared to the information on the general population that was gathered in the 2011 census.

2.4 Summary of Service Users by Ethnic Group Compared to ONS 2011 Census Information

Ethnic Group	Ethnic breakdown of service users in the Trust (number)	Ethnic Breakdown of service users in the Trust (%)	Ethnic Breakdown 2011 Census (number)	Ethnic Breakdown 2011 Census (%)
White; British	171074	87.77	1598854	94.55
White; Irish	423	0.22	5330	0.32
White; Other White includes Eastern European	2181	1.22	26434	1.56
Mixed; White and Black Caribbean	234	0.12	3995	0.24
Mixed; White and Black African	214	0.11	1964	0.12
Mixed; white and Asian	312	0.16	5166	0.31
Mixed; Other Mixed	543	0.28	3299	0.20
Asian or Asian British; Indian	299	0.15	6872	0.41
Asian or Asian British; Pakistani	605	0.31	11953	0.71
Asian or Asian British; Bangladeshi	112	0.06	1721	0.10
Asian or Asian British; Other Asian	466	0.15	7286	0.43
Black or Black British; Caribbean	98	0.06	848	0.05
Black or Black British; African	361	0.19	4526	0.27
Black or Black British; Other Black	155	0.08	1052	0.06
Asian or Asian British Chinese	154	0.08	5664	0.33
Other Ethnic Group includes Iranians and Arabs	948	0.49	4400	0.26
Travellers including Gypsy, Roma Traveller/Irish Traveller	132	0.07	1600	0.09
Not stated and declined to disclose	8667	4.4		
NULL	7940	4.08		
Total	194918	100	1690,964	

2.4.1 16607 8.48% of service users' race/ ethnicity is not available as it has not been provided. This compares to 5.34 % last year. There are variations from the census norms which the Trust will use to explore access issues.

2.4.4 Length of waiting time from referral to first contact by ethnicity

The Trust has produced its own figures on the length of waiting time from first referral to first contact analysed by ethnicity. There are some differentials in these which will be explored and appropriate action taken. A degree of caution must be applied in interpreting these figures because of the number of service users whose ethnicity is not known or not stated which could significantly affect the figures in each category.

Ethnic Group	No. of patients	Average length of time (days)
White; British	52528	10.44
White; Irish	110	12.73
White; Other White includes Eastern European	564	25.14
Mixed; White and Black Caribbean	64	11.15
Mixed; White and Black African	64	7.27
Mixed; white and Asian	107	10.48
Mixed - Other Mixed	163	11.03
Asian or Asian British; Indian	80	8.18
Asian or Asian British; Pakistani	186	8.09
Asian or Asian British; Bangladeshi	34	7.63
Asian or Asian British; Other	144	7.31
Black or Black British; Caribbean	35	10.50
Black or Black British; African	98	5.01
Black or Black British; Other Black	44	7.91
Asian/Asian British - Chinese	41	11.58
White - Gypsy	31	14.04
Irish - Traveller	8	13.81
Other Ethnic Group - Arabs	335	20.87
Null	2690	9.94

Not stated	2866	16.19
Decline to disclose	94	12.33
Other Ethnic Group – any other	6	8.30

2.4.5 Length of hospital stays by ethnicity

The Trust has again analysed the length of inpatient stay by ethnicity. Following feedback these figures have been produced for long stay wards, acute wards and short stay respite to provide a more accurate understanding of differences between ethnic groups These figures are for the period 1st April 2017 to 31st March 2018 Some patients were admitted to hospital prior to 1st March 2017 and this is not reflected in these figures. There are some differences in these which will be explored.

Length of hospital stay by Ethnicity 01/04/2017 - 31/03/2018

ACUTE WARDS:

Ethnic Group	No. of patients	Average length of stay in hospital	Shortest length of stay in hospital	Longest length of stay in hospital
White British	2845	45.22	0	365
White; Irish	5	66.2	4	124
White; Other White	47	35.39	2	263
Eastern European	1	195	195	195
Mixed; White and Black African	2	37	23	51
Mixed White/Black Caribbean	4	151	26	365
Mixed; white and Asian	10	44.4	3	163
Mixed; Other Mixed	16	48	3	197
Asian/Asian British Bangladesh	4	93	11	290
Asian or Asian British; Indian	7	37.29	15	214
Asian or Asian British; Pakistani	24	35.42	3	279
Asian or Asian British; Other Asian	12	46.17	1	125
Black or Black British; Caribbean	4	71.5	7	237
Black or Black British; African	15	34.33	1	104
Black or Black British; Other Black	6	52.5	6	120
Asian / Asian British - Chinese	5	60.8	16	96

Other Ethnic Group Any other	23	47.95	16	298
Other Ethnic group includes Arabs	1	74	74	74
White - Gypsy	3	136.5	192	216
Null	71	20.49	0	145
Not stated	21	18.29	3	219
Declined to disclose	2	9	16	48
Total	3127		0	365

Long Stay wards:

Ethnic Group	No. of patients	Average length of stay in hospital	Shortest length of stay in hospital	Longest length of stay in hospital
White British	528	176.64	0	365
White; Irish	1	365	365	365
White; Other White	8	116.63	37	314
Mixed; White and Black Caribbean	1	38	38	38
Mixed white, Asian	1	12	12	12
Traveller	1	55	55	55
Mixed White/Black African	1	46	46	46
Mixed; Other Mixed	2	198.5	92	365
Other Ethnic group – any other	5	50.6	6	282
Asian/Asian British Indian	2	93	79	214
Asian or Asian British; Pakistani	6	61	2	178
Asian or Asian British; Other Asian	4	197.75	36	365
Black or Black British; African	10	209.6	31	365
White - Gypsy	1	13	13	13
Black, Black British Caribbean	2	27	42	70

Asian / Asian British - Chinese	2	196	59	365
Other ethnic group - Arab	1	321	321	321
Declined to disclose	1	27	27	27
Iranian	1	150	150	150
Not stated	2	11	63	219
Null	9	10.11	1	38
Total	589		0	365

Short stay/respite stay:

Ethnic Group	No. of patients	Average length of stay in hospital	Shortest length of stay in hospital	Longest length of stay in hospital
White British	203	26	1	257
Mixed white and Asian	0	0	0	0
White; Other White includes Eastern European	1	37	37	37
Mixed; Other Mixed	3	14	3	28
Asian, Asian British Indian	1	18	18	18
Asian or Asian British; Pakistani	6	25.17	15	34
Asian or Asian British; Other Asian	3	51.33	4	144
Asian/Asian British Chinese	1	11	11	11
Black or Black British; African	1	41	41	41
Black or Black British; Other	1	37	37	37
Gypsy	1	7	7	7
Other ethnic group, any other	5	8.2	2	27
Null	4	12.5	5	20

Not stated	1	49	49	49
Total	226		0	257

2.5 Summary of Service Users by age compared to the ONS 2011 Census

Age	Breakdown of Service Users in the Trust by age (Number)	Breakdown of Service Users in the Trust by age (%)	ONS Census 2011 Breakdown by age (number)	ONS Census 2011 Breakdown by age (%)
0-18	35182	18.05	346436	20.5
18-29	40002	20.52	250209	14.8
30-44	37386	19.18	311330	18.4
45-64	36746	18.85	470521	27.8
Over 65	45592	23.39	312469	18.5
Null	10	0.01		
Total	**194918**	**100.00**	**1,690,965**	

2.5.1 Comparing the age categories of the Trust to those of the ONS 2011 Census the number of service users in the 0 – 18 and 45 - 64 categories are less than the Census figures, which needs to be explored. The number of service users in the over 65 age group is expected due to the increased prevalence of age related mental health problems in this group. 0.01% of the trust's data on the age of service users was incomplete .

2.6 Summary of Service Users by Sexual Orientation

Sexual Orientation	Breakdown of service users by sexual orientation (number)	Breakdown of service users by sexual orientation (%)
Person does not know	4344	2.23
Null	168843	86.62
Persons of the opposite sex	20487	10.51
Persons of the Same or opposite sex	349	0.18
Persons of the Same Sex	408	0.21
Prefer not to say	394	0.20
Other	93	0.05
Total	**194918**	**100.00**

2.6.1 In 2005 HM Treasury and the Department of Trade and Industry completed a survey to help the Government analyse the financial implications of the Civil Partnerships Act (such as pensions, inheritance and tax benefits). They concluded that there were 3.6 million gay people in the United Kingdom – around 6% of the total population or 1 in 16.66 people.

Most of the time, the figure of between 5-7% of the population is used. Stonewall, a National Lesbian, Gay and Bisexual campaigning organisation feel this is a reasonable estimate. However, as this question was not asked in the 2011 UK census there is no way of knowing for sure how many Lesbian, Gay or Bisexual people there are in the UK.

Comparing these estimated figures with the Trust's service users the Trust has an under-representation of those who have declared that they are lesbian, gay or bisexual. This is a particularly sensitive area for many service users and this is possibly reflected in the fact that for 169237 or 86.82% of service user's information about their sexual orientation is not stated, not known or they have preferred not to say. However this is a 20.83% deterioration on last year's figures.

2.7 Summary of Marital and Civil Partnership Status of Service Users within the Trust compared to the ONS 2011 Census.

Status	Breakdown of service users in the Trust by Marriage Civil Partnership (number)	Breakdown of service users in the Trust by Marriage Civil Partnership (%)	ONS Census 2011 Breakdown by Marriage/ Civil Partnership (number)	ONS Census 2011 Breakdown by Marriage/ Civil Partnership (%)
Divorced/ Civil Partnership Dissolved	7333	3.76	132910	9.1
Married / Civil Partnership	33236	17.05	720888	49.31
In a relationship	3847	1.97		
Living with a partner	3387	1.74		
Not Disclosed	13033	6.69		
Separated	4446	2.28	34250	2.34
Single	98791	50.68	464109	31.73
Surviving Partner/ Widowed	16195	8.31	109897	7.52
Null	14530	7.45		
Not known	120	0.06		
Total	**194918**	**100.00**	**1,462,054**	

2.7.1 For 27683 or 14.2 % of service users marital and civil partnership status information is not available as service users have refused to give it. This is a 6.11% improvement in the data completeness compared to last year. 'In a relationship' and 'living with a partner' were added as additional fields in PARIS in 2016 to better reflect the range of relationships amongst our service users. There are no categories in the 2011 census with which to compare these options.
There is a variation between the Trust's data for marriage and civil partnership and that of the ONS 2011 in the categories of those who are divorced or whose civil partnership has been dissolved, those married or in civil partnerships and those who are single.

2.8 Summary of gender of service users within the Trust compared to the ONS 2011 Census

Status	Breakdown of service users in the Trust by gender (number)	Breakdown of service users in the Trust by gender (%)	ONS Census 2011 breakdown by gender (number)	ONS Census 2011 breakdown by gender (%)
Male	93642	48.04	828146	48.97
Female	99938	51.27	862814	51.03
Null	1134	0.58		
Birth sex female gender neutral	124	0.06		
British sex male gender neutral	42	0.02		
Indeterminate	18	0.01		
Not known/not specified	20	0.01		
Total	**194918**	**100.00**	**1,690,960**	

2.8.1 The gender breakdown of the Trust's service users is very similar to that of the ONS data. For 1154 or 0.6 % of service users the data on gender is incomplete. This is an improvement of 0.06% compared to last year. Additional fields have been added to PARIS to allow service users' gender to be recorded in ways that better reflect their gender identity.

2.9 Summary of Service Users by religion compared to the ONS 2011 Census service user Population by religion

Religion	Breakdown of Service Users in the Trust by religion (number)	Breakdown of Service Users in the Trust by religion (%)	ONS 2011 Census Breakdown by religion (number)	ONS 2011 Census Breakdown by religion (%)
Any other	3652	1.87	5124	0.30
Buddhist	322	0.17	3881	0.23
Christian	81085	41.6	1174586	69.46
Hindu	118	0.06	3516	0.21
Jewish	81	0.04	937	0.06
Muslim	1371	0.07	20143	1.19
Sikh	117	0.06	2440	0.14
None	45625	23.41	371479	21.97
Null	13199	6.77		
Baha-i	39	0.02		
Pagan	173	0.09		
Declined to disclose	3879	1.99		
Unknown	29977	15.38		
Not stated	15280	7.84	108854	

				6.44
Total	**194918**	**100.00**	**1,690,960**	

2.9.1 Data on religion is not available for 49136 or 25.21 % of the Trust's service users as it has not been given. This is a deterioration of 15.2% compared to the level of data completeness last year.

There are differences between the data on the religion of the Trust's service users and the data in the 2011 Census in the categories of any other religion, Christian, Muslim, Hindu, Sikh and none.

2.10 Summary of Servicer Users by Disability

Disability	Breakdown of Service Users in Trust (number)	Breakdown of Service Users in Trust (%)
Hearing Impairment	4090	2.1
Mobility impairment	4409	2.26
Multi-sensory impairment	525	0.27
Other Disability	1052	0.54
Physical disability	2204	1.13
Visual Impairment	6928	3.55
Speech Impairment	560	0.29
Null	166118	84.71
Total number of unique referrals	194918	

2.10.1 The Trust has been able to report on the numbers of service users with hearing impairment, mobility impairment, multi- sensory impairment, other disability, physical disability, visual impairment and speech impairment. Some service users have more than one disability so may appear in more than one category. Figures from the Royal National Institute of Blind people suggest that 1 in 30 people have sight loss, and figures from Action on Hearing loss state that 1 in 6 people or 16.66 % have some kind of hearing loss. The figures for service users with mental health difficulties or learning disabilities have not been included. Information from the 2011 census states that 38% of the population of the North East and 33% of the population of Yorkshire and Humber report a long standing illness or disability with 20% of the population of the North East and 19% of the population of Yorkshire and Humber reporting a limiting long standing illness or disability

3. Equality Objectives

3.1 Service user and carer involvement is essential to help the Trust deliver and develop services which are service user centred and feedback on services is essential in order to continually improve our services in response to what we are told. The Trust has well-established mechanisms for engaging with its service users and carers in a variety of ways.

3.2 In March 2016 each locality was asked to develop an equality objective for 2016 – 2020, together with an outline of the actions for the first year. There was evidence of good consultation and activities in some localities which have led to the development of the equality objectives. The equality objectives and progress made in the first year are detailed below.

3.2.1 **Durham and Darlington Equality Objective 2017 - 2020**
To continue to ensure that the principles of Green Light are embedded in services

Progress:
Baseline assessments using the Greenlights audit tool on equalities, personal care and accessible information were completed for all specialities. Timescales slipped slightly due to staffing pressures but all service leads have developed action plans to address the issues highlighted in the audit. Reports on progress were made at LMGB meetings in January and April.

3.2.2 **York and Selby overall objective 2016 - 2020**: Working with partners to improve access and experience of mental health services for students and young people (16 – 25) in York and Selby.

Progress: The locality has made good progress with this equality objective, evidence of which was provided to the EDHR steering group, and is to continue work on the objective for the period 2018 – 2020.

3.2.3 **Forensic Services Equality Objectives 2017/2020**
Objective 1 To improve the support for staff who are on extended forms of planned maternity / paternity / adoption leave.

Progress:
Guidance to address the issues identified in the original staff survey has been clarified and a re- audit is underway to identify further actions needed.

Objective 2 Consider in line with Service user requests on how to celebrate diversity within the service.

Progress:

A stall celebrating diversity was in place at annual event within Ridgeway. This was well received but no further suggested requirement for group events with service users preferring individual approach. This is being reviewed periodically.

Objective 3 To provide clarity on the role and function of the E & D Champions within the service

Progress:

LMGB are discussing the results of the clarification of the E and D champion role and are to make decisions about how to take this forward. The EDHR team have provided support and input into forensic services in a variety of ways throughout the year.

3.2.4 **Teesside objective 1 2016-2020.** To continue implementation of the Greenlight audit in adult services, building on the work carried out last year and completing the self-assessment.

The locality has made good progress with this equality objective, evidence of which was provided to the EDHR steering group, and is to continue work on the objective for the period 2017 – 2020 An RPIW was held to improve access to the acute care pathway. During the week teams developed standard work for crisis plans and developed examples of good crisis plans for staff to access and use. Standard work was also developed for AMH inpatient areas that support an effective and collaborative response from across the two specialities. Communication was identified as a key area for improvement. A number of strategies were developed during the week that have led to improved collaborative working and have eliminated delays for service users when accessing the AMH acute care pathway. Staff confidence has also significantly improved and a shadowing program has further enhanced staffs knowledge of each other's services.

Objective 2. Under/ Over - Represented Communities 2017 - 2020

Based upon the information identified from analysis of our data, the locality has begun to explore the reasons for the under/over representation of particular BAME communities within services. This has involved utilising a Community development approach to review experience of our services for those communities, and identify remedial actions that need to be taken to support access and retention for people to achieve successful outcomes. Work this year has included work in MHSOP to improve access to dementia services for the South Asian community, which has included running locally based clinics, awareness raising videos in Urdu and partnership work with Middlesbrough College to encourage the South Asian community to seek employment in the trust. Adult mental health services have undertaken a series of focus groups with the South Asian community which identified six key themes:

- Culture of secrecy/shame surrounding mental health particularly psychosis.
- A lack of understanding of mental ill health, again in particular psychosis
- There were differences between genders. Women generally talked about feeling more restricted and isolated and this impacted on their mental health.
- Religion and mental health-it was important to acknowledge and understand religious beliefs when addressing mental health needs.
- Language. Interpreting services are important so that people can express their feelings in their first language.
- Many people did not understand that NHS services are confidential. This was an important concern to address.

3.2.5 **North Yorkshire objective 2016 - 2020:** To better understand the mental health needs of the farming communities in North Yorkshire and where appropriate take action to improve and increase access to services.

Progress: The locality has made good progress with this equality objective, evidence of which was provided to the EDHR steering group, and is to continue work on the objective for the period 2017 – 2020. This includes the development of a training package which is being rolled out to staff, attendance at the NFU health and wellbeing event and work with the communications team to develop methods of using social media to communicate key messages about mental health to the farming community in North Yorkshire.

3.2.6 **Trust Wide – Workforce 2016 -2020**

Overall objective: To undertake research to better understand the causes of any differences where staff who share similar characteristics report lower levels of satisfaction in either the staff friends and family test or the staff survey and to take steps to reduce or eliminate any lower levels of satisfaction.

Progress

The research was completed in 17/ 18 and a report on the findings and recommendations in relation to BAME staff will be presented to EMT in May 2018. Further reports on disabled and LGB staff are to follow.

As the research element of this objective is now ended and much of the work involved in reducing or eliminating lower levels of experience and outcome are now included in the work around the workforce race equality standard and the workforce disability equality standard that the objective is amended to reflect the work already going on in these work streams.

4. Analysis of the effects of the Trust's policies and practices

4.1 Equality analyses are carried out on all Trust policies and procedures and these are available on the Trust website.

4.2 Equality analysis is also carried out on service developments and improvements and is an integral part of the Trust's project management processes through which all major service changes are progressed.

5. Equality in Practice

The Trust is committed to ensuring that all people have equal access to its services. Some of the initiatives the Trust has taken to realising this vision are described in the information relating to the Trust's equality objectives in section 3. Others are described below.

5.1 Disability Access Audits

The Trust recognises the importance of ensuring that people with disabilities can access its premises. The Health and Safety team have carried out audits on all inpatient sites. These audits are to continue as part of the health and safety workbook audit programme and in 17/18 have carried out audits on outpatient areas. It must be acknowledged that .the audit only covers limited areas and do not include clinic rooms, ward and other areas in which patients are seen or areas which are solely used by staff.

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5.2 Interpreting Services

In order to deliver an equitable service to those whose first language is not English the Trust has recently let a three year contract to an interpreting agency, ensuring quick access to appropriately qualified interpreters. The quality and usage of the service is regularly monitored.

5.3 Dementia

The North East Dementia Alliance commissioned a report on Dementia in minority communities in North East England in August 2012. In response to this the Trust has started to pilot some work with its South Asian communities in Stockton and Middlesbrough. During 16/17 the trust undertook a lot of work with a South Asian community organisation to raise awareness of dementia amongst the community and to seek to increase early referrals into services. This included training community members in dementia awareness and carrying out some consultations to better understand how MHSOP need to be changed to meet the needs of the community. As a result referrals into services have increased, a drop in session has been established at a community venue in Stockton and a video in Urdu has been produced further raise awareness in the community of dementia and the treatments available. This work has now been extended to all services in Stockton and Middlesbrough. Work has been undertaken with Middlesbrough College to run a course for the South Asian which provides them with insight into the work of an HCA in the trust. Attendees are then offered the opportunity of undertaking voluntary work and if successful are then given a place on the trust's bank. This work was undertaken following feedback from South Asian patients on MHSOP wards in Teesside that they would like staff to be able to speak to them in their own language.

5.4 Data Completeness

Measurement is key to understanding whether there are differences in experience or outcomes for those in protected groups and then acting on these. Crucial to this is achieving a high level of data completeness and accuracy in the demographic data on PARIS.

6 Conclusions

6.1 The levels of data completeness available to the Trust to measure its performance in its public sector duties have either remained static or deteriorated. Further work is needed to improve rates of completeness in certain categories. Higher levels of data completeness would allow the Trust to have greater confidence in its understanding of the makeup of its service users and their needs.

6.2 Good progress has been made on the Trust's equality objectives and localities have taken ownership of these and are committed to achieving them

6.3 In addition to the work on the equality objectives the Trust has a number of other initiatives (described in 5 above) in which clinical services have recognised a need for focused work with some of its minority communities to ensure that they have equal access to mental health and learning disability services.

7. Recommendations

7.1 It is proposed that the information contained in this report is published on the Trust's website as evidence that the Trust is meeting its public sector equality duties.

7.2 The Board are asked to approve the changes to the equality objectives for workforce (point 3.2.6)

7.3 It is recommended that further work be undertaken to understand the high level of blanks and not known in most categories on PARIS and to working to support staff to improve the level of data completeness so that we can better understand any differences in outcomes and experiences for our patients.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

PUBLICATION OF STAFF EQUALITY DATA

1 APRIL 2017– 31 MARCH 2018

Published 22nd May 2018

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

If you need this information summarised in another language or format such as Braille, talking tape or DVD please call the number below.

Polish:
Jeżeli potrzebujesz streszczenia tych informacji w innym języku lub formacie, np. w Braille'u lub w formie nagrania dźwiękowego, zadzwoń na poniższy numer.

Arabic:
إذا أردت منا تلخيص هذه المعلومات بلغة أخرى أو بصيغة مختلفة مثل لغة بريل أو شريط صوتي أو قرص DVD
يرجى الاتصال برقم الهاتف التالي.

Bengali:
যদি আপনি অন্য একটি ভাষায় এই তথ্যের সংক্ষিপ্তসার চান অথবা ব্রেইল, কথা বলা টেপ অথবা ডি.ভি.ডি. ফরম্যাট-এ এই তথ্য চান, তাহলে অনুগ্রহ করে নিচের নম্বরে টেলিফোন করুন।

Farsi:
در صورتی که مایلید خلاصه این اطلاعات را به زبان یا فرمت دیگری مانند بریل، نوار یا دی وی دی دریافت کنید، لطفا با شماره زیر تماس بگیرید.

Hindi:
यदि आप इस सूचना का सारांश किसी अन्य भाषा या स्वरूप में, जैसे ब्रेल, टाकिंग टेप या DVD में चाहते हों, तो कृपया नीचे दिए गए नंबर पर फोन करें।

Kurdish (Kurmanji):
Heke hun vê agahîyê bi kurtî bi zimanekî din an formateke din a wek Braille (ji bo kêmasîya dîtinê), teypa axaftinê yan jî DVD dixwazin, ji kerema xwe telefonî hejmara jêrîn bikin.

Punjabi:
ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਦਾ ਸਾਰ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫਾਰਮੈੱਟ ਜਿਵੇਂ ਬ੍ਰੇਲ, ਟਾਕਿੰਗ ਟੇਪ ਜਾਂ DVD ਵਿੱਚ ਚਾਹੀਦਾ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।

Simplified Chinese:
如果您需要该条信息用其他语言或格式概述，例如盲文，录音磁带或 DVD。请联系以下号码：

Urdu:
اگر آپ کو ان معلومات کے خلاصہ کی کسی دیگر زبان یا شکل مثلاً بریل، ٹاکنگ ٹیپ یا ڈی وی ڈی میں ضرورت ہو تو برائے مہربانی درج ذیل نمبر پر کال کریں۔

Telephone 0191 3336267

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

PUBLICATION OF EQUALITY DATA

1. INTRODUCTION

1.1 The general equality duty of the Equality Act 2010 requires the Trust in the exercise of its functions to have due regard to the need to :

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

1.2 The Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to service users who share a relevant protected characteristic who are affected by its policies and practices. The protected characteristics are gender, race, sexual orientation, gender reassignment, disability, religion and belief, marriage and civil partnership, age and pregnancy and maternity.

1.3 The Trust has published information to meet its public sector duties for the last six years.

1.4. The information in this report as far as possible replicates the indicators of the Workforce Race Equality standard (WRES). Additional indicators have been included in the disability section to prepare the trust for the introduction of the Workforce Disability Equality Standard in April 2018. The information relates to staff employed by the trust and contains information from about age, gender, disability, race and sexual orientation for the period 1st April 2017 – 31st March 2018.The information sources are as follows:

- Indicator 1 is data obtained from ESR, the trust's electronic staff rota. VSM in this indicator stands for very senior manager.
- Indicator 2 is data pulled from NHS jobs which is the database the trust uses to advertise jobs and to recruit staff.
- Indicator 3 has been sourced from detailed records kept throughout the year on disciplinary cases.
- Indicator 4, the relative likelihood of staff accessing non mandatory training and CPD has been obtained from responses to a question in the staff friends and family test.
- Indicators 5 – 11 and 5 – 16 in relation to disability come from the national staff survey which again was sent to all staff.
- Information for the indicator on the make-up of the trust board has been pulled from ESR and shows the percentage difference between the board makeup and that of the trust as a whole by each protected characteristic. A minus sign preceding the figure indicates that the representation on the board of a particular protected characteristic is less than the representation of that characteristic in the trust as a whole. A plus sign preceding the figure would indicate that the board representation of a particular characteristic is greater than that in the trust as a whole.

2. AGE:

	Indicator.	Data for reporting year
	For each of these four workforce indicators, compare the data for Age Groups.	
1.	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members)	**Clinical Staff %**

Band	**17-25**	**26-35**	**36-45**	**46-55**	**56-65**	**66+**
1-4	5	19	20	37	18	1
5-7	6	28	26	30	10	0
8 abcd	0	13	38	39	9	1
9	0	0	25	75	0	0
VSM	0	0	0	50	50	0
Medics	0	13	37	39	10	1

Non- clinical staff %

Band	**17-25**	**26-35**	**36-45**	**46-55**	**56-65**	**66+**
1-4	3	13	19	34	28	3
5-7	1	21	28	30	19	1
8 abcd	0	3	31	50	16	0
9	0	0	0	0	0	0
VSM	0	0	0	75	25	0

2.	Likelihood of staff being appointed from shortlisting across all posts.	**17-25**	0.29	**46-65**	0.26
		26-35	0.28	**66+**	0.46
		36-45	0.22		
3.	Likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	**17-25**	0.016	**46-65**	0.013
		26-35	0.010	**66+**	0.014
		36-45	0.016		
4.	Relative likelihood of staff accessing non-mandatory training and CPD.	It is not possible to provide this information for age.			
	National NHS Staff Survey indicators For each of the four staff survey indicators, compare the outcomes of the responses for each of the age groups.				
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	**16-30**	29%		
		31-40	28%		
		41-50	29%		
		51+	28%		
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	**16-30**	15%		
		31-40	17%		
		41-50	21%		
		51+	21%		
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promoting.	**16-30**	93%		
		31-40	90%		
		41-50	90%		
		51+	91%		

8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	**16-30**	6.4%
		31-40	5.3%
		41-50	6.5%
		51+	7.5%
9.	KF17. % feeling unwell due to work related stress in the last 12 months**.**	**16-30**	38%
		31-40	38%
		41-50	42%
		51+	37%
10.	KF18. % attending work in the last 3 months despite feeling unwell because they felt pressure	**16-30**	48%
		31-40	50%
		41-50	53%
		51+	50%
11.	Overall staff engagement	**16-30**	3.92
		31-40	3.89
		41-50	3.85
		51+	3.79
	Board representation indicator: For this indicator, compare the difference for age groups.		

		Age	**Voting**	**Non-voting**	**NEDs**
12.	Percentage difference between the organisation's Board voting membership, non-voting membership and NEDs and its overall workforce.	**17-25**	-4%	-4%	-4%
		26-35	-21%	-21%	-21%
		36-45	-24%	-24%	-24%
		46-55	+42%	+17%	+13%
		56-65	+9%	+17%	+64%
		66+	-2%	-2%	-2%

AGE BREAKDOWN FOR TRUST STAFF

Age Range	**17-25**	**26-35**	**36-45**	**46-55**	**56-65**	**66+**	**Grand Total**
Number	277	1367	1590	2173	1031	74	6512
%	4	21	24	33	16	2	100

The data on age is complete.

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3. **DISABILITY**:

	Indicator.	Data for reporting year		
	For each of these four workforce indicators, compare the data for Disability.			
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members)	**Clinical Staff %**		
		Band	**Disabled %**	**Not Disabled %**
		1-4	10	90
		5-7	8	92
		8 abcd	6	94
		9	0	100
		VSM	0	100
		Medics	1	99
		Non-Clinical Staff %		
		Band	**Disabled %**	**Not Disabled %**
		1-4	7	93
		5-7	7	93
		8 abcd	7	93
		9	0	100
		VSM	0	100
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	Non-disabled staff are 1.8 times more likely to be appointed than disabled staff.		
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	The likelihood of disabled staff entering a formal disciplinary process is 0.8 compared to non-disabled. Disabled staff are therefore less likely to enter the formal disciplinary process than staff without a disability.		
4.	Relative likelihood of staff accessing non-mandatory training and CPD. (Based on responses to Q4 staff FFT).	Disabled staff and staff without disabilities are equally likely to access non- mandatory training and CPD.		
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, <u>compare the outcomes of the responses for disability/non disability.</u>			
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	**Disabled**	34%	
		Not disabled	26%	
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	**Disabled**	28%	
		Not disabled	17%	
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promoting.	**Disabled**	86%	
		Not disabled	91%	
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	**Disabled**	12%	
		Not disabled	5%	

9.	KF17. % feeling unwell due to work related stress in the last 12 months	**Disabled**	53%
		Not disabled	35%
10.	KF18. % attending work in the last 3 months despite feeling unwell because they felt pressure e) Have you felt pressure from your manager to come to work?	**Disabled**	68%
		Not disabled	46%
		Disabled	24%
		Not disabled	17%
11	Q5f: How satisfied are you with each of the following aspects of your job: f) the extent to which my organisation values my work	**Disabled**	44%
		Not disabled	54%
12	Q20f (Appraisal): Were any training, learning or development needs identified	**Disabled**	67%
		Not disabled	70%
13	Q20g (Appraisal): Did your manager support you to receive this learning and development	**Disabled**	54%
		Not disabled	62%
14	Q20b Did your appraisal help you improve how you did your job?	**Disabled**	22%
		Not disabled	26%
15	Q27b (Reasonable adjustment): Has your employer made adequate adjustments to enable you to carry out your work?	**Disabled:** 79%	
16.	Overall staff engagement	**Disabled**	3.7
		Not disabled	3.88
	Board representation indicator: For this indicator, compare the difference for disability/non disability.		
17.	Percentage difference between the organisation's Board voting, non- voting and NED membership and its overall workforce.	The difference between the trust board, voting, non-voting and NED membership is -8% in all categories.	

DISABILITY BREAKDOWN FOR TRUST STAFF

Not disabled	Disabled	Grand Total
4194	341	4535
92%	8%	100%

1976 staff, 30% have not declared on ESR whether they are disabled or not.

When compared to staff without a disability those who identify as disabled:

- Experience a higher level of harassment, bullying and abuse from patients, relatives or the public and from staff than those without a disability. They have also experienced more discrimination from managers/team leader or other colleagues.
- Are nearly half as likely to be appointed from shortlisting compared to those without a disability
- Are less likely to enter the disciplinary process than those without a disability
- Are significantly more likely to have felt unwell due to work related stress in the last 12 months
- Are significantly more likely to have attended work in the last three months despite feeling unwell
- Less satisfied with the the extent to which the organisation values their work
- Felt less supported by their manager to receive training and development identified during appraisal
- Reported less that their appraisal helped them to improve how they did their job.
- 5% fewer staff reported that reasonable adjustments had been made in 2018 when compared to 2017.

It should be noted that although the staff survey results have deteriorated since last year the percentage difference between the national staff survey results for disabled and non- disabled staff has not significantly increased.

4. GENDER

	Indicator.	Data for reporting year		
	For each of these four workforce indicators, compare the data for gender.			
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	**Clinical Staff %**		
		Band	**Male**	**Female**
		1-4	26	74
		5-7	19	81
		8abcd	26	74
		9	33	67
		VSM	0	100
		Medics	48	52
		Non-clinical staff %		
		Band	**Male**	**Female**
		1-4	13	87
		5-7	34	66
		8abcd	29	71
		9	0	0
		VSM	50	50
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	Females are 1.1 times more likely to be appointed than males once shortlisted.		
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	Men are 2.3 times more likely to enter the formal disciplinary process.		
4.	Relative likelihood of staff accessing non-mandatory training and CPD. (Based on responses to Q4 staff FFT).	There is no difference in the relative of male and female staff accessing CPD.		
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare the outcomes of the responses for male/female.			
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	**Male**	33%	
		Female	27%	
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	**Male**	18%	
		Female	19%	
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promoting.	**Male**	86%	
		Female	93%	
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	**Male**	7%	
		Female	6%	
9.	KF17. % feeling unwell due to work related stress in the last 12 months**.**	**Male**	38%	
		Female	38%	
10.	KF18. % attending work in the last 3 months despite feeling unwell because they felt pressure	**Male**	48%	
		Female	51%	

11.	Overall staff engagement	**Male**			3.75
		Female			3.89
	Board representation indicator: For this indicator, compare the difference for male/female.				
12.	Percentage difference between the organisation's Board voting, non- voting and NED membership and its overall workforce.	**Gender**	**Voting**	**Non-Voting**	**NEDs**
		Female	-53%	-28%	-58%
		Male	+53%	+28%	+58%

GENDER BREAKDOWN FOR TRUST STAFF

Female	Male	Grand Total
5091	1421	6512
78%	22%	100%

The data on age is complete.

- Men are overrepresented in bands 8, 9, VSM and medics when compared to the overall staff makeup.
- Men are 2.3 times more likely to enter the disciplinary process than women.

5. RACE/ETHNICITY:

	Indicator.	**Data for reporting year**		
	For each of these four workforce indicators, compare the data for White and BME staff.			
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members)	**Clinical Staff %**		
		Band	**White**	**BAME**
		1-4	98	2
		5-7	97	3
		8abcd	99	1
		9	100	0
		VSM	100	0
		Medics	63	37
		Non-clinical staff %		
		Band	**White**	**BAME**
		1-4	99	1
		5-7	97	3
		8abcd	99	1
		9	0	0
		VSM	100	0
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	White staff are 1.6 times more likely to be appointed from shortlisting compared to BAME staff.		
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	BAME staff are 3.3 times more likely to enter the formal disciplinary process.		
4.	Relative likelihood of staff accessing non-mandatory training and CPD. (Based on responses in Q4 FFT)	Using the figures of staff who actually responded to the SFFT (90 BAME and 2429 White) there is no difference in opportunity to access non-mandatory and CPD training.		
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.			
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	**White**	28%	
		BAME	34%	
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	**White**	19%	
		BAME	29%	
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promoting.	**White**	91%	
		BAME	80%	
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	**White**	6%	
		BAME	18%	

9.	KF17. % feeling unwell due to work related stress in the last 12 months**.**	**White**		39%	
		BAME		35%	
10.	KF18. % attending work in the last 3 months despite feeling unwell because they felt pressure	**White**		52%	
		BAME		33%	
11.	Overall staff engagement	**White**		3.84	
		BAME		3.93	
	Board representation indicator: For this indicator, compare the difference for White and BME staff.				
12.	Percentage difference between the organisation's Board voting, non- voting and NED membership and its overall workforce.	**Ethnicity**	**Voting**	**Non-Voting**	**NEDs**
		BAME	+8.5%	-4	-4
		White	- 8.5	+4	+4

RACE/ETHNICITY BREAKDOWN FOR TRUST STAFF

White (including Medics)	6234	96%
BAME (including Medics)	241	4%
Total	6475	100%
White (excluding Medics)	6083	98%
BAME (excluding Medics)	142	2%
Total	6225	100%

The data for 36 people, 0.06%, is not available on ESR.

- BAME staff are underrepresented in bands 8a and above in non- clinical and clinical posts and in bands 1-4 in clinical posts when compared to the percentage of BAME staff in the overall workforce.
- BAME staff are overrepresented in the medical staff.
- BAME staff are 3.3 times more likely to enter the disciplinary process than white staff.
- More BAME staff than white staff have experienced harassment, bullying or abuse from patients, relatives or the public and staff in the last 12 months.
- More White staff have felt unwell due to work related stress in the last 12 months than BAME staff.
- More White staff have attended work in the last 3 months despite feeling unwell than BAME staff.
- Apart from Medical staff there are low numbers of BAME staff employed by the trust.
- Have higher staff engagement than white staff

It should be noted that when compared to the results for 2017 the results in indicators 5 -10 for both BAME and white staff have deteriorated, however the percentage difference between the results for white and BAME staff has also increased, meaning that our BAME staff are reporting significantly worse experiences than our white staff. Actions to address these issues will be detailed in the trust's WRES which will be published in July.

A number of actions have already begun to address some of the issues highlighted by this data. These include:

- A review of recruitment decisions where shortlisted BAME job applicants were not appointed to posts during the last 12 months.

- A review of disciplinary cases involving BAME staff during the last twelve months.
- The development of a TEWV BAME leadership and management programme for bands 5-7.
- Work is being carried out to support senior TEWV doctors to prepare for potential board level positions in the future.
- The development of a TEWV bullying and harassment resolution procedure.

6. SEXUAL ORIENTATION:

	Indicator.	Data for reporting year		
	For each of these four workforce indicators, compare the data for Heterosexual/Lesbian/gay/bisexual.			
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members).	**Clinical staff %**		
		Band	**Heterosexual**	**LGB**
		1-4	98	2
		5-7	97	3
		8 abcd	98	2
		9	100	0
		VSM	100	0
		Medics	97	3
		Non-clinical staff %		
		Band	**Heterosexual**	**LGB**
		1-4	99	1
		5-7	97	3
		8 abcd	98	2
		9	0	0
		VSM	100	0
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	Heterosexual staff are 1.2 times more likely to be appointed from shortlisted posts than LGB staff.		
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	LGB staff are 2.5 times more likely to enter the formal disciplinary process than heterosexual staff.		
4.	Relative likelihood of staff accessing non-mandatory training and CPD. (Based on responses to Q4 staff FFT).	Heterosexual staff and LGB staff are equally likely to access non-mandatory training and CPD.		
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare the outcomes of the responses for each of heterosexual/lesbian/gay/bisexual.			
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	**Heterosexual**	28%	
		Lesbian, Gay and Bisexual	28%	
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	**Heterosexual**	18%	
		Lesbian, Gay and Bisexual	22%	
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promoting.	**Heterosexual**	91%	
		Lesbian, Gay and Bisexual	95%	
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	**Heterosexual**	6%	
		Lesbian, Gay and Bisexual	6%	
9.	KF17. % feeling unwell due to work related stress in the last 12 months.	**Heterosexual**	38%	
		Lesbian, Gay and	37%	

		Bisexual	
10.	KF18. % attending work in the last 3 months despite feeling unwell because they felt pressure	**Heterosexual**	50%
		Lesbian, Gay and Bisexual	49%
	Board representation indicator: For this indicator, compare the difference for heterosexual/lesbian/gay/bisexual.		
11.	Percentage difference between the organisations' Board voting, non- voting and NED membership and its overall workforce.	Percentage difference between the organisations' Board voting, non-voting and NED membership and its overall workforce is -3%	

SEXUAL ORIENTATION BREAKDOWN FOR TRUST STAFF

Heterosexual	LGB	Grand Total
5408	145	5553
97%	3%	100%

959 staff, 15% have not declared their sexual orientation on ESR.

When compared to heterosexual staff, LGB staff are

- 2.5 times more likely to enter the disciplinary process, however it should be noted that 8 of the total number of people in the disciplinary process identified as LGB and for 15% of staff data on sexual orientation is not available so great caution must be applied to this data.
- Less likely to feel unwell due to work related stress in the last 12 months.

7. CONCLUSIONS

7.1 There are clear differences in some of the metrics for staff from protected groups.

7.2 Actions to address the issues for BAME staff will be identified in the WRES and the associated action plan which will go to Board in July 2018.

7.3 Actions to address the differences in experience and outcome for disabled staff are being addressed in the Disability Confident Action plan.

7.4 Amongst the benefits of addressing these are:

- Organisations that treat their staff fairly, listen to them and develop their talent to the full, are ones that provide better care for all patients.
- Developing a more inclusive workplace can produce considerable benefits for all staff, for organisational finances and productivity,

7.5 The Audit Commission report ' The Journey to Race Equality', the principles of which can be applied to all protected groups, emphasised the importance of leadership at all levels of the organisation, especially at trust board level, in prioritising equality, setting the culture, raising expectations, increasing accountability and following through with action.

8. RECOMMENDATIONS

8.1 It is proposed that the information contained in this report is published on the Trust's website as evidence that the Trust is meeting its public sector equality duties.

8.2 The Board is asked to note the differences in experience and outcome for staff from protected groups and to note the actions outlined in 7.2 and 7.3 and to support the development of further actions.

ITEM NO. 18

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**22nd May 2018**
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:	**22nd May 2018**
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
332	1.5.18	Lease relating to premises known as "The Pharmacy" at West Park Hospital	Patrick McGahon, Director of Finance and Information Phil Bellas, Trust Secretary
333	1.5.18	Lease relating to premises known as "The Pharmacy" at Lanchester Road Hospital	Patrick McGahon, Director of Finance and Information Phil Bellas, Trust Secretary
334	1.5.18	Lease relating to premises known as "The Pharmacy" at Roseberry Park Hospital	Patrick McGahon, Director of Finance and Information Phil Bellas, Trust Secretary
335	2.5.18	Variation to the collaboration agreement relating to clinical practitioner offer (North Yorkshire CAMHS)	Patrick McGahon, Director of Finance and Information 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

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 19

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**22 May 2018**
TITLE:	**Policies Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
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 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 policy paper contains the following information:

- Three policies that have undergone full review and require ratification:
  - CORP-0048-v4.1 Business Continuity Policy
  - CORP-0041-v4.1 External Agency Visits, Inspections and Accreditations

- One policy that has been upgraded from a procedure and requires ratification:
  - CORP-0009-v5 Asbestos Management Policy

- One policy that has undergone minor amendment:
  - IT-0010-v5.1 Information Security and Risk Policy

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meeting held on 09 May 2018

DATE:	**22 May 2018**
TITLE:	**Policies and Procedures Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

1. INTRODUCTION & PURPOSE:

The purpose of this report is to advise the Board of Directors on the policies and procedures that have been ratified by the Executive Management Team.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 It is important that the Trust policy portfolio is updated and revised in a timely way to ensure best practice, current legislation and regulation is reflected in policy content. Policies no longer required to control and assure practice should be terminated and withdrawn from the portfolio.

2.2 Following the last revision of the Trust's Integrated Governance arrangements, it was agreed that the Executive Management Team ratify all new and revised Trust policies.

2.3 Each policy ratified by the Executive Management Team will have gone through the Trust's consultation process.

2.4 Currently all corporate Trust policies are ratified by the EMT on behalf of the Board of Directors, following approval by the appropriate specialist committees and groups. All decisions regarding the management of the policy framework must be ratified by the EMT.

3. KEY ISSUES:

3.1 The following policies have undergone full review and require ratification:

CORP-0048-v4.1 Business Continuity Policy
Review date: 09 May 2021

The above has undergone full review but not required any change. The policy is therefore to be ratified for a further 3 years.

CORP-0041-v4.1 External Agency Visits, Inspections and Accreditations
Review date: 09 May 2021

The above has undergone full review with minor amendment to roles and responsibilities. The policy is therefore to be ratified for a further 3 years.

CORP-0009-v5 Asbestos Management Policy
Review date: 09 May 2021

The above has undergone full review and has been revised from a procedure to a policy.

3.2 The following has undergone minor amendment:

IT-0010-v5.1 Information Security and Risk Policy
Review date: 14 February 2021

Following a number of incidents regarding stolen laptops, a paragraph has been added to this policy to reiterate the correct steps to ensure that laptops are held securely while in transit and in the staff member's home overnight.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

Sound policy development improves patient experience and enhances patient safety and clinical effectiveness.

4.2 Financial/Value for Money:

Any financial implications from the proposals arising from operational and/or practice changes will be managed by the Directorates responsible for policy implementation.

4.3 Legal and Constitutional (including the NHS Constitution):

The Trust requires a contemporary policy portfolio to ensure practice is compliant with legislation, regulation and best practice. The policy ratifications, review extensions and withdrawals will ensure the portfolio is managed to provide the necessary evidence based operational and practice frameworks.

4.4 Equality and Diversity:

The current policy portfolio ensures the Trust meets the required legislative and regulatory frameworks and all policies are impact assessed for any

equality and diversity implications. Policy revision and /or specific implementation plans would result from any adverse impact assessments.

4.5 Other implications:

None identified

5. RISKS:

None identified

6. CONCLUSIONS:

The decisions detailed above made at the EMT meeting on 11 April 2018 have been presented for ratification.

7. RECOMMENDATIONS:

The Board is required to ratify the decisions of the Executive Management Team and is requested to accept this report.

Author: Colin Martin
Title: Chief Executive