SPECIAL MEETING OF THE BOARD OF DIRECTORS
THURSDAY 24TH JUNE 2021
AT 1.00 P.M.

The meeting will be held via MS Teams

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

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

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

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

The timings provided in the agenda are indicative only.

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

Joining instructions for the event have been circulated separately.

AGENDA

Standard Items (1.00 pm – 1.15 pm):

1	Apologies.	**Chairman**	**-**
2	Chairman's Introduction.	**Chairman**	**Verbal**
3	To approve the minutes of the last meeting held on 27th May 2021.	**-**	**Draft Minutes**
4	To receive any declarations of interest.	**-**	**Verbal**
5	To review the Board Action Log.	**-**	**Report**
6	Chairman's Report.	**Chairman**	**Verbal**
7	To note any matters raised by Governors.	**Board**	**Verbal**

Strategic/Governance (1.15 pm – 2.10 pm):

8	Chief Executive's Report.	**CEO**	**Report (to follow)**
9	To consider the report of the Audit and Risk Committee.	**Committee Chairman (JM)**	**Report**
10	**NHS Foundation Trust Annual Report and Accounts 2020/21:** (1) To approve the Annual Report and Annual Accounts 2020/21. (2) To approve the Letter of Representation. (3) To authorise the signing off of: ▪ The Annual Report ▪ The Performance Report ▪ The Accountability Report ▪ The Remuneration Report ▪ The Annual Governance Statement ▪ The Statement on the Accounting Officer's Responsibilities ▪ The Foreword to the Accounts ▪ The Statement of the Financial Position ▪ The Letter of Representation ▪ Any certificates relating to the above as required by NHS England/Improvement. (4) To approve the submission of the Annual Report and Accounts to NHS England/Improvement and Parliament. *(Notes:* *(1) A copy of the External Auditors' Audit Completion report has been circulated to all Board Members.* *(2) Any additional information or updated documents will be circulated prior to the meeting.)*	**CEO/DoFI**	**Draft Annual Report and Accounts 2020/21** **Draft Letter of Representation** **Report of the Director of Finance and Information on the Annual Accounts**

11	**Quality Account 2020/21** (1) To approve the Quality Account 2020/21. (2) To authorise the signing off of the document. (3) To approve the submission of the Quality Account to the Department of Health and Social Care. *(Notes:* *(1) Any amendments to the draft Quality Account following discussions at the Audit and Risk Committee meeting, to be held on 18th June 2021, will be reported verbally to the meeting.* *(2) Any further stakeholder feedback, received following the publication of this agenda, will be circulated to Board Members under separate cover.)*	**DoN&G/ DoPCPC**	**Draft Quality Account 2020/21 (to follow)**
12	**Data Security and Protection Toolkit** To approve the Data Security and Protection Toolkit submission to NHS Digital.	**DoFI**	**Report**

Exclusion of the Public (2.10 pm):

13	**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 any particular applicant for, or recipient or former recipient of, any service provided by the Trust.* *Information which, if published would, or be likely to, inhibit -* *(a) the free and frank provision of advice, or* *(b) the free and frank exchange of views for the purposes of deliberation, or* *(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.* *Information which is held by the Trust with a view to its publication, by the Trust or any other person, at some future date (whether determined or not), and it is considered reasonable, in all the circumstances, to withhold the information from disclosure until that date.*	**Chairman**	**Verbal**

Miriam Harte
Chairman
18th June 2021

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 27th MAY 2021 COMMENCING AT 1.00 PM

The meeting was held via MS Teams

Present:
Ms M Harte, Chairman
Mr B Kilmurray, Chief Executive
Dr H Griffiths, Deputy Chairman
Prof P Hungin, Non-Executive Director
Mr J Maddison, Non-Executive Director
Mr P Murphy, Non-Executive Director
Mrs B Reilly, Non-Executive Director
Mrs S Richardson, Senior Independent Director
Mrs R Hill, Chief Operating Officer
Mrs E Moody, Director of Nursing and Governance
Mrs L Romaniak, Director of Finance and Information
Mrs S Pickering, Director of Planning, Commissioning, Performance and Communications (non-voting)

In Attendance:
Mr P Bellas, Trust Secretary
Mrs W Johnson, Team Secretary

Observers/Members of the Public
Dr S Baxter, Public Governor, Redcar & Cleveland
Ms H Griffiths, Public Governor for Harrogate and Wetherby
Dr M Sani, Public Governor, Stockton on Tees
Mrs J Wardle, Public Governor for Durham
Ms S Liu, Research Student, University of York
Mr M Discombe, Health Service Journal

21/102 APOLOGIES

Apologies for absence were received from Dr A Khouja, Medical Director, and Dr S Dexter-Smith, Director of People and Culture.

21/103 MINUTES

***Agreed** – that the minutes of the last meeting held on 29th April 2021 be approved as a correct record and signed by the Chairman.*

21/104 DECLARATIONS OF INTEREST

There were no declarations of interest.

21/105 PUBLIC BOARD ACTION LOG

The Board noted that:

(1) Further to minute 20/44 (25/2/20) the revised terms of reference of the Quality Assurance Committee were due for consideration under confidential agenda item 7.

(2) Further to minute 21/55 (25/3/21) information on the work being undertaken to make improvements to capturing patient experience, and to increase the number of responses, had been provided to Board Members via email on 26th May 2021.

The Chairman advised that this matter would be kept under review.

21/106 CHAIRMAN'S REPORT

The Chairman reported that:

(1) The main focus over the last two months had been responding to the matters raised by the CQC following its inspection of AMH Inpatient Services and PICUs in January 2021. As highlighted in the Chief Executive's Report (minute 21/108 refers) the CQC had commenced a re-inspection of the services and the Board looked forward to its outcome.

(2) A successful meeting of the Council of Governors had been held on 18th May 2021. The Governors' comments about communications and information sharing had been taken on board.

(3) As reported to the last meeting of the Resources Committee, the Trust, notwithstanding ongoing pressures and challenges, had delivered two-thirds of its business plan in 2020/21. This included the completion of some major projects, for example, the delivery of Foss Park ahead of plan and the work on the Right Care Right Place priority which had informed commissioner investment and service developments.

(4) Positive media coverage over the last two weeks, covering mental health awareness and perinatal services, had been encouraging.

21/107 MATTERS RAISED BY GOVERNORS

The Chairman reported that there had been limited attendance at the pre-Board meeting with Governors. This probably reflected the truncated agenda for the Board meeting. No issues had been raised for consideration by the Board. The Governors had highlighted the impact of ongoing pressures, particularly the work required in response to CQC investigations, on the welfare and morale of staff. This had been acknowledged and Governors had been advised that the Trust continued to seek to enhance the care and support provided to them.

21/108 CHIEF EXECUTIVE'S REPORT

The Board received and noted the Chief Executive's Report.

In regard to the Care Quality Commission, Mr. Kilmurray reported that:

(1) Good progress continued to be made on the delivery of actions in response to the warning notice received from the regulator.

(2) Meetings had been held with the CQC and the Quality Board and the updated action plan had been shared with them.

(3) The enforcement notice would remain in place until the outcome of a re-inspection by the CQC.

(4) Since the preparation of the report the CQC had commenced an inspection of AMH inpatient wards and PICUs. Eleven wards had been visited, to date, covering Roseberry Park, West Park, Lanchester Road, Cross Lane and Foss Park. Although the wards were busy, staff were eager to engage with the inspectors about the work they had undertaken. The inspections were due to conclude later in the day but it was unlikely that any feedback would be received until the following week, at the earliest, when focus groups with staff were due to be held. Overall, the inspection, to date, had been largely positive but a couple of issues had been identified by the regulator.

(5) Work continued on embedding assurance processes and other changes. Feedback from the peer reviews, undertaken over the last few weeks, would be used to inform future improvement work. It had also been shared with the Quality Improvement Board and the CQC.

Arising from the report:

(1) The Non-Executive Directors highlighted the benefits of using discussions at team meetings to embed the new processes for learning from incidents.

Clarity was sought on the progress being made on this approach.

Mrs. Moody advised that:

(a) The new processes for learning included weekly patient safety bulletins and the learning library. At present the latter development provided a single place to access patient safety briefings on the intranet but further developments were planned.

(b) For inpatient services, daily ward level safety reviews were held which covered, amongst other matters, environmental risks and patient safety alerts. This approach was being tested through the peer reviews.

(c) For community teams, staff could access the learning library but the integrated assurance processes had not yet been extended to them.

(d) It was recognised that the majority of serious incidents occurred in the community. To support learning the Chairs of the SI review panels, working with the SI team and the review managers, were identifying immediate lessons learnt, from the cases reviewed, and sharing them with the teams.

(2) Clarity was sought on the approach being taken to the peer reviews.

It was noted that the peer reviews included senior clinical staff from CNTW and CCG Chief Nurses. Visits to wards were undertaken by at least two members of this pool and lasted between 2 to 4 hours. During the visits to wards, the peer

review team members mirrored the approach taken by the CQC, for its inspections, including conversations with staff and patients. To date, peer review visits had been held to all adult inpatient wards and PICUs and several secure inpatient wards. Visits were also planned to the remaining seven wards in secure inpatient services. These had been paused during the CQC inspection but were due to recommence in a couple of weeks' time.

Mrs. Moody reported that excellent feedback on the caring and compassionate approach of staff had been received from the peer review teams.

The Non-Executive Directors:
(a) Welcomed the use of the peer review approach.
(b) Noted that the proactive involvement of the CCGs in the peer reviews was part of their responsibilities for quality and safety included in the contracts.

(3) Mr. Murphy (the Chairman of the Resources Committee) reported that, on the advice of the Quality Improvement Board, the Committee had made recommendations to the Board that the implementation of CITO should be brought forward so that its benefits could be realised earlier than originally planned. He considered that this demonstrated that the Trust was investing in improving patient safety and would continue to do so.

It was noted that the recommendations of the Resources Committee were due to be considered in the confidential session of the meeting.

Mr Kilmurray highlighted that the enhancements to be provided through CITO were a key enabler of the delivery of the strategic goals; would embed improvements to clinical record keeping; and allow clinicians to spend more time with patients through reducing administration.

(4) The Chairman welcomed the expansion of Schwartz rounds, Trustwide, as these provided an additional means of understanding the pressures faced by staff and supporting their resilience.

It was noted that all Board Members could attend them.

21/109 QUALITY ASSURANCE COMMITTEE

The Board received and noted the report on the business transacted and matters arising from the meeting of the Quality Assurance Committee held on 6th May 2021.

Mrs. Reilly, the Chair of the Committee:
(1) Informed the Board of the matters considered at the meeting.
(2) Advised that the Committee had previously highlighted potential concerns about Ebor Ward in the North Yorkshire and York Locality, from quality and safety metrics, and the Stockton Access and Affective Team in the Teesside Locality.

At the meeting:

(a) The Committee had received a briefing on Ebor Ward together with a summary of actions taken by the Locality in response to the issues identified.

(b) The Teesside Locality had shared an impressive infogram which articulated the issues, the actions, and the progress being made on improvements to the Stockton Access and Affective Team.

(3) Reported that, although there were no actions for consideration by the Board at this time, the Committee remained concerned about:

(a) Staff health and well-being.

It was noted that, following discussions with Mrs. Reilly, the Director of People and Culture had offered to provide an assurance statement on this matter to the Committee.

(b) The continuing high levels of acuity and complexity of patients, organisation wide.

Mrs. Reilly considered that these issues needed to be further investigated given their bearing on patient safety.

Arising from the report:

(1) Clarity was sought on the inclusion of a new 'very high risk' in the North York and York Locality risk register, in regard to complex risk assessment and management processes, as it was understood that this had been mitigated through the actions taken in response to the CQC inspection in January 2021.

Mrs Hill advised that the risk reflected that staff had found the implementation of changes to the processes to be challenging but they had now been completed as expected.

(2) Board Members welcomed the progress made on the ligature reduction programme with only the works to Stockdale Ward to be completed.

(3) It was noted that there were no issues arising from the ligature reduction programme to bring to the attention of the Board.

(4) Mrs. Richardson, the Chairman (designate) of the People, Culture and Diversity Committee reported that an early priority for the Committee would be to consider the ability of staff to pause, rest, recover and resume with a focus on the support which could be put in place for the first three elements.

The Board noted that, through its work, the Committee would be seeking to balance out the pressure on staff arising from patient acuity and dependency.

(5) Clarity was sought on the re-establishment of the thematic assurance groups (e.g. the patient safety and patient experience groups), as the Trust came out of Covid-19 restrictions, and the development of integrated assurance reporting covering those functions.

Mrs. Reilly advised that discussions on integrated assurance reporting, supported by the Head of Corporate Performance, were due to be held at a meeting later in the day.

(6) Clarity was sought on whether the staffing establishment reviews, through which the need for additional investment had been identified, reflected the present increases in demand and acuity.

In response Board Members noted that:

(a) The investment approved under minute 21/52 (25/3/21) represented the first phase and had focussed on inpatient services.
(b) The investment had not taken into account separate surge modelling, but considered acuity and dependency and a progressive approach to releasing time for clinicians to spend with patients and to support key documentation.
(c) The surge forecasting, which had not informed the business case for the inpatient investment, had been based on recorded activity at the end of Quarter 3 and expected future demand including service developments.
(d) The impact of the inpatient investment could not be gauged at present. The Trust had made strides but there was a functional lag to recruitment.
(e) Community services had also seen additional pressures. Significant additional investment had been made in them through the Long Term Plan. This was not only focused on recruitment but on changes to service delivery.
(f) At this stage it was too early to understand the impact of other preventative measures e.g. the investment in schools.
(g) Work was being undertaken, with a broader scope, to determine requirements for further inpatient investment.

In response to questions it was confirmed that:

(a) Increased complexity and acuity of patients was being seen across the whole system and the Trust was not an outlier.
(b) Commissioners were aware of the situation.

21/110 MENTAL HEALTH LEGISLATION COMMITTEE

Prof, Hungin, the Chairman of the Mental Health Legislation Committee provided a verbal update on the matters considered by the Committee at its meeting held on 7th May 2021 as follows:

(1) The revised template for reporting to the Board had been adopted.
(2) The Committee was progressing into a new phase and needed to familiarise itself with the potential changes and amendments to the Mental Health Act arising from the Simon Wesley report published in December 2018.
(3) The terms of reference of the Committee had been revised following the Well-Led Review.
(4) The Committee was assured that the Trust was performing appropriately against the requirements of mental health legislation and had discussed any exceptions in detail.

21/111 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 any particular applicant for, or recipient or former recipient of, any service provided by the Trust.

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

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

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

Following the transaction of the confidential business the meeting concluded at 3.35 pm.

Board of Directors

Public Action Log

RAG Ratings:

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

Date	Ref No.	Action	Owner(s)	Timescale	Status

No Outstanding actions

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 8

PUBLIC

BOARD OF DIRECTORS

DATE:	**Thursday, 24 June 2021**
TITLE:	**Chief Executive's Report**
REPORT OF:	**Brent Kilmurray, Chief Executive**
REPORT FOR:	**Information and Discussion**

This report supports the achievement of all the 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:

Following the issuing of enforcement actions regarding concerns on Adult Acute and PICU wards in January 2021 we have completed an extensive programme of work to address the significant concerns of the Care Quality Commission (CQC). The CQC rated these services as inadequate for Safe and Well Led domains. The CQC returned in June to revisit these services. On 8 June the CQC wrote to the Chief Executive with some initial high level feedback. This report sets out the key messages.

Care Quality Commission (CQC)

Background

Following a focussed inspection of our Adult Acute and Psychiatric Intensive Care Unit wards in January 2021 an enforcement notice was issued. A substantial programme of work was set away to address significant concerns. We were given until 3 May to complete the actions. CQC inspectors returned to inspect these services at the beginning of June.

Key Issues

he following reflects an overview of the CQC's findings:

- There were improved systems to record and understand patient risks.

- Patient safety incidents were pulled through into the patient overview sections and could be easily found.
- Meetings were observed where risks were discussed and cross referenced to records to ensure risks and observations and leave decisions were properly recorded.
- Daily ward safety briefings facilitated a shared understanding of risks for all staff. Some staff fed back that patient risks being anonymised for confidentiality purposes was not helpful. This is now being looked into.
- Most staff reported being well supported through the changes process including coaching, webinars and supervision.
- The ligature reduction programme had been completed since the previous inspection.
- There was improved learning from serious incidents through leaders communicating reports and safety briefings, staff could talk about recent incidents and lessons learnt.
- Audits and checks to improve governance and assurance of embedding of changes were in place.

The inspectors also found:

- There were examples where not all risks have been reflected in safety summaries.
- There was an incident regarding sexual safety, which had not been reflected in a safety summary and the risk had not been identified in records. The CQC has requested more information about this and other sexual safety incident data.
- Not all incidents had pulled through into the patient overview section.
- A window had not been locked into position presenting a ligature risk, this was addressed on the day of the inspection.
- Staff were concerned about the lack of seclusion facilities.
- There was a discrepancy on the date of an environmental risk assessment on one of the wards.
- A paper file system for safety briefing reports and recommendations was not up to date.

The CQC has asked that this feedback be reported back at the Board meeting in public and recommend that the Board has the opportunity to discuss it.

The CQC has 50 days to publish its report. As Directors are aware, the CQC has now commenced its Well Led and Core Services inspection, and this timescale will probably fall during the current inspection period. We will therefore discuss further with the CQC their intentions and whether we should delay this until the main report is published or whether it should be published within the expected timescale.

Recommendations

The Board is asked to:

- Note the initial feedback from the CQC as reported from their letter of 8 June 2021.
- Discuss or raise questions regarding the feedback.

Committee Key Issues Report

Report Date: 24 June 2021		**Report of: The Audit and Risk Committee**
Date of last meetings: ▪ 10 June 2021 (Ordinary) ▪ 18 June 2021 (Special)		**Membership Numbers: 3** Quoracy met - 100% attendance including the Chairman for both meetings *Mary Booth, Public Governor for Middlesbrough, observed the meeting held on 18 June on behalf of the Council of Governors* *Members of the Committee expressed their thanks and appreciation to Dr Hugh Griffiths for his contributions and commitment to the work of the Committee at his last meeting on 18 June*
1	**Agenda**	The Committee considered the following matters: **10 June 2021**: ▪ The Counter Fraud Progress Report ▪ The Counter Fraud Work Plan 2021/22 ▪ The Internal Audit Progress Report ▪ The (updated) draft Annual Report and Opinion of the Head of Internal Audit ▪ The External Audit Progress Report ▪ The draft Annual Report and Accounts 2020/21 ▪ The Committee's Assurance Tracker **18 June 2021** ▪ The draft Quality Account 2020/21 ▪ The External Auditors' draft Audit Completion Report ▪ The (updated) draft Annual Report and Accounts 2020/21 ▪ The Committee's Assurance Tracker
2a	**Alert**	The Committee wishes to alert members of the Board that: ▪ In response to a survey, undertaken by the Internal Auditors as part of their fieldwork for an assignment on whistleblowing and Freedom to Speak Up Guardian procedures, some comments were received from respondents which suggested potential issues about staff attitudes to the Trust's whistleblowing and speaking up arrangements. Findings had been shared with the Director of People and Culture who was reviewing themes. ▪ As part of their work on value for money, and arising from the CQC report published in March 2021, the External Auditors identified a significant weakness in arrangements in regard to governance and how the Trust ensures it makes informed decisions and properly manages its risks. Management has responded to the External Auditors' recommendation on this matter. The Committee was content with both the External Auditors' recommendation and Management's response. Further information on this matter is included in the External Auditors' Audit Completion Report which has been circulated to Board Members under separate cover.
2b	**Assurance**	The Committee wishes to draw the following positive assurances to the attention of the Board: ▪ The Head of Internal Audit has advised that his, overall, Audit Opinion for 2020/21 is that: *"From my review of your systems of internal control, I am providing good assurance that there is a sound system of internal control, governance and risk management designed to meet the organisation's objectives and that controls*

		are generally being applied consistently." ▪ In their draft Audit Completion Report (see above) the External Auditors' provided assurance that the financial statements give a true and fair view of the financial position of the Trust as at 31st March 2021 and that they have been properly prepared; there were no unadjusted misstatements in the financial statements; issues in relation to governance had been picked up through the value for money recommendation; those elements of the Annual Report (which were subject to audit) had been properly prepared and were consistent with the financial statements; there was nothing to cast doubt on the Trust's ability to continue as a 'going concern'; and that there was nothing to report in regard to the Annual Governance Statement. ▪ The Trust was not an outlier in regard to its ratings in the Counter Fraud Functional Standards Return (formerly the SRT). ▪ The Internal Auditors found no fundamental or concerning matters from their interim review of the Data Security & Protection Toolkit, including when benchmarking against other audited NHS providers. ▪ Through its Assurance Tracker the Committee can evidence that it has complied with its Terms of Reference

2c	**Advise**	The Committee wishes to advise members of the Board that:
		• The Counter Fraud Work Plan for 2021/22 was approved.
		• In regard to the Counter Fraud Functional Standards Return:
		  • There was one 'red' rated standard. This related to the requirement for risk analysis to be undertaken in line with the Government Counter Fraud Profession (GCFP) fraud risk assessment methodology. The rating was due to the prescribed national training programme not yet being available.
		  • Further assurance was requested on whether the Trust has well-established and documented routes on its website to enable the public to report fraud.
		  • The LCFS has been asked to bring a report to the Committee on the actions required to move the Trust's 'amber' ratings to 'green' together with the resources required to do so, so the value of progressing can be considered.
		• There were no matters of concern arising from the Counter Fraud Progress Report.
		• It has reviewed the Annual Report and Accounts and has recommended their approval to the Board.
		• It has reviewed the Quality Account 2020/21 and, subject to some amendments to provide additional context (including the impact from the CQC's regulatory feedback and a consistent tone with the introduction to the Annual Report) and noting that further stakeholder views might be received, has recommended its approval to the Board.
		• Significant progress has been made on reducing the number of outstanding 'high' and 'medium' graded Internal Audit recommendations. Management responses have now been provided for all the recommendations. Internal Audit queried whether patient information which related to Covid could be actioned ahead of the revised action date and the Committee queried progress on supervision.

2d	**Review of Risks**	▪ With the exception of the Value for Money recommendation, the work undertaken by the External Auditors on key audit risks did not highlight any material issues to bring to the Committee's attention.
3	**Actions to be considered by the Board**	The Committee has recommended to the Board: ▪ That the Annual Report and Accounts 2020/21 should be approved for submission to NHS England/Improvement and Parliament. ▪ That, subject to certain amendments, the Quality Account 2020/21 should be approved for submission to the Department of Health and Social Care; and

		The above recommendations are due to be considered under public agenda items 10 and 11 respectively.		
4	**Report compiled by**	*John Maddison Chairman of Committee* *Phil Bellas Trust Secretary*	**Minutes available from**	*Angela Grant Senior Administrator*

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Annual report and accounts 2020/21

Tees, Esk and Wear Valleys NHS Foundation Trust

Annual report and accounts 2020/21

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

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Foreword by the chairman and chief executive

COVID-19 dominated healthcare last year and we're incredibly proud of colleagues who worked tirelessly during this time and continue to do so. They supported patients, families and each other, while keeping up with new guidance, reduced staffing levels and living with the uncertainties that have been felt by people everywhere during the pandemic. Thank you.

Brent was delighted to join us as chief executive in June 2020 and we took the opportunity to really listen to people and to think about the future direction of the organisation. We know we have not always got it right but we believe that by truly listening and working together we can make changes and improve the experience of TEWV for everyone.

We started Our Big Conversation and heard from patients, staff, families, carers and partners about what they thought of TEWV now and what they wanted us to become. We co-created our new strategy for the next five years, "Our Journey to Change" based on these conversations. It sets out where we want to be and how we will get there through a new shared vision, set of values and three core commitments to patient, carers, colleagues and partners.

Earlier this year, following an unannounced inspection from the Care Quality Commission (CQC), our acute wards for adults and psychiatric intensive care units were rated as inadequate for both safe and well-led. We continue to demonstrate the improvements we're making and have given assurance that patients are safe on our wards. We have already seen some positive changes that are really making a difference to both our patients and staff. We are grateful to colleagues for everything they have done to support this.

There's still work to do. That's why it's so important we continue to take time for some deeper reflection to make sure we take the right course of action and that the changes we make are meaningful.

Looking forward, we will be focussing on getting the basics rights; making care planning collaborative, co-created and comprehensive, providing quality and safe care and working on transformation programmes including the introduction of new crisis care models and working with partners on the Community Mental Health Framework.

We have learned a lot this year and we're committed to making positive changes and continuing to improve the care we deliver. We will do this with the support of our colleagues, partners and commissioners, and the expertise of patients, carers and governors.

Finally, we would both like to express a heartfelt thank you to our staff, the Board, the Council of Governors, our many partners and stakeholders, service users and carers for all of their support over this past year and for their continued commitment to working alongside us in the future.

Brent Kilmurray
Chief executive

Miriam Harte
Chairman

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

The challenges the Trust has faced over the last couple of years continued into 20220/21, however, our new strategy, Our Journey to Change, which was co-created with staff, patients, carers and partners, gives us a firm foundation to make progress.

COVID-19 created risks and certainly impacted our performance. While it did not, initially, cause the major pressures felt elsewhere in the NHS there were challenges in maintaining service delivery because of increased infection prevention and control measures and social distancing. The tireless efforts of staff to provide high quality care in difficult and often uncomfortable working environments are recognised and commended.

In the second half of the year, we started to experience the expected surge in demand and acuity as social isolation and anxiety arising from the pandemic impacted people's mental health. This is expected to continue into 2021/22.

In spite of the pandemic our finances have been resilient, reflecting helpful national financial arrangements that have allowed the NHS to respond to the challenges of Covid-19 throughout 2020/21.

During the year, the findings of inspections and other reviews have given us greater insight and clarity on the improvements we need to make. I am proud of the rapid progress we have made in responding to concerns raised by our regulators and in strengthening our governance processes. However, we do not underestimate the size of the task ahead.

With our focus on co-creation with patients, their carers and families and with staff and partners we are now well placed to become the organisation we aspire to be and to enable people to lead their best possible lives.

Brent Kilmurray
Chief executive
24th June 2021

TEWV at a glance

Tees, Esk and Wear Valleys NHS Foundation Trust was created in April 2006 and became a foundation trust in July 2008 under the NHS Act 2006. In June 2011 we gained responsibility for services in Harrogate and Richmondshire and in October 2015 we took over the contract for mental health and learning disability services in the Vale of York.

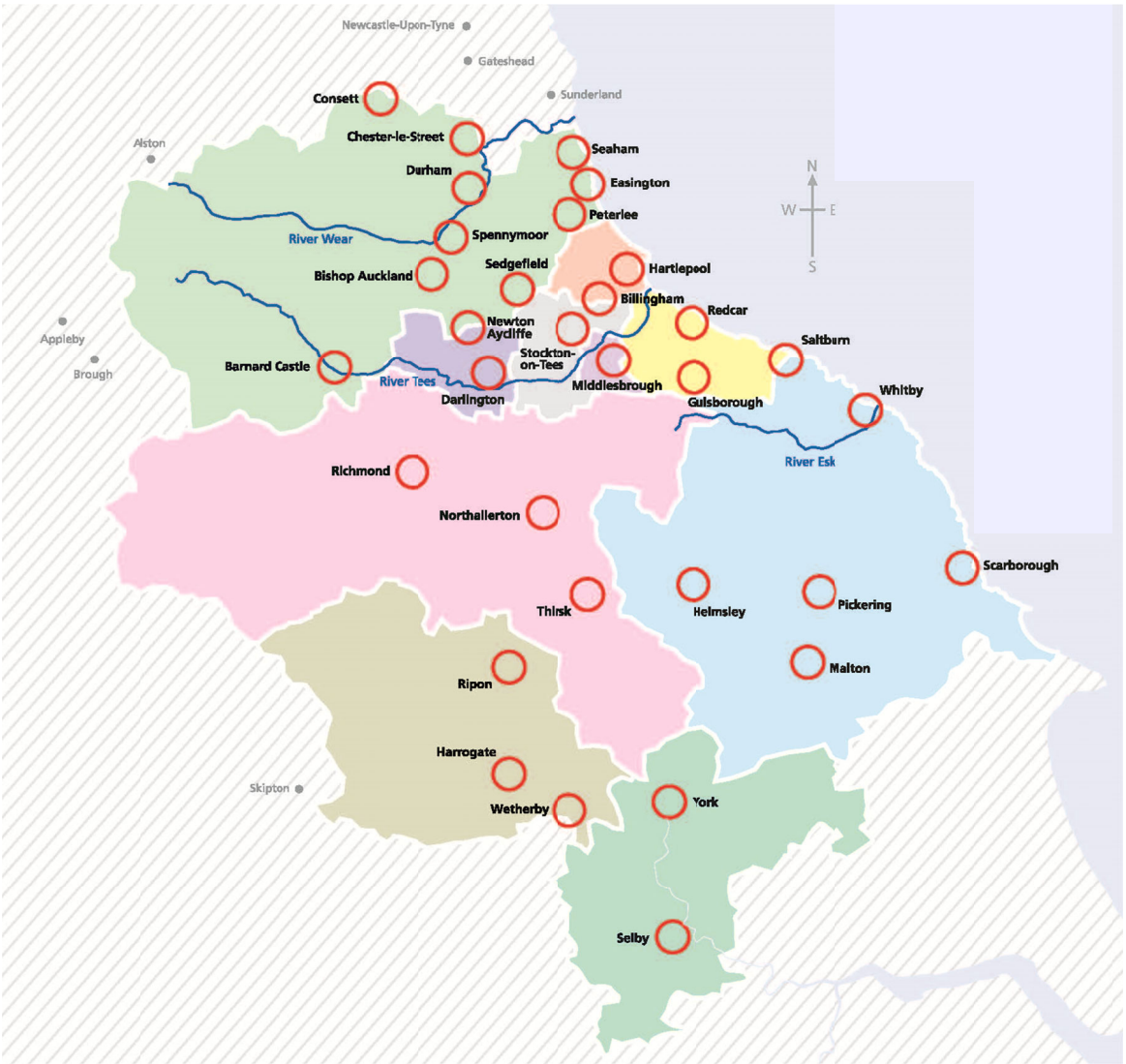
As a foundation trust we are accountable to local people through our Council of Governors and are regulated by NHS Improvement and the Care Quality Commission.

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

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 in North East England, Cumbria and parts of Lancashire.

The area we serve



Our Journey to Change

Our Journey to Change sets out why we do what we do, the kind of organisation we want to be and the three big goals we're committing to over the next five years. It is the result of our biggest ever listening exercise and has been co-created with staff, patients, carers and partners.

Our Purpose

We want people to lead their best possible lives.

The type of organisation we want to be

We will co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism, involving them and their carers as equal partners. We will listen, learn, improve and innovate together with our communities and will always be respectful, compassionate and responsible.

Our Values

- Respect – listening, inclusive, working in partnership
- Compassion – kind, supporting, recognising and celebrating
- Responsibility – honest, learning, ambitious

Our Goals

- To co-create a great experience for our patients, carers and families
- To co-create a great experience for our colleagues
- To be a great partner

Achieving our goals

To make sure we achieve our goals we have co-created five key priorities, each with a set of actions that we will carry out this year.

1. Co-creation is at our core

We'll know we've achieved this when patients, carers and staff work confidently together, living our values, sharing a purpose and achieving our goals. Patients and carers in particular have a strong and authentic voice. Their opinions, feedback, concerns and ideas are always sought out.

To do this we will:

- Expand the way we use peer support.
- Develop an involvement and leadership structure to support services. Our ambition is for patients and carers to be involved, as equal partners, in all aspects of service planning, design, implementation, delivery, evaluation and all aspects of the assurance process.
- Establish a Lived Experience Advisory and Reference Network (LEARN)/

2. We have a clear clinical approach

We'll know we've achieved this when we offer compassionate clinical care, which is:

- Built on and recognises strengths so people stay connected to their community and those who care for them.

- Designed in close collaboration with the individual and their carer – this is what we mean by co-creation.
- Honest and with shared decision-making, with services available where and when people need them to make sure there's continuity of care.
- Safe, effective and inclusive of peoples' rights.
- Makes the best use of staff expertise.
- Helping people to live well.

By compassionate we mean:
- We'll be there when people need us.
- Showing human contact, kindness and care every time someone's in contact with our services.

To do this we will:
- Make care planning collaborative, co-created and comprehensive.
- Ensure our clinical services comply with the Human Rights Act.
- Provide choice and quality of care which is NICE compliant and safe. We will make sure that the offer is clearly stated, available and accessible to staff, patients and referrers in each area.
- Engage with transformation work in our local communities to provide support and challenge to plans to maximise the benefits of the transformation.

3. We have a leading role in our system

We'll know we've achieved this when we work effectively with a range of partners in different systems and places so people's mental health, learning disability and autism needs are better understood and their quality of life is increased and supported.

To do this we will:
- Help communities work in new ways to increase and improve the support available to improve the wellbeing of people with a mental health, learning disability or autism needs.
- Make sure the people with mental health needs, a learning disability or autism, and their carers can positively influence discussions, planning and decisions in all systems and places.
- Work with local partners to promote good mental wellbeing and tackle stigma across all age groups.

4. We're a great place to work

We'll know we've achieved this when we help everyone who works at TEWV to feel proud of their personal contribution to supporting people to live their best possible lives. People feel that working at TEWV positively impacts on their lives and their wellbeing.

To do this we will:
- Engage with staff at all levels to co-create our new ways of working together.
- Support people to be the best they can be through a focus on compassionate and inclusive leadership that supports us all to develop and find our work meaningful.
- Support all staff to develop, by making sure there is fair access to training that is relevant and adds value.
- Support career progression by focusing on skills and experiences which people can bring to different roles.
- Ensure organisational systems and processes are supportive of a great place to work.

5. Our corporate services support and empower the front line

We'll know we've achieved this when we offer excellent, innovative care that's supported by systems that are effective, accessible and empower people who use them. These systems provide wrap around support for our colleagues, patients, carers and partners. People are easily connected to the accurate information they need, our physical spaces support high-quality care and our decision making processes are simple and transparent.

To do this we will:

- Connect the right people with the right expertise to identify problems and create solutions.
- Make sure our governance systems support safe, simple and responsive decision making.
- Ensure our digital systems offer the best possible opportunities for collaboration and communication.
- Always provide the right information, at the right time and in the right format.
- Make sure our physical spaces support the new types of care we want to deliver.

Our services

Our services are organised primarily by location, through our localities:

- Durham and Darlington
- Teesside
- North Yorkshire and York

There is a fourth locality that is based around a service not a geographical area, forensic services.

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

- Adult mental health (AMH) services
- Mental health services for older people (MHSOP)
- Children and young people's services (CAMHS)
- Adult learning disability (ALD) services

Key issues, opportunities and risks which could affect the Trust in delivering its objectives and/or its future success and sustainability

There are a number of risks that could impact on the delivery of Our Journey to Change. An analysis of the principal strategic risks, together with the controls and mitigation, is included in our Board Assurance Framework and is described in our Annual Governance Statement.

In many ways the issues and risks impacting on us also provide opportunities. These include:

- Feedback from Our Big Conversation was challenging but helped us develop Our Journey to Change. This sets out how we will get where we want to be.
- Regulatory action taken by the Care Quality Commission (CQC) and NHS England/Improvement (NHS E/I) has provided greater insight and key learning into the improvements we need to make. With the establishment of the internal Quality Improvement Board and the external regional Quality Board and Improvement Director Team, we have support in moving forward and delivering our strategic goals.
- Our response to weaknesses found in our governance arrangements, by the external and

independent well-led review, we have a platform to strengthen our structures, systems and processes.
- The ongoing defect rectification work at Roseberry Park will allow us to develop a fit for purpose inpatient estate which fully supports the delivery of high quality clinical care.
- Expected changes arising from integrated, system and place based working could impact on our sustainability but also could provide us with greater influence to make changes for the benefit of patients and their carers.

How we performed in 2020/21

How we measure our performance

Each year the Board of Directors identifies and agrees a number of stretching, performance and quality standards. These are measured by key performance indicators for the Trust to work towards as part of our commitment to year-on-year improvement. 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 to give assurance that we are continuing to deliver operationally.

The report highlights key areas of concern that could impact operationally; areas we feel require additional monitoring as well as providing positive assurance on areas we are performing well on.

We make it available to service users and carers, the wider public and commissioners and a summary is presented and discussed with our Council of Governors once a quarter.

Whilst these indicators were agreed for 2020/21 we did not implement them initially due to the need to plan and mobilise our response to the pandemic. Instead, during the first half of 2020/21, the Board of Directors received an Interim Trust Dashboard to help understand and assess the impact of the pandemic on the quality of services being delivered.

In August 2020, we reinstated the Trust Dashboard that contained the measures originally agreed as part of the Business Planning process for 2020/21. We also used statistical process control (SPC) charts as a way of demonstrating and thinking about whether things were really improving, staying the same or getting worse. For example, was the change being seen in the numbers due to normal variation or real change?

The Board of Directors discusses the Trust Dashboard each month to consider where we have positive assurance but also to identify and understand areas of concern. Where there are areas of concern, detailed analysis is undertaken and presented as part of the report. This would include key conclusions and what actions are being taken to improve performance.

As part of the continuous improvement of the Trust's Performance Management Framework, we identified a need for a more integrated approach to quality and performance assurance and improvement. During 2021/22 we will develop an Integrated Board Assurance and Performance Report. This new approach will attempt to bring together the agreed measures/assurance from the Board Sub Committees into a single integrated report. The benefits of such an approach include:

- Integrated assurance about the quality of services being delivered to ensure we are meeting our goals and the standards within the CQC domains.
- Integration of all aspects of performance, including financial, operational, workforce and contractual, to bring a more rounded understanding of factors impacting, or opportunities to change performance and outcomes.
- Triangulation of data and information (both qualitative and quantitative) about the delivery of our services which should then enable appropriate assurance to be provided to the Board or

an informed discussion at the Board if assurance cannot be provided.

- Ability to identify areas of concern more easily and understand what else is impacting in order to assess whether the actions being taken will have the desired impact.

Performance against key standards

The following table is our dashboard of key performance measures for 2020/21. During the first half of 2020/21 the Board of Directors received an Interim Trust Dashboard to help understand and assess the impact of the pandemic on the quality of services being delivered. In August 2020, this was replaced with the Trust Dashboard that contained the measures originally agreed as part of the Business Planning process for 2020/21. Please note we have only included commentary on areas requiring improvement.

Key for SPC icon definitions

Special cause of improving nature or lower pressure due to higher values

Special cause of concerning nature of higher pressure due to lower values

Common cause – no significant change

Variation indicates inconsistently hitting, passing or falling short of the target

Variation indicates consistently falling short of the target

Quality

Measure Name	Variation ending March 2021	Assurance ending March 2021	Annual Standard 20/21	Actual Position 20/21	Commentary
1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral			90.00%	93.93%	
2) Percentage of patients starting treatment within 6 weeks of an external referral			60.00%	66.51%	

3) The total number of inappropriate OAP days over the reporting period (rolling 3 months) *NB This indicator measures the number of days a patient spends in a hospital within the Trust that is not the one to which we would expect them to have been admitted due to no beds being available in the hospital we would have expected them to have been admitted to*			1833	2061	We want to ensure that as many people as possible who need a hospital admission receive their care in their local hospital. This is because we understand this improves continuity of care but is also important to ensure people can stay in touch with family and friends more easily. Unfortunately we haven't been able to meet the standard we set ourselves on this indicator due to pressures we experienced in the second half of the year from individuals needing access to inpatient services. We have been able to ensure that anyone needing our care could be admitted to a bed within the Trust, but unfortunately this was not always in their local hospital. We are continuing to work on how we can better support people in the community and hopefully avoid the need for admission. Where admissions are needed, we are working to also ensure that we focus on supporting each person to return home as soon as they are well enough to do so.
4) Percentage of patients surveyed reporting their overall experience as excellent or good			94.00%	90.71%	Ensuring that people have a good experience of the care they receive is a key measure of the quality of our services and one of our key areas of focus. Unfortunately this year our performance hasn't changed or improved and people are still telling us that their experience could be better. Whilst we have not reached our target of 94% we are very pleased to see that 9 out of every 10 patients reported their overall experience as being 'excellent' or 'good'. However we do still want to improve the position further and will continue to put in place actions to support improvement.
5) Percentage of serious incidents which are found to have a root cause of contributory finding			32.00%	36.94%	Whilst we may not always be able to prevent incidents happening we do want to ensure that, when they do, we learn from them. As we learn we would expect that the number of times where the care we delivered was part of the reason for the

					incident would reduce. Unfortunately we did not achieve the standard we set ourselves for the year. We have put in place a range of actions to improve how we deliver care and share learning across the organisation and which we expect to lead to improvement.
6) Percentage of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) – month behind *This is a clinical outcome measure; an improvement in HoNOS is shown by an increase in the patient's actual HoNOS score. The change is identified by comparing the first HoNOS score calculated on admission, and the score on discharge.*			60.00%	49.43%	Whilst nationally we compare well in terms recording the clinical outcomes we are delivering, we want to ensure that; through the care we are providing, those outcomes improve over time. Unfortunately this year we did not see as many improvements in outcomes as we wanted to. We have undertaken detailed analysis in all 3 geographical localities to understand the local position better and have agreed some key actions across the Trust to support improvements.
7) Percentage of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) – month behind			65.00%	67.59%	

Activity

Measure Name	Variation ending March 2021	Assurance ending March 2021	Annual Standard 20/21	Actual Position 20/21	Commentary
8) Number of new unique patients referred		N/A	N/A	84,333	
9) Percentage of new unique patients referred with an assessment completed (2 months behind)		N/A	N/A	72.33%	
10) Percentage of new unique patients referred and taken on for treatment (3		N/A	N/A	32.40%	It is important that we understand whether people who access our services go on to receive treatment after their initial assessment. This is important so

months behind)					that we can ensure that the pathways for people through our services run appropriately and people receive timely treatment when needed in the services we deliver. During the year it can be seen that the number of patients taken on for treatment has reduced and it is important that we understand why. We have undertaken detailed analysis in our 3 localities to understand the position better and as a result actions are in place to improve performance in this area.
11) Number of unique patients discharged (treated only)		N/A	N/A	33,485	
12) Bed occupancy (AMH and MHSOP Assessment and Treatment Wards)			90.00%	79.07%	
13) Number of patients occupying a bed with a length of stay from admission greater than 90 days (AMH and MHSOP assessment and treatment wards) – snapshot			61	37	
14) Percentage of patients re-admitted to assessment and treatment wards within 30 days (AMH and MHSOP)			9.90%	10.48%	Whilst admissions to an inpatient bed are sometimes necessary, we would want to ensure that, where possible after leaving hospital, patients can be supported to live in the community without further admission. We can see that we didn't achieve this quite as often as we wanted to. We will continue to work on this in 2021/22.

Workforce

Measure Name	Variation ending March 2021	Assurance ending March 2021	Annual Standard 20/21	Actual Position 20/21	Commentary
15) Finance vacancy rate		N/A	N/A	-5.83%	
16) Percentage of staff in post with a current appraisal - snapshot			95.00%	96.83%	
17) Percentage compliance with all mandatory and statutory training - snapshot			92.00%	92.46%	
18) Percentage sickness absence rate (month behind)			4.30%	5.14%	As an employer, we understand how important the health and wellbeing of our staff is. We also know this can impact on the services we deliver, so understanding our sickness rate, and how we can better support staff wellbeing, is critical. At the end of the year there hasn't been any real change in our level of sickness however it is still higher than we would like. Given the impacts of the Covid 19 pandemic during this year, the fact that there wasn't a significant increase in sickness is a positive position on which to end the year. We continue to focus on supporting the health and well-being of our staff and this work is captured in one of our new Strategic goals.

Money

Measure Name	Annual Standard £000 20/21	Actual Position £000 20/21	Commentary
19) Delivery of our financial plan (Income and Expenditure or I&E)	-1,998	-16,741	The Trust's outturn I&E position for the 2020/21 was a deficit of £16,741k, which included impairments of £25,841k. Impairments are excluded from NHS financial performance measurement because they are technical adjustments linked to asset revaluations. Excluding impairments, the Trust's end of year financial position was a surplus of £9,100k. This included significant non-recurrent national funding to support our pandemic response including income for increased untaken leave costs, challenges to successfully recruit externally and significantly reduced travel costs. A key forward challenge for the Trust is the recruitment of staff, including additional staff to support the pandemic response and NHS Long Term Plan priorities; this is reflected in the non-recurrent reported surplus. The Trust has made recent commitments to enhance inpatient staffing establishments that also require a sustained recruitment focus which is now progressing.
20) Cash Releasing Efficiency Savings (CRES) delivery	4,127	3,538	The Trust delivered CRES during 20/21 equivalent to £3,538k, which was £589k behind plan, but mitigated by non-recurrent under spending, including significant travel cost reductions. The Trust established a Finance Sustainability Board during 2020/21 to support a more strategic focus on the Trust's underlying financial position. This includes oversight of 2021/22 and longer term financial planning activities.
21) Cash against plan	60,972	80,936	The Trust's year end cash balances were £80,936k, which was £19,964k ahead of plan: • Statement of Financial Position: national capital funding for planned children and young people schemes, VAT recovery on capital works, other movements in working capital. • I&E: national funding for holiday provisions and for increased untaken leave costs linked to the pandemic, and the impact of non-recurrent I&E surplus reported above.

Progress of 2020/21 quality account priorities

Making Care Plans more personal

Feedback from service users shows that our current approach to care planning does not always promote a personalised approach, hence this being identified as a priority in 2020/21.

What we said we would do:	What we did:
• Re-audit and report as per Q4 2017/18. • Compare and contrast review of patient experience. • Develop and implement a communications and engagement plan to ensure all relevant stakeholders are aware of changes to the CPA and introduction of DIALOG (a clinical tool that allows for more personalised Care Planning) and review this plan with key stakeholders (staff, service users, carers, local authorities and GPs). • Continue User Acceptance Testing (UAT) of DIALOG and wider CITO developments (moving from artificial to real-life testing). • Work with information technology team to ensure a finalised, working version of DIALOG is embedded within CITO. • Develop guidance to support the implementation of revised CPA processes including DIALOG. • Develop training and supporting materials in relation to the implementation of revised CPA processes including CITO pilot (this may not include the final version of DIALOG). • Pilot training to support staff to implement the revised CPA processes. • Evaluate the pilot CPA training, making revisions where necessary. • Roll out the revised CPA training across the Trust.	• COVID-19 severely impacted progress against this priority over the past year. The lead for this piece of work has been redeployed for much of this time to support the patient and staff swabbing, antibody clinics, outbreak response and vaccination programme. However, aspects of the work have continued, for example, training has been delivered for trainee and newly qualified nurses on a variety of courses, but this has been to a much lesser extent than during previous years. Links have been maintained with the development group for CITO (a system which will overlay the Trust's patient record to make it easier to record and view patient records). These actions have been rolled over into 2021/22. • In January 2021 the Trust Board received a business case for, and has approved additional resources to support, the development and implementation of CITO as part of resourcing a wider EPR Programme. In March 2021, the Trust Board agreed to additional resources that would bring forward the target date to implement CITO to August 2022.

Improve the Clinical Effectiveness and Patient Experience in times of Transition from CYP to AMH Services

Young people with ongoing or long-term health or social care needs may be required to transition into adult 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 transfer into, and evidence that young people may fail to engage with services without proper support.

We initially agreed to put a two-year Quality Improvement priority in place, focusing on this specific transition. We have extended this as the full extent of the work required has become apparent.

What we said we would do:	What we did:
• Extend the work of the NHSI Transitions Collaborative project into an internal 3-year project that oversees the development and delivery of key quality improvements. • Develop an action plan with this Preparing for Adulthood Collective to implement key learning in the first year of the project, and establish strategies and targets for year two and year three. • Instigate quality Improvement plans for the effectiveness of the panel process following the evaluations of transition panels which has taken place in Q4 2019/20.	• The majority of these actions were suspended due to COVID-19. Towards the end of 2020-21 we began to implement the project Improving Transitions and Service Provision for People aged 16 to 25 years which is linked to the Trust's wider work around the NHS England CAMHS whole pathway commissioning.
• Sustain and maintain improvements in the clinical effectiveness and patient experience at times of transition from CAMHS to AMH throughout the year.	• We have, however, managed to maintain our improvement targets over this time period in terms of actual numbers. We saw an extra 703 young people through their transition period and completed a transition plan for an extra 784 during 2020/21 compared to 2018/19. This is positive especially against the backdrop of the pandemic and an extremely high caseload.

Reduce the number of preventable deaths

It is recognised that people with a mental health problem, autism and/or a learning disability are likely to experience a much earlier death than the general population. Therefore a key focus for the Trust will be on mortality review processes.

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 that we carry these out.

What we said we would do:	What we did:
• Fully introduce 48-hour follow up for all AMH patients after discharge from inpatient ward.	• We have fully introduced 48-hour follow-up processes for all AMH patients after discharge from inpatient wards (previously 72 hours).
• Produce report, recommendations and evaluation from the Family Conference, held in March 2019. • Produce action plan from the Family Conference and implement these actions.	• The Family Conference was to be followed by a second event on March 28 2020 however the COVID-19 lockdown prevented this from going ahead. Due to the sensitive nature of the Family Conference it was not the type of event that could be held remotely. One of the reasons for the success of the 2019 event was due to the support that was in place for the families that attended who were still grieving and distressed about the loss of their loved one.
• Involve a lived experience service user/carer representative in the Environmental Risk Group.	• We have invited a service user/carer representative with lived experience to be a member of the Environmental Risk Group and they have attended one meeting so far. The Environmental Risk Group have overseen a comprehensive programme to reduce the risk of ligatures across inpatient services. This has included the fitting of new, safer, ensuite showers, toilets and hand basins as well as the pilot of the Oxehealth Digital Care Assistant in three wards. This is a system that detects movement in bedroom areas and seclusion rooms through the measurement of a patient's vital signs and can send alerts to staff where risks to the patient may be arising.
• Implement actions from the external review of unexpected deaths of adult, forensic and older person's services inpatients.	• We have implemented the actions from the external review of unexpected deaths of adult, forensic and older person's services inpatients.

• Review our Zero Suicide Plan in view of the Family Involvement Event and Safety Summit in Q2 2020/21. Set up a task and finish group to be an umbrella steering group around preventing harm and deaths, chaired by the medical director.	• The Suicide Prevention and Self Harm Reduction Group, chaired by the medical director, was established as planned. The group continues to develop a framework to ensure the Trust is supported in coordinating activities designed to reduce the risk of suicide and frequency of suicide attempts. The group also focuses on sharing learning and good practice around suicide prevention and self-harm.

Increasing the proportion of inpatients who feel safe on our wards

A known theme among mental health inpatients, nationally, is that they do not feel safe whilst on our wards. This is identified as a priority for improvement for trusts in the NHS Long-Term Plan (2019). Feedback from our stakeholders in 2019/20 indicated awareness of this as an issue and we therefore agreed to include this as one of our priority areas for improvement within the Quality Account 2020/1 with the aim to increasing the proportion of inpatients who feel safe on our wards.

What we said we would do:	What we did:
• Use existing data to identify priority wards and actions, collate existing Friends and Family Test (FFT) and other data.	• We undertook a deep dive into the patient survey narrative provided by patients to further understand the reasons why our patients might not feel safe. The key themes identified were due to the environment, due to their illness, other patients and staffing.
• People with lived experience to talk to people currently on inpatient wards with the highest and lowest current FFT scores, produce a lessons learned report, develop a plan for each ward identified as a priority and deliver actions from this plan.	• This action has been rolled over to our Quality Improvement Business Plan for 2021/22 due to impacts from the pandemic.
• Undertake work to improve liaison with the police.	• This has now been embedded as business as usual routine practice.
• Continue monitoring of key performance indicators (KPIs) during the pilot phase of body cameras and develop a business case for further roll-out of these cameras (if supported by monitoring of benefit KPIs).	• Although the pilot phase of body cameras has continued during 2020/21, there has been no monitoring of KPIs undertaken due to the COVID-19 pandemic. We plan to expand and continue the pilot during 2021/22 by rolling out to a further five wards. Consideration will be given to further implementation based on an

	evaluation/benefits realization.
• Install the technology required for sensor technology in five wards and develop required governance in relation to this pilot work. A benefits realisation of the pilot will be undertaken.	• We have tested the Oxehealth Digital Care Assistant in three wards across the Trust. Approval has been given to extend this to a further 12 wards including some seclusion and Section 136 areas – the approach will include three workstreams, overseen by an Implementation Steering Group chaired by the Director of Nursing and Governance that will meet every three to four weeks until three months post go-live when the ongoing project and partnership working is then overseen by a Partnership Board. The Partnership Board will report key information into our Senior Leadership Group meeting. We see this initiative as being key to our plans for keeping patients safe.

Equality of service delivery to different groups

Strategic objectives:

A revised Equality, Diversity and Human Rights Strategy for 2020–2023 was approved by the Board of Directors in January 2020 in order to more fully realise the vision, mission and strategic goals of the Trust. As part of the development of this strategy a consultation was held with service users, carers, staff and partner organisations. There was an encouraging level of engagement in the consultation exercise. A number of very clear themes emerged and these themes have helped to shape the objectives in the strategy.

Objective 1
To ensure we have a suitably trained and skilled workforce to address the needs of trans patients and staff.

Progress
Good progress has been made with staff training on working with trans staff and service users. Feedback from staff has been very positive and bespoke sessions have been delivered to some teams who are working with a trans service user. The review of HR policies to ensure they meet the needs of trans staff, particularly in relation to recruitment and staff records will be complete by end of Q2 2021/22.

Objective 2
To increase the recording of disability and sexual orientation on our staff (ESR) and patient (Paris) record keeping systems. Staff and training is developed to support staff to ask demographic questions.

Progress
A publicity campaign has been launched to address this issue and training is being developed to support staff to ask demographic questions. This will ensure we have complete data which can then inform the services we provide.

Objective 3
To increase the number of BAME service users who access services within the Trust and report a positive experience.

Progress
Localities have made good progress in working with their BAME communities. For example Teesside held a recruitment event for members of the BAME community to encourage them to apply for jobs in the Trust and to identify barriers to them doing so. Actions are currently underway to address this.

Publication of patient information is available on the TEWV website at:
https://www.tewv.nhs.uk/about-us/how-we-do-it/equality-and-diversity/

Going concern

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

The 2021/22 annual plan provides for a surplus of £4.7m (2.2% of turnover) for first 6 months of the year. This reflects ongoing national financial arrangements that have operated throughout the pandemic and includes substantial non-recurrent funding flows.

At the time of writing, plans for the second half of the year have not yet been submitted pending confirmation of national financial arrangements. 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".

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.

Brent Kilmurray
Chief Executive
24th June 2021

The Directors' Report

The chairman, deputy chairman, chief executive and other Board members as at 31 March 2021

Miriam Harte, Chairman of the Trust
Miriam has a wealth of experience within the NHS, having spent the last 12 years as a non-executive director. She was on the Board at City Hospitals Sunderland NHS Foundation Trust for nine years and, most recently, was a non-executive director with Northumberland, Tyne and Wear NHS Foundation Trust. She is also a chartered accountant and has extensive business experience.
Qualifications: BA, MA, FCA
Principal skills and expertise: Leadership, strategy, communications and change management
Term of office: 1 April 2019 to 31 March 2022
Date of Initial appointment: 1 April 2019
(Note: the chairman had no other material commitments during the year)

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 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: MBBS, FRCPsych
Principal skills and expertise: Service improvement, policy development, clinical leadership and management
Term of office: 1 April 2018 to 31 March 2021* (see below)
Date of Initial appointment: 1 April 2015 (prior to his appointment Hugh served as an associate non-executive director of the Trust (non-voting) between 1 September 2014 and 31 March 2015.
Notes: Hugh completed his second, three year, term of office as a non-executive director on 31 March 2021. He was appointed by the Council of Governors for a further term of three months to maintain continuity of expertise on the Board. This was because of concerns raised by the CQC following inspections of our adult inpatient wards and PICUs in January 2021. Hugh stood down from his role as the chairman of the Quality Assurance Committee on 31 March 2021.

Professor Pali Hungin, Non-Executive Director
Pali, a GP by background, qualified at Newcastle University and practiced in the Stockton area for 25 years. He was the founding dean of medicine and the head of the School of Medicine, Pharmacy and Health at Durham University from 2003 to 2014 and the president of the British Medical Association in 2017. He is currently Emeritus Professor at the Institute of health and society in the Faculty of Medical Sciences at Newcastle University. Pali served as a governor of TEWV from its inception as a Foundation Trust to 2016. He presently leads the Academy of Medical Royal Colleges' commission on impending developments in healthcare and the evolving role of clinicians. He also works with Genome England and is the trustee treasurer of the Royal Medical Benevolent Fund.
Qualifications: MBBS MD FRCP FRCGP FRSA
Principal skills and expertise: Academic developments, recruitment and retention of clinical staff, physical health status of service users, organisational culture
Term of office: 1 September 2019 to 31 August 2022
Date of initial appointment: 1 September 2019
Note: Pali became the chairman of the Mental Health Legislation Committee on 1 April 2021.

John Maddison, Non-Executive Director and Chairman of the Audit and Risk Committee (from 1 September 2020)
John retired in June 2019 after working in the NHS for 37 years. He studied economics and accountancy at Loughborough University and joined the NHS as a graduate trainee accountant in Yorkshire. The majority of John's career was based in the North East working in finance, primarily in the acute sector and senior positions at the strategic tier including NHS England. He was Director of Finance and Informatics at an acute Foundation Trust in the North East and a large teaching hospital in the North Midlands before joining Gateshead Health Foundation Trust in 2014 as Group Director of Finance and Informatics and latterly as Deputy Chief Executive and Acting Chief Executive for the final year prior to retirement.
Qualifications: BSc Econ/Acc, Chartered Institute of Public Finance and Accountancy
Principal skills and expertise: Operational and strategic finance and planning, governance and risk management and performance management
Term of office 1 July 2020 to 30 June 2023
Date of initial appointment: 1 July 2020 (prior to his appointment John served as an associate non-executive director of the Trust (non-voting) between 1 January 2020 and 30 June 2020.

Paul Murphy, Non-Executive Director and Chairman of the Resources Committee
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 mental health, wellbeing, and services for children and young people.
Qualifications: BA (Hons) English and 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 2019 to 31 August 2022*
Date of initial appointment: 1 September 2016

Bev Reilly, Non-Executive Director and Chairman of the Mental Health Legislation Committee (to 31 March 2021)
Bev has been a nurse for 32 years. Until recently, Bev was the Director of Nursing and Quality for NHS England covering Cumbria and the North East. Her career has spanned a number of organisations across acute, primary and community care settings at a local, regional and national level. She is experienced in quality assurance and regulatory

requirements having led on this as part of her role within NHS England and close working with NHS Improvement and the Care Quality Commission.
Qualifications: RGN, BA (Hons)
Principal skills and expertise: Nursing leadership, quality assurance, patient safety, patient and staff experience, risk management, strategic planning, partnership working
Term of office: 1 September 2019 to 31 August 2022
Date of initial appointment: 1 September 2019
Note: Bev became the Chairman of the Quality Assurance Committee on 1 April 2021.

Shirley Richardson, Non-Executive Director, Senior Independent Director (from 23 June 2020) and Chairman of the West Lane Project Committee
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 2019 to 31 August 2022*
Date of initial appointment: 1 September 2016

Brent Kilmurray, Chief Executive
Brent has been an NHS executive director since 2005, working in senior roles across a range of acute, community health and mental health NHS organisations. He joined us after two years as Chief Executive of Bradford District Care NHS Foundation Trust, a combined community and mental health trust providing services in Bradford and the Yorkshire Dales, as well as children's services in Wakefield.
His Board level experience includes executive and divisional roles at City Hospitals Sunderland NHS Foundation Trust, joint Managing Director at NHS South of Tyne and Wear Community Health Services, Executive Director of Business Strategy and Performance for South Tyneside Foundation Trust and Chief Operating Officer and Deputy Chief Executive for TEWV.
Alongside his Trust role, Brent also sits on the NHS Providers Board of Trustees, which is a national membership body for all NHS organisations where he represents provider views in discussions alongside other Trust chief executives and chairs from across the country.
Qualifications: MA European Studies and BA (Hons) Government and Politics
Principal skills and expertise: Quality improvement and innovation, leadership development, partnership and system working, operational service management, performance management, tendering and business development, contract management, commercial matters
Appointed: June 2020

Ruth Hill, Chief Operating Officer
Ruth has over 25 years' experience in the NHS and local government, including her role as Director of Operations in York and Selby at the Trust. Ruth has also worked in commissioning, quality improvement, public health and service development in a number of roles across the North East.
Qualifications: Masters, Nye Bevan Programme
Principal skills and expertise: Service improvement, coaching, management and leadership skills, quality improvement, operational delivery
Appointed: August 2018

Dr Ahmad Khouja, Medical Director
Ahmad is a practicing consultant psychiatrist in forensic learning disabilities. He was appointed medical director in March 2018> before 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 and a Master Coach. He has led on recovery and harm minimisation for the Trust.
Qualifications: MRCPsych, MBChB, BA (Hons) DPhil (Oxon)
Principal skills and 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 and Deputy Chief Executive
Elizabeth joined the Trust in July 2015 as Director of Nursing and Governance. She has over 25 years' experience in the NHS having registered as an RMN in 1991. Before joining the Trust, Elizabeth held a variety of clinical, professional and managerial roles across inpatient and community mental health and learning disability settings. Elizabeth is responsible at Board level for the professional leadership of nursing, quality and safety. She is a certified leader for the Trust's Quality Improvement System and a Think On coach.
Qualifications: RMN, PGDip Professional practice
Principal skills and expertise: Mental Health nursing skills, project management, service improvement, managerial and leadership skills, patient and carer experience, patient safety, quality and assurance
Appointed: August 2015

Liz Romaniak, Director of Finance and Information
Liz joined the NHS over 30 years ago and gained extensive associate/deputy director and board-level experience from roles within commissioning and community and mental health provider organisations. Liz's previous role was Director of Finance, Contracting and Estates at Bradford District Care NHS Foundation Trust. Here she led work to develop the organisation's long term financial plan and successfully navigate all financial aspects of the Trust's Monitor FT application and due diligence processes. Liz also had responsibility for planning and performance and between 2017 and 2021 was Deputy Chief Executive. Liz has lobbied, including via NHS representative bodies, for parity of esteem (and resources) for mental health, including relating to capital developments. Liz is also a board member of the AuditOne NHS Audit consortium.
Qualifications: Qualified accountant, ACMA
Principal skills and expertise: NHS finances (strategy, costing, financial accounting and management, commissioner and provider), financial strategy, planning and performance management
Appointed: October 2020
*Note: *indicates that the individual has been reappointed as a Board member of the Foundation Trust.)*

Changes to the membership of the Board of Directors during 2020/21

- David Jennings, Non-Executive Director and Chairman of the Audit and Risk Committee, retired from the Board in August 2021.

- Colin Martin retired from his role as Chief Executive in June 2020.

- Patrick McGahon retired from his role as Director of Finance and Information in August 2020.

- Drew Kendall acted as the Director of Finance and Information from July to October 2020.

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 is available for inspection on our website www.tewv.nhs.uk.

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 with regard to NHS Improvement's well-led.

The well-led framework is based on eight domains covering:

- Clarity of vision and credibility of strategy.
- Leadership capacity and capability.
- Clarity of roles and systems of accountability.
- The appropriateness and accuracy of information.
- Engagement with service users and carers, the public, staff and external stakeholders.
- Learning, continuous improvement and innovation.
- Processes for managing risks, issues and performance.
- Culture.

In 2020/21 we commissioned the Good Governance Institute to undertake a review and to provide an independent perspective on our leadership and governance functions using the well-led framework.

Overall, the review identified several areas of good practice including: partnership working, positive engagement with our regulators, the process for developing Our Journey to Change (through Our Big Conversation), the focus on staff, our reputation for good quality services and service innovation, research and development through our partnership with the University of York and the provision of capacity for quality improvement.

However, the review also highlighted the need for a substantial development agenda to ensure we can make the progress we aspire to. It was recognised we were already working to address many of the issues and challenges arising from the review.
An implementation plan has been developed in response to the findings and recommendations which is overseen by the Board.

There are no material inconsistencies between the findings of the well-led review and the information provided in the Annual Governance Statement and the performance report.
The NHSI Well-led Framework is available at: www.england.nhs.uk/well-led-framework/

Arrangements for monitoring improvements in the quality of healthcare and progress towards meeting any national and local targets, incorporating Care Quality Commission assessments and reviews and the NHS foundation trust's response to any recommendations made

The quality strategy describes the arrangements for the governance of quality across the organisation. Those arrangements include the clinical governance systems for services together with the clinical assurance systems that detail how the corporate governance teams and Trust-wide 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 and progress against the 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 and Improvement Group, a sub-group of the Senior Leadership Group.

Each clinical directorate, in our operational localities, 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 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, Trust wide quality assurance groups, Quality Assurance Committee and commissioners are in place. Over the past year we have focused more on learning.

During COVID-19 we revised business continuity arrangements adopting the strategic command model to ensure the continuation of service delivery. Quality and safety of services was a focus throughout this structure to ensure oversight and the provision of assurance on critical areas.

The corporate quality governance teams manage the operational systems to provide quality performance information for the service and Trust-wide quality assurance groups and committee. These include, for example, the patient safety team, the compliance team, complaints and PALS teams, clinical audit and effectiveness team, quality data team and patient and carer experience team. The compliance team implements a programme of peer and service user review across services to monitor the quality of service delivery against the regulatory fundamental standards. All corporate teams also monitor quality improvement action plans developed from areas for improvement and risks identified and report into the Trust-wide assurance groups and the Quality Assurance Committee. Key information on the CQC activity and ratings for the Trust along with information on complaints and incidents can be found within the Trust's Quality Account (published on the Trust's website). The Quality Compliance Group further supports quality assurance and improvement in line with CQC requirements. It's chaired by the Director of Quality Governance and attendance includes the Heads of Service and Modern Matrons from across the organisation. The group provides information and shares learning from quality improvement activities, external assurance mechanisms including CQC inspections.

The Trust wide quality assurance groups track the performance against the quality strategy scorecard and other key performance indicators relating 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 and report to the Quality Assurance Committee.

The Quality Assurance Committee provides an assurance and exception report to the Board of Directors on a monthly basis.

The Trust also 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 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 Account.

Registration with the Care Quality Commission (CQC) and periodical/special reviews

In January 2021, the CQC carried out an unannounced, focussed inspection of five of our acute wards of adults of working age and psychiatric intensive care units (PICU). Inspectors found that some risk assessment and management processes were not fully effective to support the delivery of safe patient care. A number of urgent and immediate actions were taken across the core service and a quality improvement event was held to address standards around risk assessment and organisational learning across all services.

In March 2021, due to enforcement action taken in the safe and well-led dimensions, the CQC inspection report rated the acute wards for adults of working age and PICUs as inadequate in these areas. The Trust was required to complete an improvement plan addressing all the requirements in the inspection report and the Section 29A Warning Notice with actions to be completed by 3 May 2021.

As well as clearly evidencing delivery of the required actions, the Trust acknowledges that a wider programme of change and improvement is required beyond this date. It's recognised that increasing multidisciplinary involvement and oversight, improving staffing establishments, building in appropriate training, expertise, sustainable support, clinical supervision and leadership to our clinical teams is critical to prioritising a culture of patient safety and continuous quality improvement. In addition, work's underway to enhance and embed organisational learning from a range of internal and external sources. This includes reviewing, strengthening and developing mechanisms for capturing and communicating learning and importantly gaining assurance of the impact of our actions to improve care for services users and their families.

Since the inspection, we have invested £5.4 million recurrently in ward staffing, with a focus on inpatient services, seven-day capacity and quality governance. An improved assurance schedule that includes a review of care documentation has been put in place to provide assurance that patients risks are assessed and that they have a safety plan in line with their needs.

A Quality Improvement Board (QIB) has been put in place, chaired by the Chief Executive and with executive team attendance. The QIB has responsibility for ward/team to board reporting on implementation and oversees quality assurance standards including regular audits and direct observations on wards. It also provides assurance to the Trust Board that actions being taken to address patient safety are improving. Community assurance processes have included the development of a dashboard to support community caseload reporting and improved clinical supervision.

Improvement Plan

A Regional Quality Board has been set up where TEWV is reporting on progress to other partners such as NHSE and ICSs as well as the CQC. We are also accessing expert support from outside the Trust to support with rapid improvement and embedding actions.

In addition to the attainment of all CQC recommendations and conditions related to the Section 29a warning notice issued by CQC in March 2021, an umbrella improvement plan has been developed with overarching work-streams which include:

- Implementing Our journey to Change.
- Board development.
- Strengthening ward/team to Board governance flow and focus on the Board Assurance Framework/Risk Registers.
- Embedding organisational learning including reviewing the involvement of families and carers in Serious Incident reviews.
- Simplification of management and governance structures to support the line of sight, communication and flow of information.
- Development of new Board integrated assurance performance report and strengthening capacity and capability in corporate and locality/specialist governance roles.
- Training and professional development for clinical staff.
- Sustainability of improvements including leadership development and strengthening lines of accountability.
- Technological improvements including the development of a new electronic patient record system.

We are confident we will continue to improve services and will work with staff, service users, carers, volunteers, governors, commissioners and partners to address the areas where standards were not as expected.

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 national ones within the NHS Oversight Framework (NHSOF). This section will focus on national targets within the NHSOF, which are formally reported to the Board on a quarterly basis and by exception to the Board on a monthly basis.

There are six operational performance measures within the NHS Oversight Framework and the Trust has consistently achieved the following four measures:

- People with a first episode of psychosis begin treatment with a NICE recommended package of care within 2 weeks of referral.
- IAPT/Talking Therapies - waiting time to begin treatment within 6 weeks.
- IAPT/Talking Therapies - waiting time to begin treatment within 18 weeks
- Data Quality Maturity Index.

In relation to the remaining two measures:

- At Trust level IAPT recovery rate has performed better than standard for 2020/21 although there has been some variance throughout the year and across the CCG areas.

This has been largely impacted by the social restrictions that were implemented in response to the COVID-19 pandemic. Actions are in place to provide assurance around this measure and improvements seen during quarter 4 indicate these are having the desired impact.

- Whilst out of area bed days have been better than standard throughout the year, the standard we agreed with NHSE has not been achieved. There have been particular challenges in the Durham and Darlington locality and actions have been identified to improve performance in this area.

In addition to these, there are 2 quality metrics and 1 workforce metric monitored internally for assurance:

- Admissions to adult facilities of patients who are under 16 years old - One Tees Valley CCG patient under the age of 16 was admitted to an adult ward during 2020/21. The young person spent one night in a Trust Adult Mental Health (AMH) unit but in a specific area separated from the main adult ward and did not come into contact with any of the Adult service users on the main part of the ward.

- Proportion of discharges from hospital followed up within 7 days - With the exception of one month, the proportion of discharges from hospital followed up within 7 days has achieved the standard. However, this measure has been replaced as a National Access Standard by the proportion of discharges followed up within 72 hours; we have consistently achieved standard throughout the year.

- Staff sickness - Whilst no national standard is applied to this measure we have reported above the Trust standard for the year. We have undertaken detailed analysis in three localities to understand the position better and as a result actions are in place to improve performance and support staff wellbeing.

Progress towards targets agreed with local commissioners

We provide regular performance information to commissioners as part of the mental health contract and covering activity and key measures of quality. Our commitment to contract performance management is evidenced through routine contract performance and quality meetings with commissioners which are regularly attended and have full participation of senior staff. 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 2020/21 mental health contract which were:

- Number of episodes of mixed sex accommodation – sleeping.
- Percentage of adults (over 18) receiving 72 hr follow up.
- Duty of candour (failure to notify).
- People with a first episode of psychosis begin treatment with a NICE recommended package of care within two weeks of referral.
- The proportion of people that wait six weeks or less from referral to entering a course of IAPT treatment against the number people who finish a course of treatment in the reporting period.
- The proportion of people that wait 18 weeks or less from referral to entering a

course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

The majority of standards were achieved for the 2020/21 financial year for the four core CCGs with one exception:

- Number of episodes of mixed sex accommodation was not achieved for Vale of York CCG in February 2021. The incident occurred when the ward implemented its COVID-19 cohorting plan which required three patients to be nursed within a COVID pod over two nights. Each patient was isolated in a bedroom with ensuite facilities but there were no communal areas available therefore this was reported as a breach of EMSA standards.

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 who works with the relevant operational staff member, service user and/or carer to resolve the issue that has been raised.

Emergency planning and business continuity

In response to the COVID-19 pandemic, the Trust invoked its emergency and service continuity plans to maintain delivery of critical services. Command and control structures were put in place to provide executive oversight of all arrangements. New technologies were used to facilitate remote appointments and remote working to reduce transmission of the virus.

National guidance was followed as well as additional methods to minimise transmission including identifying areas to separate and care for COVID-19 positive patients, risk assessments for individual staff and workplaces, providing a vaccination programme for staff and patients and lateral flow testing to identify asymptomatic individuals.

We reviewed and completed the assurance process for NHS England's Core Standards for Emergency Preparedness, Resilience and Response.

Service improvements following staff or patient surveys/comments

We gain important feedback from patient and carer surveys, which enable us to focus improvements on specific wards and services for instance:

- Adult mental health community services: Patients stated they wanted the service to be pro-active not reactive. For example, that they were given ways of coping with anxiety/depression without trying to find out the causes and triggers. The team altered the care pathways so the early focus on meetings is getting to know you – talking through how difficulties began, how they affect the person now and what their goals for recovery are. They then discuss the options with the individual and agree how best their goals can be met. The team hopes this focus will make choices and treatment feel more informed and shared.

- Children and young people's community services: A number of young people have said they did not feel the team helped them feel in control of their lives, helped them do the right things that mean something to them or helped them feel good about themselves. The team re-established the participation group for the service to look at how to improve the service with the support of young people. The agenda going

forward will be to look at how they can ensure the young person feels at the centre of their care.

- Learning disability inpatient ward: 25% of patients stated they weren't aware of the side effects of their medication. As an immediate response a new easy read document has been created. When a patient is admitted the leaflets are read daily to aid retention and then once per month. This is added to the patient care list and the visual patient information white board in the clinic to support staff to complete this task. Patients are also given the leaflets relevant to the medication they take which they can keep in their bedrooms and refer to when needed. Staff are in the process of developing a new innovative way to make the information more accessible and enjoyable for example a flash card game.

- Forensic secure inpatient ward: Patients reported they didn't feel safe on the ward. The ward encouraged people to talk to their named nurse/keyworkers about concerns, all patients are given the opportunity to talk to an advocate, support is made available to provide time for patients to reflect and offer de-briefs following difficult situations and all patients are able to request a patient alarm.

- Eating disorders inpatient ward: Patients stated there was unfamiliar male staff on night shifts making them feel uncomfortable and vulnerable, they added that they needed more staff around. It's recognised more regular and familiar faces are essential in such a specialist unit and where temporary staffing is needed this is explored using regular bank first. The ward encouraged patients to develop a Do's and Don'ts poster to support non-regular staff with what helps and doesn't help in individual circumstances. The ward does ensure there is a good mix of staff (male/female/substantive/temporary) to ensure there is familiar staff on all shifts. This is an ongoing process and as a team they continue to receive feedback on how this process is progressing.

Involving local people

In addition to Our Big Conversation, through which service users and carers were encouraged to share their thoughts and ideas on what they think about the Trust and its future direction, we continued to deliver a programme of service user and carer Involvement.

This has been managed using the virtual platform, MS Teams.

We supported people to attend virtual meetings with a user guide and briefing session. Involvement of service users and carers over the last year has included:

- Carer working group – A group of carers, representatives from carer organisations and staff meet regularly to take forward outcomes of the 2019 carer conference. They have also developed a Carers' Charter which was approved by the Board.
- A new group of carers, representatives from carer organisations and staff has been set up to look at how carers can be supported, involved and receive information.
- Service user and carers are part of our Trustwide Quality Assurance Groups. The groups have helped many of the members who had felt particularly isolated during COVID-19.
- Eating Disorders Collaborative for North East and North Cumbria.
- Crisis working group – this group has had a direct impact on the service provision within crisis services.

- Recording procedure working group – a challenge for both staff and involvement members to work together on a sensitive subject. This has been a good example of true co-creation and resulted in a new procedure being written by the group.
- Service users and carers along with governors taking part in focus groups.
- Taking part in the selection process for our new chief executive.
- Recruitment – this area of involvement has increased a great deal over the last year Training and support has been offered to service users and carers.
- A locality based newsletter to help people feel connected and informed. This is co-produced and edited by a carer.

We have 297 service users and carers registered to take part in a wide range of involvement activities. During the past year we received 307 individual requests for involvement and issued over £39,000 involvement payments.

Recent comments from service users and carers about their involvement:

"It has been the difference between me seeing my GP for more mental health support. Involvement has kept me focussed and enabled me to maintain my mental wellbeing."
"Involvement work has allowed me to connect with people when I had been self -isolating for some time. It gave me hope and motivated me."

"I feel valued and useful knowing that my lived experience is helping to make a difference."

Service user and carer involvement groups continue to have a significant impact in our business planning priorities.

Compliance with accounting guidance

The Trust prepared the financial statements in accordance with the NHS Group Accounting Manual (2020-21) 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.

Statement as to disclosure to auditors

Each of the directors, holding office on 31 March 2021, 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 to make themselves aware of any such information and to establish that the auditor is aware of that information.

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 2020/21 was as follows:

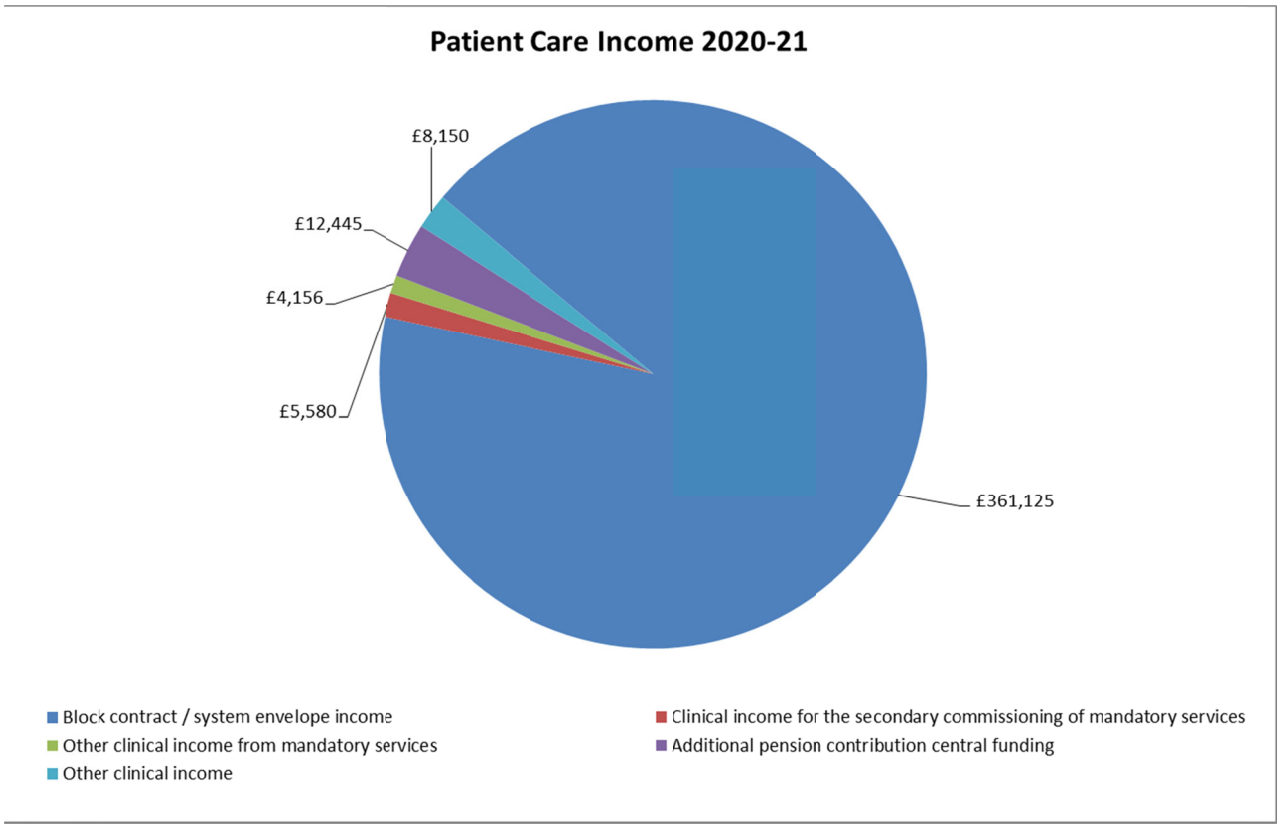
	2020-21 Invoices	
	Number	**£000s**
NHS creditors		
Total bills paid	1,038	21,673
Total bills paid within target	964	21,163
Percentage of bills paid within target	92.9%	97.6%
Non-NHS creditors		
Total bills paid	63,065	121,398
Total bills paid within target	59,668	115,995
Percentage of bills paid within target	94.6%	95.5%

It is Trust policy to pay all creditors as they fall due, unless extenuating circumstances are apparent. For example, a dispute in the amount being charged, or the service/goods provided.

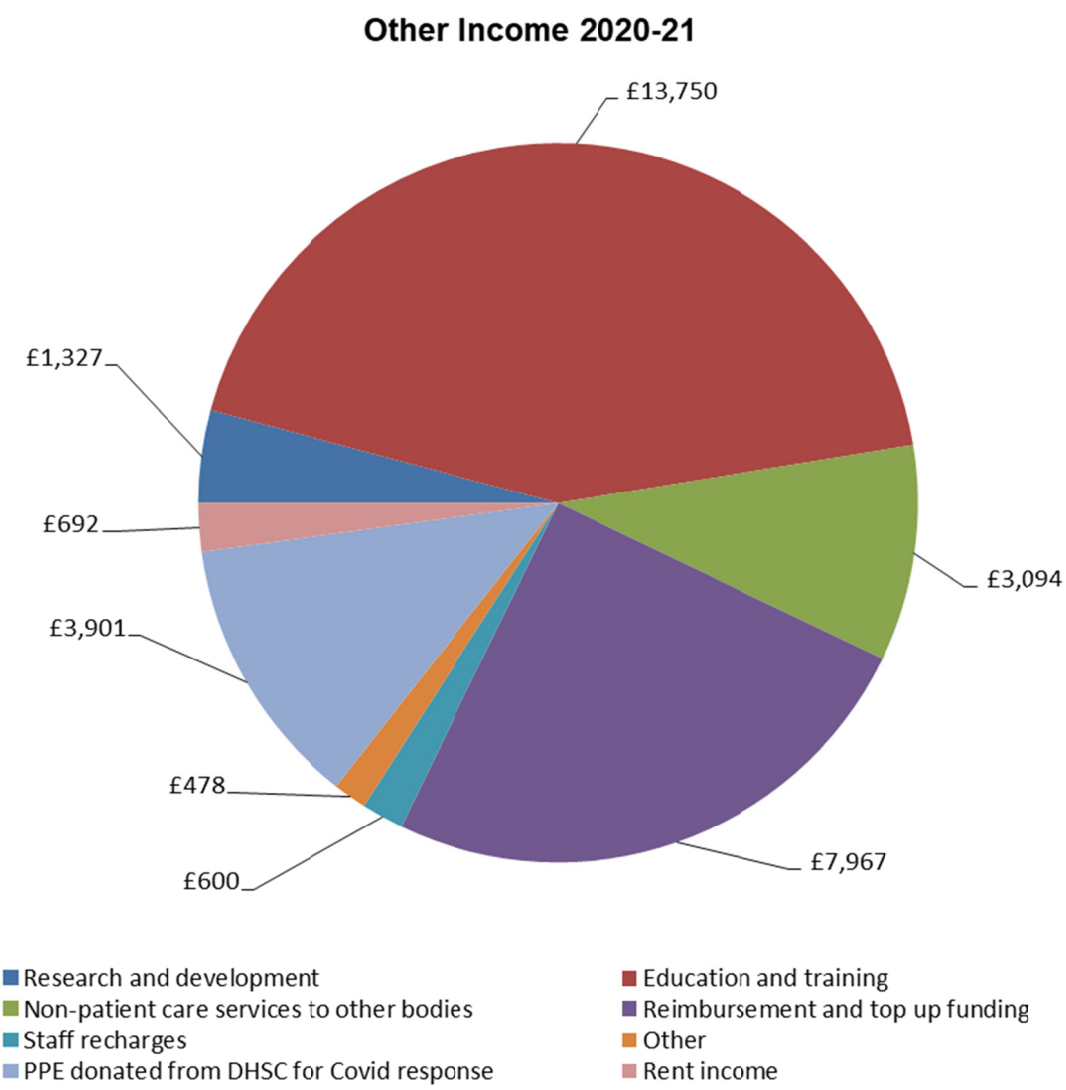
The total potential liability to pay interest on invoices paid after their due date during 2020/21 would have been £1,788,261, a decrease on 2019/20 amounts (£2,337,149). There have been minimal claims under this legislation, therefore the liability is only included within the accounts when a claim is received.

Income generation

During 2020/21, income generated was £423m from a range of activities, with 92.4% being from direct patient care. Patient care income came from the following areas:



There was a further £31.8m income received from education and training, reimbursement (top up) funding, donated PPE and other non-patient care services.



As the two charts above illustrate, Trust income from the provision of goods and services for the purposes of the health service in the UK exceeded income from the provision of goods and services for any other purposes. This income had no negative impact on the provision of health services.

The Remuneration Report

Annual Statement on remuneration

Information on the Board's Nomination and Remuneration Committee is provided in the section on Governance in the Accountability Report.

The Committee agreed a Very Senior Manager (VSM) Pay Framework. Details of this policy are set out below.

This Framework does not cover the remuneration of:

- the Chief Executive
- or Medical Director

During 2020/21 the Committee made a basic pay cost of living increase of 1.03% to the chief executive, the medical director's allowance and to those senior managers covered by the VSM Pay Framework. This was in line with Government recommendations.

Details of the salaries and allowances and pension benefits of senior managers in 2020/21 and payments made to past senior managers are provided in the tables in this section.

No other changes were made to the VSM or senior manager pay during this period.

Miriam Harte
Chairman of the Board's Nomination and Remuneration Committee

Senior managers' remuneration policy

The key features of the VSM Pay Framework are set out in the table below. No changes were made to the components of the VSM Pay Framework during 2020/21.

Basic pay	The VSM 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 in 2014, updated by any subsequent cost of living increases, and are equivalent to 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 £1,669,775. 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 an RRP during 2020/21.
Allowances	A director's 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. The Nomination and Remuneration Committee of the Board of Directors agreed to the incorporation of an 'earn back' clause whereby up to 10% of salary is put at risk pending an annual review of performance against objectives set.
Remuneration above £150,000	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	Not Applicable

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.

- Diversity and inclusion: The Nomination and Remuneration Committee's approach to diversity and inclusion is based on the Trust's Human Rights, Equality and Diversity Policy. This Policy, which is available on the Trust's website, lays down expected standards in relation to equality, diversity and human rights in employment and service delivery. These standards say that we:

- Respect and protect the human rights of all service users, staff and anyone else who has a relationship to the Trust.
- Take breaches of policy very seriously, particularly those that when breached have a harmful effect on other people. Victimisation, harassment, discrimination (or an attempt to do so) and bullying will not be tolerated and will, where substantiated lead to disciplinary action.
- Staff who identify with protected groups have the right to be treated fairly and with dignity and respect and without the fear of unlawful discrimination, harassment, victimisation or bullying.
- Commit to the ongoing development of staff awareness and knowledge of equality, diversity and human rights. Staff development begins on employment and continues throughout an individual's career until they leave the Trust.
- Commit to monitoring, evaluating and reporting on issues of equality, diversity and human rights in employment and service provision.
- Work towards best practice standards of equality, diversity and human rights and not merely comply with legislation.
- Promote equality, foster good relations and take an anti-discriminatory approach in all areas of employment and service delivery.
- Ensure barriers to accessing services and employment are identified and removed so that no person is treated less favourably because they identify with a protected group/s.
- Recognise the importance of this policy in the employment relationship it has with its staff and in provision of services for service users, and will reflect this commitment in all Trust policies, procedures and practices, etc.

The policy extends outside the workplace and Trust staff should be aware that workplace behaviour includes time when they are not physically at work but are participating in activities where work is a factor, for example, team nights out, shopping trips with colleagues etc. This is because abusive, discriminatory and/or unethical behaviour outside of work could still affect the relationship between the Trust and its employees, particularly if it is deemed to be so serious that it would warrant disciplinary action or allegations of gross misconduct, as would be the case if the individual or group concerned were at work.

The policy supports the delivery of the Trust's Equality Strategy. Progress on the delivery of the Equality Objectives, included in the Strategy, is monitored by the Equality, Diversity and Human Rights Steering Group.

Further information on Equality and Diversity is provided in the Accountability Report, while demographic information on the Trust's senior managers is provided in the Staff Report.

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 VSM Pay Framework since 2014. This includes 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 and Risk 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.

Senior managers' remuneration tables (subject to audit)

Name and Title	2020-21						2019-20					
	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 Colin Martin, Chief Executive (left 29 June 20)	40 - 45	-	2,400	-	45 - 50	0	170 - 175	-	10,300	37.5 - 40.0	220 - 225	1,100
Mr Brent Kilmurray, Chief Executive (Started 29 June 20)	135 - 140	-	5,600	-	140 - 145	0	-	-	-	-	-	-
Mrs Ruth Hill, Chief Operating Officer	130 - 135	-	7,700	42.5 - 45.0	180 - 185	200	125 - 130	-	7,100	60.0 - 62.5	190 - 195	600
Mr Patrick McGahon, Director of Finance and Information (left 05 August 20)*****	50 - 55	-5 - 0	0	-	45 - 50	0	135 - 140	5 - 10	-	7.5 - 10.0	150 - 155	1,200
Mr Drew Kendall, Acting Director of Finance and Information (Started 18 July 20, left 18 October 20)	20 - 25	-	1,890	-	25 - 30	-	-	-	-	-	-	-
Mrs Liz Romaniak, Director of Finance and Information (Started 19 October 20)	60 - 65	-	0	20.0 - 22.5	80 - 85	0	-	-	-	-	-	-
Mrs Elizabeth Moody, Director of Nursing and Governance and Deputy Chief Executive	115 - 120	0 - 5	14,600	47.5 - 50.0	180 - 185	0	115 - 120	-	14,200	-	125 - 130	1,300
Dr Ahmad Khouja**, Medical Director	170 - 175	35 - 40	0	32.5 - 35.0	240 - 245	1,000	165 - 170	35 - 40	-	57.5 - 60.0	260 - 265	4,300
Mr David Levy, Director of Human Resources and Organisational Development (left 25	100 - 105	-	0	-	100 - 105	0	110 - 115	-	-	-	110 - 115	-

February 21)												
Mrs Sarah Dexter-Smith, Director of Therapies *** (left 14 February 2021), Director of People and Culture (Started 15 February 2021)	105 - 110	0 - 5	0	75.0 - 77.5	180 - 185	0	90 - 95	0 - 5	-	25.0 - 27.5	120 - 125	3,800
Mrs Sharon Pickering, Director of Planning, Commissioning, Performance and Communications	110 - 115	-	10,200	25.0 - 27.5	145 - 150	400	100 - 105	-	600	7.5 - 10.0	110 - 115	1,300
Mrs Jennifer Illingworth, Director of Quality Governance (left 5 January 2020), Director of Operations – Director of Operations - County Durham and Darlington (started 6 January 2020)	110 - 115	-	8,400	77.5 - 80.0	195 - 200	200	100 - 105	-	8,100	10.0 - 12.5	120 - 125	1,400
Mr Levi Buckley, Director of Operations – Director of Operations - County Durham and Darlington (left 3 November 2019)	-	-	-	-	-	-	60 - 65	-	-	10.0 - 12.5	70 - 75	1,500
Mrs Donna Sweet, Director of Operations - County Durham and Darlington (started 4 November 2019, left 4 January 2020)	-	-	-	-	-	-	70 - 75	0 - 5	2,200	22.5 - 25.0	100 - 105	600
Mrs Naomi Lonergan, Director of Operations - North Yorkshire and York	110 - 115	-	5,500	40.0 - 42.5	155 - 160	0	100 - 105	-	5,200	62.5 - 65.0	170 - 175	700
Mr Dominic Gardner, Director of Operations – Teesside	105 - 110	-	0	27.5 - 30.0	135 - 140	600	105 - 110	-	0	30.0 - 32.5	135 - 140	2,700
Mrs. Lisa Taylor, Director of Operations - Forensic Services	100 - 105	-	3,800	40.0 - 42.5	145 - 150	100	95 - 100	-	3,600	105.0 - 107.5	205 - 210	500
Mrs Avril Lowery, Director of Quality Governance (started 01	100 - 105	-	0	107.5 - 110.0	210 - 215	700	15 - 20	-	-	22.5 - 25.0	35 - 40	-

February 2020)												
Mr Phil Bellas, Trust Secretary	85 - 90	-	0	22.5 - 25.0	110 - 115	0	85 - 90	-	-	15.0 - 17.5	105 - 110	-
Dr Ruth Briel, Senior Clinical Director, Kaizen Promotion Office (left 30 September 2019)	-	-	-	-	-	-	40 - 45	5 - 10	-	-	50 - 55	2,500
Mrs Miriam Harte, Chairman	50 - 55	-	0	-	50 - 55	2,600	50 - 55	-	-	-	50 - 55	3,000
Mr Richard Simpson, Non-Executive Director **** (left 31 August 2019)	-	-	-	-	-	-	5 - 10	0 - 5	-	-	5 - 10	1,900
Mr Marcus Hawthorn, Non-Executive Director (Senior Independent Director) (left 31 March 2020)	-	-	-	-	-	-	15 - 20	-	-	-	15 - 20	-
Mr David Jennings, Non-Executive Director (Chairman of the Audit and Risk Committee) (left 31 August 2020)	5 - 10	-	0	-	5 - 10	1,100	15 - 20	-	-	-	15 - 20	1,000
Dr Hugh Griffiths, Non-Executive Director	10 - 15	-	0	-	10 - 15	0	10 - 15	-	-	-	10 - 15	1,900
Mrs Shirley Richardson, Non-Executive Director (Senior Independent Auditor - role started 23 June 2020)	15 - 20	-	0	-	15 - 20	200	10 - 15	-	-	-	10 - 15	2,200
Mr Paul Murphy, Non-Executive Director	10 - 15	-	0	-	10 - 15	600	10 - 15	-	-	-	10 - 15	1,100
Prof. Pali Hungin, Non-Executive Director (Started 1 September 2019)	10 - 15	-	0	-	10 - 15	0	5 - 10	-	-	-	5 - 10	300
Mrs Beverley Reilly, Non-Executive Director (Started 1 September 2019)	10 - 15	-	0	-	10 - 15	0	5 - 10	-	-	-	5 - 10	600
Mr John Maddison, Non-Executive Director (Started as Associate NED 1 January 2020, became full NED 1 July 20) (Chairman of the Audit and Risk	15 - 20	-	0	-	15 - 20	0	0 - 5	-	-	-	0 - 5	-

Committee - role started 01 September 2020)												

Remuneration ranged from	5 - 10
Remuneration ranged to	240 - 245
Band of highest paid directors total remuneration (£000) #	170 - 175
Median of total remuneration	30,615
Ratio (Director to Median)	5.6

Remuneration ranged from	5-10
Remuneration ranged to	260-265
Band of highest paid directors total remuneration (£000) #	170 - 175
Median of total remuneration	27,416
Ratio (Director to Median)	6.3

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 clinical excellence award and additional clinical programmed activity worked during the reported period.
*** Other remuneration is on call arrears
**** Other remuneration is related to meeting attendance
***** Other remuneration is repayment of a recruitment and retention award
# Pension related benefits, other remuneration and benefit in kind have been excluded from this calculation, as they are not known for all staff.

Pension related benefits

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Expenses of Governors

At 31 March 2021 the Trust had 47 Governors (2019-20, 45), with 16 receiving reimbursement of expenses (2019-20, 23). The total amount reimbursed as expenses was £348, (£4,718 in 2019-20)

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.

Brent Kilmurray
Chief Executive
24th June 2021

Senior Manager's Pension Benefits Table

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 2021	Lump sum at retirement age related to accrued pension at 31 March 2021	Cash Equivalent Transfer Value at 31 March 2021	Cash Equivalent Transfer Value at 31 March 2020	Real Increase in Cash Equivalent Transfer Value for time in post less employee pension contributions
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000
Mrs Ruth Hill, Director of Operations - Chief Operating Officer	2.5 - 5.0	0.0 - 2.5	45 - 50	95 - 100	826	768	40
Mrs Liz Romaniak, Director of Finance and Information (Started 19 October 20)	0.0 - 2.5	0.0 - 2.5	50 - 55	115 - 120	943	880	19
Mr Drew Kendall, Acting Director of Finance and Information (Started 18 July 20, left 18 October 20)	0.0 - 2.5	-2.5 - 0.0	30 - 35	70 - 75	596	593	-10
Mrs Elizabeth Moody, Director of Nursing and Governance and Deputy Chief Executive	2.5 - 5.0	-2.5 - 0.0	60 - 65	170 - 175	1,251	1,187	48
Dr Ahmad Khouja, Medical Director	2.5 - 5.0	-2.5 - 0.0	60 - 65	125 - 130	1,171	1,109	37
Mrs Sarah Dexter-Smith, Director of People and Culture (Started 15 February 2021)	2.5 - 5.0	5.0 - 7.5	25 - 30	55 - 60	486	413	58
Mrs Sharon Pickering, Director of Planning, Performance and Communications	0.0 - 2.5	-2.5 - 0.0	45 - 50	100 - 105	897	852	31
Mrs Jennifer Illingworth, Director of Operations - County Durham and Darlington	2.5 - 5.0	5.0 - 7.5	40 - 45	85 - 90	751	663	73
Mrs Naomi Lonergan, Director of Operations - North Yorkshire and York	2.5 - 5.0	0.0 - 2.5	15 - 20	15 - 20	224	185	23
Mr Dominic Gardner, Director of Operations – Teesside	0.0 - 2.5	0.0 - 2.5	25 - 30	55 - 60	500	462	23
Mrs. Lisa Taylor, Director of Operations - Forensic Services	2.5 - 5.0	0.0 - 2.5	30 - 35	70 - 75	585	536	35
Mrs Avril Lowery, Director of Quality Governance (started 01 February 2020)	5.0 - 7.5	15.0 - 17.5	45 - 50	145 - 150	1,164	1,017	134
Mr Phil Bellas, Trust Secretary	0.0 - 2.5	-2.5 - 0.0	15 - 20	25 - 30	338	308	18

Mr Brent Kilmurray, Chief Executive, is not in the NHS pension scheme, therefore there are no entries in the table above.

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 increases in lump sum for five senior managers is due to the inflation factor used (1.7%) 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.

The above table is accurate as at 31 March 2021. Actions (yet to be announced) following the McCloud judgement may impact on some or all of the figures shown.

Brent Kilmurray
Chief Executive
24th June 2021

Staff report

Staff costs (subject to audit)

	Permanent	Other	2020/21 Total	2019/20 Total
	£000	£000	£000	£000
Salaries and wages	231,483	19,863	**251,346**	224,270
Social security costs	20,423	1,951	**22,374**	20,093
Apprenticeship levy	1,065	116	**1,181**	1,068
Employer's contributions to NHS pension scheme	36,998	4,026	**41,024**	37,463
Pension cost - other	78	9	**87**	77
Temporary staff	-	8,421	**8,421**	8,748
Total gross staff costs	**290,047**	**34,386**	**324,433**	**291,719**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**290,047**	**34,386**	**324,433**	**291,719**
Of which				
Costs capitalised as part of assets	302	-	**302**	244

Average number of employees (WTE basis)

	Permanent	Other	2020/21 Total	2019/20 Total
	Number	Number	Number	Number
Medical and dental	204	108	**312**	319
Administration and estates	1,185	100	**1,285**	1,203
Healthcare assistants and other support staff	331	20	**351**	319
Nursing, midwifery and health visiting staff	3,404	779	**4,183**	3,942
Scientific, therapeutic and technical staff	982	55	**1,037**	812
Healthcare science staff	6	-	**6**	3
Social care staff	15	7	**22**	32
Total average numbers	**6,127**	**1,069**	**7,196**	**6,629**
Of which:				
Number of employees (WTE) engaged on capital projects	5	-	**5**	4

Demographic information

Our workforce is primarily white, broadly in line with our local population and at the end of March 2021 there were 5919 female members of staff (79%) and 1551 male members of staff (21%).

The number of male and female directors and senior managers (members of the Board of Directors and Senior Leadership Group) is five male and 13 female.

Sickness absence figures (January to December 2020)

Sickness absence figures can be accessed via NHS Digital using the following link: **https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates**

Staff policies and actions taken

We have a range of policies and procedures which support our commitment to being a good employer and providing equal opportunities to present and potential employees:

- Our recruitment and selection procedure is followed for each recruitment episode. The procedure has been equality impact assessed ensuring application of the procedure does not impact negatively on people with disabilities. We are signed up to the disability confident scheme and guarantee an interview to all applicants with a disability who meet the minimum essential criteria for a job vacancy. We will make reasonable adjustments to the recruitment process if this is required and we have signed up to the Business Disability Forum to help us with this.
- We provide a number of health and wellbeing support mechanisms to help staff throughout their employment. Specific advice can be gained from occupational health as to recommendations to support a staff member whilst at work. Reasonable adjustments will be made for disabled staff and we have implemented a reasonable adjustment pack to support this process. If a staff member can no longer work in the role they are employed, we will explore redeployment into another suitable alternative role.
- We are fully committed to ensuring all staff with disabilities and long term health conditions have a positive experience and have equitable access to training, career development and promotion. To facilitate this, our workplace adjustments procedure provides for individual workplace adjustment plans detailing the adjustments that staff would need to undertake their job role but also to access training and career development and to achieve promotion.
- We are aware non-disabled staff are 1.29 times more likely to be appointed from shortlisting and that 86% of disabled staff believe the Trust provides equal opportunities for career progression or promotion. Work is ongoing as part of the Trust's Workforce Disability Equality Scheme (WDES) to address these issues.
- We regularly share information with staff on matters of concern to them as employees through our weekly staff briefing and on our staff intranet. The all staff briefings were increased during COVID-19 due to the increase in information that we needed to share.
- Local consultative committees (LCC) take place on a monthly basis within each locality and a joint consultative committee (JCC) takes place bi-monthly (we met more regularly during COVID-19). Items affecting the workforce are discussed at both LCC and JCC at which staff side representation are in attendance.

For any formal changes affecting the workforce we follow the organisational change procedure and consultation consisting of group meetings and 1 to 1 meetings with staff (along with staff side representation). Staff have an opportunity to provide comments in relation to proposals prior to implementation.

This year we have also taken on board a lot of feedback from Our Big Conversation. We have also instigated monthly coffee breaks for staff to talk with the Director for People and Culture and other leads about anything relating to employment in the Trust.

Occupational health

The 2020/21 staff flu campaign was the most successful to date with 71.5% of frontline healthcare workers receiving a flu vaccination. Uptake rates were nearly 3% higher than the previous year.

At the end of April 2021 86% of staff had received a first COVID-19 vaccination, with 75% having had a second dose vaccination.

We worked closely with our occupational health provider to rapidly respond to issues arising from the COVID-19 pandemic.

People Asset Management (PAM) provides a comprehensive occupational health service to the Trust. The service provision includes a range of services including pre-employment screening, vaccination and immunisation, specialist occupational health employment advice, employee assistance and MSK specialist service. We continue to work collaboratively to maintain and improve staff health and wellbeing.

In addition to occupational health services we offer a wide range of health and wellbeing support services for staff, such as an employee support, employee psychology service and staff mindfulness as well as health improvement information through our staff intranet, weekly briefings and monthly health and wellbeing newsletter.

Health, safety and security

The health, safety and security team continues to ensure staff receive advice, support and training, during the last year this was particularly linked to the COVID-19 pandemic.

As a consequence of this, policies and procedures have been reviewed, updated and approved and are available on the Trust website.

We developed the COVID-19 workplace risk assessments to be completed across the Trust and linked with this we have provided updated guidance in line with Government guidance and Health and Safety Executive (HSE).

We used Microsoft ‘Teams’ to deliver roadshows and question and answer sessions which were available for all staff in relation to risk assessments.

The team have continued to monitor incidents and reported RIDDORs including setting up an agile meeting to discuss COVID incidents. The Trust-wide Health, Safety, Security and Fire Group meets on a quarterly basis.

With the Trust now working in a different way, the health, safety and security team have provided guidance and information for staff working from home, including display screen assessments, using MS Teams and over the phone.

Countering fraud and corruption

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.

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 our premises.

The Trust’s Local Counter Fraud Specialist (LCFS) reports to the Audit and Risk Committee quarterly, and through an annual report, and performs a programme of work designed to provide assurance to the Board about fraud and corruption. The LCFS provides regular fraud awareness sessions to staff, investigates concerns reported by staff and liaises with the

police. If any issues are substantiated, we take appropriate criminal, civil or disciplinary measures.

Equality Strategy and Objectives 2020-2023

Further information about the Equality and Diversity and Human Right (EDHR) strategy can be found in the Performance Report.

Information from the strategy relating to staff is below:

Objective 1
Ensure that where it is agreed, staff that require a workplace adjustment have these in place.

Progress
Good progress is being made on the actions in the EDHR strategy and the WDES relating to workplace adjustments. The revised workplace adjustments policy will be completed in Q1 21/22. Some limited central resource to support workplace adjustments is now available from the employee support service. Work is also taking place to better support staff who have neurodivergent needs.

Objective 2

To ensure we support and respond to staff who experience verbal aggression and that we take actions that reduce the number of incidents of verbal aggression towards staff.

Progress

A publicity campaign to reduce verbal aggression against staff will be launched in the summer. Processes are in place to support staff who experience verbal aggression and training is available to support staff to address this issue.

Key Equality Data

The Trust publishes the following equality data annually. These reports were all published in 2020.

Publication of information on staff is available on the TEWV website at:
www.tewv.nhs.uk/about-us/how-we-do-it/equality-and-diversity/

Workforce Race Equality Standard and Action Plan:www.tewv.nhs.uk/content/uploads/2021/01/WORKFORCE-RACE-EQUALITY-STANDARD-2020-revised-dates.pdf

Workforce Disability Equality Standard and Action Plan:www.tewv.nhs.uk/content/uploads/2021/03/WORKFORCE-DISABILITY-EQUALITY-STANDARD-2020-revised-dates.pdf

Equality Delivery System 2: www.tewv.nhs.uk/about-us/how-we-do-it/equality-and-diversity/

Sexual Orientation Workforce Equality Standard and Action Plan:
www.tewv.nhs.uk/content/uploads/2021/01/WORKFORCE-SEXUAL-ORIENTATION-EQUALITY-STANDARD-2020-revised-dates.pdf

Actions taken by the Trust

We have taken a number of actions to address issues of differences in outcomes and experiences for both staff and service users from protected groups.

Details of these are contained in:

- The Equality objective section above.
- The Equality Strategy 2020–2023.
- The Workforce Race Equality Standard document.
- The Workforce Disability Equality Standard document.
- The Sexual Orientation Workforce Equality Standard document.

Staff turnover

Staff turnover figures can be accessed via NHS Digital using the following link: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Staff Engagement

We believe that good staff engagement is essential to delivering better quality care to service users and carers.

Through our “Big Conversation” staff actively helped us frame our purpose, visions, values, goals and priorities.

“To co-create a great experience for our colleagues” is one of the strategic goals of our Journey to Change. By 2025 we are committed to staff feeling:

- Proud, because your work is meaningful.
- Involved in decisions that affect you.
- Well led and managed.
- That your workplace is fit for purpose.

It will be the “norm that opinions, feedback, concerns and ideas are always sought out, heard and acted upon at every level and within every location.

Staff survey results

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

- The response rate to the 2020 survey among Trust staff was 38% compared to 45% in 2019.
- 2,785 participants in total – a decrease of 186 staff.
- Overall staff engagement score remained at 7 out of 10.
- Picker Institute commission the staff survey on behalf of 26 other mental health and learning disabilities Trusts. TEWV were ranked 11 out of 27.

	2020/21		2019/20		2018/2019	
	Trust	**Benchmarking group**	**Trust**	**Benchmarking group**	**Trust**	**Benchmarking group**
Equality, diversity and inclusion	9.3	9.1	9.2	9.0	9.4	8.8
Health and wellbeing	6.5	6.4	6.2	6.0	6.5	6.1
Immediate managers	7.2	7.3	7.2	7.3	7.3	7.2
Morale	6.5	6.4	6.3	6.3	6.5	6.2
Quality of appraisals	**	**	5.6	5.8	6.1	5.7
Quality of care	7.4	7.4	7.3	7.4	7.3	7.3
Environment – bullying and harassment	8.3	8.2	8.2	8.0	8.3	7.9
Safe environment – violence	9.4	9.4	9.3	9.3	9.3	9.3
Safety culture	6.9	6.9	6.8	6.8	7.0	6.7
Staff engagement	7.1	7.2	7.0	7.0	7.2	7.0

We were pleased to see we were above response average by 5% or 6% for satisfaction with level of pay, having adequate resources to do the job, not experiencing MSK problems as a result of work activities, feeling the organisation acts fairly in relation to career progression, not experiencing discrimination.

However we were below the average on staff feeling that the organisation treats them fairly when they are involved in errors/near misses/ incidents.

Compared to results last year more people felt there were adequate staff to do their job properly and we have fewer staff reporting harassment or physical violence. We are not complacent about these results as they are not at the level we want to be at.

From 2018 onwards, the results from questions have been grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those. The response rate to the 2020 survey among Trust staff was 38% compared to 44.9% in 2019. Scores for each indicator together with that of the survey benchmarking group (24 Mental Health and learning disability trusts) are presented below.

Future priorities

- Development of a new approach to grievances and disciplinaries.
- Embedding regular team development plans with shared objectives.
- Improving feedback, for example, in appraisals and supervision .
- Flexible working opportunities and wellbeing at work.

- Supporting staff with caring responsibilities and needing reasonable adjustments.

Recording of trade union facility time (1 April 2020 to 21 March 2021)

Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
26	6652.71

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	12
1 – 50%	13
51-99%	0
100%	1

Percentage of pay bill spent on facility time

Total cost of facility time	£69,558 (calculated as per regulations)
Total pay bill	£324,131,000 (calculated as per regulations)
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.021%

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	9% (calculated as per regulations)

Consultancy Costs

The Trust paid £781,000 in consultancy costs during 2020/21.

Off-payroll arrangements

Off-payroll payments will only be used in exceptional circumstances where it is identified as business critical, such as patient safety. The process for these arrangements consists of sign off by the Chief Executive and regular review, as such payments are only used as a temporary measure.

The following tables contain data on the Trust's highly paid and/or senior off-payroll engagements.

Table 1: Off-payroll worker engagements as at 31 March 2021 (earnings of at least £245 per day)

	Number
Number of existing engagements as of 31 March 2021	33
The number that have existed for less than 1 year at the time of reporting	22
The number that have existed for between 1 and 2 years at the time of reporting	4
The number that have existed for between 2 and 3 years at the time of reporting	2
The number that have existed for between 3 and 4 years at the time of reporting	4
The number that have existed for 4 or more years at the time of reporting	1

Table 2: All off-payroll workers engaged at any point during the year ended 31 March 2021 (earnings of more than £245 per day)

	Number
Number of temporary off-payroll workers engaged between 1 April 2020 and 31 March 2021	80
Of which:	
Number not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35	80
Number subject to off-payroll legislation and determined as out of scope of IR35	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which, number of engagements that saw a change to IR35 status following review	0

Table 3: For any off-payroll engagements of board members and/or senior officials

with significant financial responsibility, between 1 April 2020 and 31 March 2021

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total number of individuals on payroll and off-payroll that have been deemed 'board members, and/or, senior officials with significant financial responsibility', during the financial year. This figure must include both on payroll and off-payroll engagements	19

Exit packages (subject to audit)

For the period 1st April 2020 to 31st March 2021:

- Four employees retired early on the grounds of ill-health at a cost of £218k.
- There were no payments for termination benefits.
- There were no other non-compulsory exit packages.

Gender pay gap

The latest gender pay gap report can be accessed via the Cabinet Office using the following link:
https://gender-pay-gap.service.gov.uk/.

A copy of the report and previous reports are available on the Trust website which can be accessed via the following link:
https://www.tewv.nhs.uk/content/uploads/2021/02/gender-pay-report-as-at-March-2020.pdf

Governance including the Foundation Trust Code of Governance Disclosures

In this section we provide information on our corporate governance arrangements. We explain who sits on the Board of Directors, its committees, and Council of Governors and how they operate.

How the Trust is governed

As a public benefit corporation, the Trust is required to have the following governance arrangements:

- 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, staff governors and governors appointed by key stakeholder organisations.
- A public and staff membership.

The Trust's Constitution requires both the Board and the Council of Governors to:

- Observe the Nolan principles of Public Life of selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

- Seek comply, at all times, with the NHS Foundation Trust Code of Governance.

Statement on the Application of the Code of Governance

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.

The Trust 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:

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.	60 & 73
A.1.1	A statement on how disagreements between the Council of Governors and Board of Directors should be resolved.	65
A.1.2	The names of: • The Chairman • The Deputy Chairman • The Chief Executive • The Senior Independent Director • The Chairmen and members of the Audit and Risk Committee • The Chairman and members of the Remuneration Committees.	24
A.1.2	The number of meetings of the Board of Directors and the Audit, Remuneration and Nominations Committees and individual attendance by Directors.	62, 67, 70 & 83
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 appointments.	75
A.5.3	The name of the Lead Governor.	74
B.1.1	The names of the Non-Executive Directors whom the Board determines to be independent, with reasons where necessary.	24
B.1.4	A description of each director's skills, expertise and experience.	24
B.1.4	A statement about the Board of Directors' balance, completeness and appropriateness to the requirements of the NHS Foundation Trust.	61
B.2.10	A description of the work of the Nominations Committee(s) including the process used in relation to board appointments.	70 & 82

B.3.1	The other significant commitments of the Chairman and any changes to them during the year.	24
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.	83
B.6.1	A statement on how the performance evaluation of the Board, its committees and its Directors, including the Chairman, has been conducted.	65
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.	65
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.	61
C.1.1	A statement from the External Auditors about their reporting responsibilities.	99
C.1.1	An explanation from the Directors of their approach to quality governance in the annual governance statement.	88
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.	69
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.	N/A
C.3.9	A description of the work of the Audit and Risk 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. • If the external auditor provides non-audit services, the value of the non-audit services	66

	provided and an explanation of how auditor objectivity and independence are safeguarded.	
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.	N/A
E.1.4	Contact procedures for members who wish to communicate with Governors and/or Directors.	85
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.	64
E.1.6	A report on the representativeness of Trust's membership and the level and effectiveness of member engagement.	84

The latest version of the code of governance is available on NHS Improvement's website: www.improvement.nhs.uk

Changes to our governance arrangements during the COVID-19 pandemic

The year began with our usual governance arrangements paused due to COVID-19. Formal meetings could not be held as our Constitution required them to be held in person. Instead we held informal teleconferences with any decisions required being taken under emergency powers.

In October, following a ballot of Board members and governors, we amended our Constitution to enable flexibility in our meeting arrangements including allowing them to be held remotely.

Under the Code of Governance we are required to provide information on attendance at meetings of the Board, the Council of Governors, the Audit and Risk Committee and our Nomination and Remuneration Committees. For completeness were have provided information on both the informal teleconferences and formal meetings held during the year.

The Board of Directors

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 to maximise the benefits for the members of the corporation as a whole and for the public.

Our Board of Directors:

- Has retained certain decisions to itself as set out in the scheme of delegation included in the Constitution (available on our website).
- Exercises certain functions in conjunction with our Council of Governors.

Any powers which the Board has not reserved to itself or delegated to a committee are exercised on its behalf by our Chief Executive.

Information on the Board Members as at 31 March 2021, including details of their skills and expertise, is provided in the Accountability Report.

The Trust's corporate directors attend and participate in meetings of the Board in a non-voting capacity. During the year these position were held by Sharon Pickering (Director of Planning, Commissioning, Performance and Communications), David Levy (Director of Human Resources and Organisational Development until his retirement in February 2021) and Dr Sarah Dexter-Smith (Director of People and Culture from February 2021).

The Board considers that, as at 31 March 2021:

- Its composition meets the requirements of the National Health Service Act 2006 and the Constitution.
- 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 31 March 2021, 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 eight informal and five formal meetings of the Board of Directors held during 2020/21:

Board Member	Position	No of Board meetings/ informal teleconferences attended	
		Teleconferences (1/3/20 – 19/10/20) (8)	Meetings (20/10/20 – 30/3/21) (5)
Miriam Harte	• Chairman of the Trust • Chairman of the Board's Nomination and Remuneration Committee • Chairman of the Council of Governor's Nomination and Remuneration Committee	8	5
Brent Kilmurray	• Chief Executive and Accounting Officer (from June 2020) • Chairman of the Senior Leadership Group	2 (2)	4
Colin Martin	• Chief Executive and Accounting Officer (to June 2020) • Chairman of the Executive Management Team	5 (6)	0 (0)
Hugh Griffiths	• Non-Executive Director • Deputy Chairman • Chairman of the Quality Assurance Committee (to 31/3/21)	8	5
Pali Hungin	• Non-Executive Director	8	5
David Jennings	• Non-Executive Director (to August 2020) • Chairman of the Audit and Risk Committee	7	0
John Maddison	• Associate Non-Executive Director (to June 2020) • Non-Executive Director (from July 2020) • Chairman of the Audit and Risk Committee	8	5

Paul Murphy	• Non-executive Director • Chairman of the Resources Committee	8	5
Bev Reilly	• Non-executive Director • Chairman of the Mental Health Legislation Committee	8	4
Shirley Richardson	• Non-Executive Director • Senior independent director • Chairman of the West Lane Project Committee	8	5
Ruth Hill	• Chief Operating Officer	7	5
Ahmad Khouja	• Medical Director	7	5
Patrick McGahon	• Director of Finance and Information (to August 2020)	5 (6)	0 (0)
Elizabeth Moody	• Director of Nursing and Governance • Deputy Chief Executive	7	4
Liz Romaniak	• Director of Finance and Information (from October 2020)	0 (0)	5
Sarah Dexter-Smith	• Director of People and Culture (from February 2021)	0 (0)	2 (2)
David Levy*	• Director of Human Resources and Organisational Development (to February 2021)	7	3 (3)
Sharon Pickering*	▪ Director of Planning, Commissioning, Performance and Communications	8	5
Drew Kendall	▪ Acting director of finance (July 2020 to October 2020)	2 (2)	0 (0)

(Notes:
** Indicates that the director holds a non-voting position on the Board of Directors*
The maximum number of events 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

The following arrangements were maintained during the pandemic to ensure the Board was kept informed of the views of Governors and members:

- Regular meetings, with a locality focus, between the chairman and governors.
- Attendance by Board members at both teleconferences and meetings of the Council of Governors.
- The provision of reports on the outcome of consultations with governors, for example on the business plan.
- Updates provided by the Chairman and directors at Board meetings.
- Governors continued to be encouraged to attend public meetings and teleconferences of the Board of Directors.

Following her appointment as the Senior Independent Director, Shirley Richardson, was also available to governors, if they had concerns about any issues which had 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 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 2020/21.

In total the Council of Governors held two informal teleconferences and three formal meetings including the Annual General Meeting (AGM) during 2020/21. Board member attendance at these teleconferences/meetings was as follows:

Name	**Number of Meetings Attended**	
	Teleconferences (2)	**Meetings (3)**
Miriam Harte	2	3
Brent Kilmurray	2	3
Colin Martin	0 (0)	0 (0)
Hugh Griffiths	1	3
Pali Hungin	1	3
David Jennings	0 (1)	0 (0)
John Maddison	2	3
Paul Murphy	2	3
Bev Reilly	2	2
Shirley Richardson	1	3
Ruth Hill	1	1
Ahmad Khouja	1	2
Patrick McGahon	0 (0)	0 (0)
Elizabeth Moody	1	2
Liz Romaniak	0 (0)	2
David Levy	1	1 (2)
Sharon Pickering	2	3

Sarah Dexter-Smith	0 (0)	1 (1)
Drew Kendall	2	0 (0)

(The maximum number of meetings to be attended by those Board Members who held office during part of the year is shown in brackets)

Resolution of disputes with the Council of Governors

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.

The dispute resolution procedure was not invoked during the year.

Further details on the dispute resolution procedure are provided in annex 9 of our Constitution.

Evaluating Board performance

The Trust usually evaluates the Board's performance and that of its committees and individual members using a scheme initially developed by Deloitte LLP.

These arrangements were suspended in 2020/21 due to the COVID-19 pandemic and as the Trust had commissioned a leadership and governance review under NHS Improvement's well-led framework from the Good Governance Institute (GGI). A summary of the findings from this review are provided in the Accountability Report. GGI has no other connection 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 and Risk, Resources, Quality Assurance, Mental Health Legislation, Nomination and Remuneration and West Lane Project 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 on our website.

The membership, roles and activities of these committees are detailed in the following sections.

The Audit and Risk Committee

Role and responsibilities

The Audit and Risk 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 Trust's objectives.

The responsibilities of the Audit and Risk 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.
    - Systems and processes for risk management within the Trust.
    - The Board Assurance Framework (BAF) and the underlying processes that indicate the degree of achievement of the corporate objectives and the effectiveness of the management of principal organisational risks.
- 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 as appropriate.

The Board, through the Audit and Risk Committee, conducts a review on the effectiveness of internal control annually based on the findings of the head of internal audit.

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 held four informal teleconferences and two formal meetings during the year. Attendance by each member was as follows:

	Informal teleconference	**Meetings**
David Jennings (Chairman to August 2020)	3 (3)	0 (0)
John Maddison (Chairman from September 2020)	4	2
Hugh Griffiths	4	2
Paul Murphy	4	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.

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 and Risk Committee in discharging its responsibilities

The Audit and Risk Committee uses an assurance tracker, a document, updated after each meeting, which enables it to review and monitor compliance with its terms of reference.

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 31 March 2021 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.
- Reviewed the draft annual accounts paying particular attention to the accounting treatment of significant items; material movements from prior years and any key matters of note.
- 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 prior to its inclusion in the Annual Report.

A special meeting of the Committee was held on 18 June 2021 to enable the Committee to review the Annual Report and Accounts and the external auditors draft reports on them.

During the 2020/21 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.
- Reviewed the strategic and operational internal audit plans ensuring that these were aligned to key strategies and reflected the principal risks facing the Trust.
- 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 sought specific assurances from management on the implementation of actions to improve the adequacy and robustness of controls for those assignments where limited or reasonable assurance.
- Considered regular reports from the Local Counter Fraud Specialist (LCFS) noting action taken on increasing fraud awareness and in response to alleged cases of fraud in the Trust and elsewhere. The Committee paid particular attention, as potential areas of risk, to the recommendations arising from the proactive reviews of expenditure with third parties, mobile IT assets and purchasing cards.
- Reviewed progress on the delivery of recommendations arising from assignments undertaken by the Internal Auditors and the LCFS.
- Reviewed the performance of the external auditors and, taking this into account, considered whether there were any matters which needed to be raised with the Council of Governors in regard to the extension of their contract.
- Reviewed changes to the Board Assurance Framework and received the corporate risk register.
- Paid particular attention to tender waivers and the controls relating to them.
- Reviewed the quality account prior to its approval by the Board.
- Reviewed assurances on the effectiveness of the Trust's emergency planning and business continuity arrangements.

- Drew the Board's attention to those matters which it considers have implications for the Trust's assurance framework.
- Considered corporate governance and accounting developments.

The External Auditors

Mazars LLP have been our external auditors since 2013.

Following a competitive tendering process in 2017/18, overseen by members of the Committee and governors, the Council of Governors re-appointed the firm for an initial period of two years (from 1 April 2018) with the option to extend for a further three years (in one year increments).

The cost of providing external audit services during 2020/21 was £55k excluding 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 6.1 and 6.2 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.

Carl Best, the director of internal audit at Audit One, is the Trust's Head of Internal Audit.

Each year the Audit and Risk 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 and Risk 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, Director of Finance and Information 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 and Risk 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

The Nomination and Remuneration Committee oversees 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 they 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 agreement of locally determined terms and conditions of service for all staff employed on national medical terms and conditions and all staff paid at, or above, Agenda for Change band 8.

The membership of the Committee comprises the Chairman of the Trust and all the non-executive directors.

The Committee held one informal teleconference and two formal meetings during 2020/21. The matters considered were as follows:

- The recruitment of a director of people and culture.
- Amendments to the role description and changes to the title of the Director of Planning, Performance and Communications to include commissioning.
- The annual remuneration report.
- The Restriction of Public Sector Exit Payments Regulations 2020.
- Changes to the structure of the executive leadership team and the portfolios of individual executive directors.

Attendance at these teleconferences/meetings was as follows:

	Informal Teleconferences	Formal Meetings
Miriam Harte (Chairman)	1	2
Hugh Griffiths	1	2
Pali Hungin	1	2
David Jennings	1	2
John Maddison	1	2
Paul Murphy	1	2
Bev Reilly	1	2
Shirley Richardson	1	1
Brent Kilmurray	1	0 (0)

The maximum number of meetings to be attended by those Members of the Committee who held office during part of the year is shown in brackets

The Chief Executive is an ex-officio member of the Committee in relation to all matters pertaining to the appointment to those director positions (excluding the role of the Chief Executive) which fall within its remit.

Advice and/or services were provided to the Committee by:

- Brent Kilmurray, Chief Executive
- David Levy, Director of Human Resources and Organisational Development
- Sarah Dexter-Smith, Director of People and Culture
- Phil Bellas, Trust Secretary

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) to deliver its business plan are appropriate, sufficient and deployed effectively.
- To provide assurance to the Board on the robustness, alignment and delivery of key strategies and plans including the financial strategy and capital plan; the workforce strategy and plan, the digital transformation strategy; and the equality strategy and workforce race equality standard plan.
- 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, and assurance on, the performance of the Trust's subsidiaries.
- To provide oversight of the management and administration of charitable funds held by the Trust.

As at 31 March 2021 the membership of the committee comprised:

- Paul Murphy, Non-Executive Director (chairman of the Committee).
- Miriam Harte, Chairman.
- John Maddison, Non-Executive Director.
- Brent Kilmurray, Chief Executive.
- Liz Romaniak, Director of Finance and Information.
- Ruth Hill, Chief Operating Officer.

(Note: All Board Members are invited to attend and participate (but not to vote) in meetings of the Committee. Executive Directors are expected to attend meetings of the Committee when matters within their portfolios are being considered.)

The Committee held two informal teleconferences and three formal meetings during 2020/21.

Mental Health Legislation Committee

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 to 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 31 March 2021 the membership of the committee comprised:

- Bev Reilly, Non-Executive Director (Chairman of the Committee)
- Miriam Harte, Chairman
- Pali Hungin, Non-Executive Director
- Ahmad Khouja, Medical Director
- Ruth Hill, Chief Operating Officer
- Elizabeth Moody, Director of Nursing and Governance and Deputy Chief Executive
- Two public governors or experts by experience (as representatives of service users and carers)

The Committee held two informal teleconferences and one formal meeting during 2020/21.

Quality Assurance Committee

The Quality Assurance Committee is the principal provider of assurance to the Board on quality, and 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.

As at 31 March 2021 the membership of the committee comprised:

- Hugh Griffiths, Deputy Chairman (Chairman of the Committee)
- Pali Hungin, Non-Executive Director
- Bev Reilly, Non-Executive Director
- Shirley Richardson, Non-Executive Director
- Brent Kilmurray, Chief Executive
- Ruth Hill, Chief Operating Officer
- Ahmad Khouja, Medical Director
- Elizabeth Moody, Director of Nursing and Governance and Deputy Chief Executive
- Avril Lowery, Director of Quality Governance
- Dominic Gardner, Director of Operations for Tees
- Jennifer Illingworth, Director of Operations for County Durham and Darlington
- Naomi Lonergan, Director of Operations for North Yorkshire and York
- Lisa Taylor, Director of Operations for Forensic Services

The Committee held five informal teleconferences and four formal meetings during 2020/21.

The West Lane Project Committee

The West Lane Project Committee was established in December 2019. Its principal objectives relate to the provision of vision and oversight on behalf of, and assurance to, the Board in regard to:

- The commissioning and coordination of reviews to support the strengthening of the Trust's structures, systems and processes including governance arrangements
- The provision of effective communication and engagement, both internally and externally, to the Trust.
- The development and establishment of the future provision of CAMHS inpatient services by the Trust.
- Matters pending the re-registration of the Trust's CAMHS inpatient services including the care of CAMHS service users in other care settings, the engagement of, and support for, staff who previously worked at the hospital, and the appraisal of any proposals for the interim delivery of these services.

As at 31 March 2021 the membership of the committee comprised:

- Shirley Richardson, Non-Executive Director (Chairman of the Committee)
- John Maddison, Non-Executive Director
- Brent Kilmurray, Chief Executive
- Ruth Hill, Chief Operating Officer
- Ahmad Khouja, Medical Director
- Elizabeth Moody, Director of Nursing and Governance and Deputy Chief Executive

The Committee held six informal teleconferences and four formal meetings during 2020/21.

The 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 which it exercises by itself or in conjunction with the Board of Directors. These include:

- To develop our membership and represent their interests.
- To assist with the development of the Trust's strategy.
- To appoint or remove the Chairman and the non-executive directors and to determine their remuneration and other terms and conditions of service.
- 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 or whether it 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.

Report of the Lead Governor

The Council of Governors appreciate the dedication and commitment of all clinical and non-clinical staff working across the Trust.

We recognise that the ongoing pandemic has caused extra pressures and stress on staff and their families, but their dedication has maintained the mental health services for users and cares.

Partnership working has been vital in maintaining mental health services for both inpatients and the community service users and carers.

Governors are proud that TEWV has played a major part in the delivery of these services and we are sure that partnership working will continue in the future, this will benefit all those who need help with their wellbeing and mental health.

The Council of Governors has received regular reports on the issues of concern raised by CQC that the Trust is dealing with and the strategy that has been developed to address the concerns.

Governors will continue to monitor and scrutinise the progress of the strategy and the improvements that the Trust has made.

The meetings of the Council of Governors have continued to be virtual meetings.

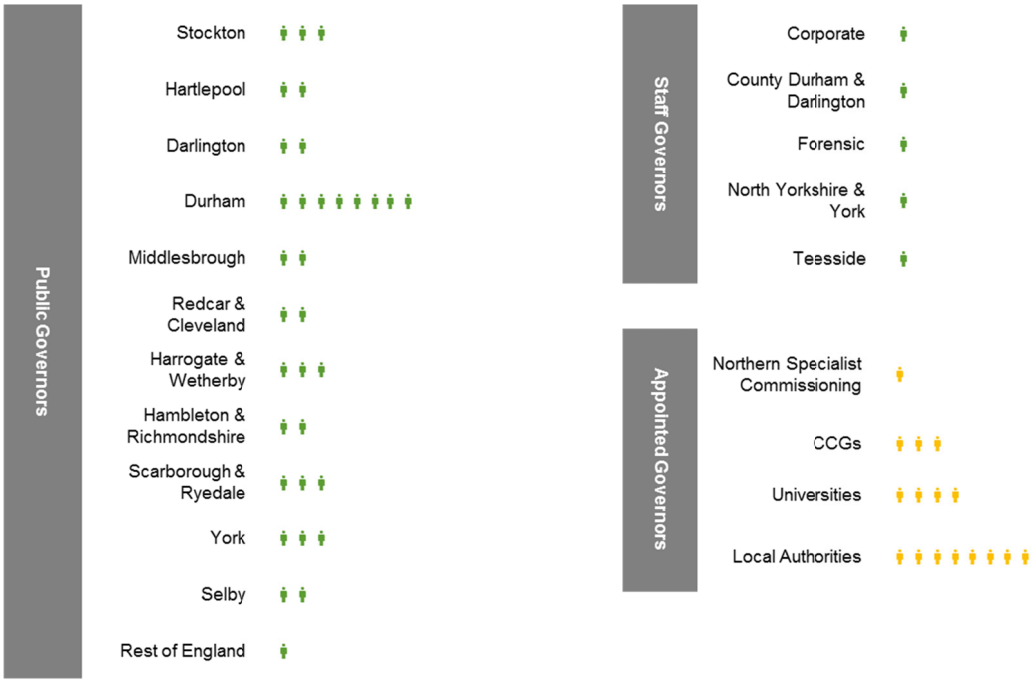
Meetings have included the Trust AGM, full Council of Governor meetings, locality meetings and development sessions both internal and external ensuring governors are kept up to date with information and their learning needs.

Governors are keen to raise the profile of the Council of Governors. We believe that perhaps some of the public do not fully understand the role the Council of Governors has in the Trust.

This is something we will pursue with the media when lockdown is over, and it is safe to do so and we are all able to meet again face to face.

Cllr Ann McCoy
Lead Governor

The Composition of the Council of Governors as at 31 March 2021



(54 seats)

Membership of the Council of Governors during 2020/21

Information on the governors who held office during 2020/21 is presented below.

As with the Board, the Council of Governors was not able to meet formally until changes were made to the Trust's Constitution in October 2021. Prior to this informal teleconferences were held. Information on attendance at both the teleconferences and formal meetings (including the Annual General Meeting) is provided below.

It is also important to note that some governors experienced technical difficulties in participating in remote meetings and events during the period.

Public Governors

Constituency	Name	Term of office	Attendance	
			Informal teleconferences (2)	Formal meetings inc AGM (3)
Darlington	**Joan Kirkbride**	1/11/18 - 30/6/20 1/9/20 - 30/6/23	**1 (1)**	**2**

Darlington	**Audrey Lax**	1/7/18 - 30/6/20 1/9/20 - 30/6/23	**0 (1)**	**1**
Durham	**Cliff Allison**	1/7/17 - 30/6/20	**0 (0)**	**0 (0)**
Durham	**Anne Carr**	1/9/20 - 30/6/23	**1 (1)**	**3**
Durham	**James Creer**	1/7/19 - 30/6/22	**2**	**3**
Durham	**Sandra Grundy**	1/7/17 - 30/6/20	**0(0)**	**0 (0)**
Durham	**Dominic Haney**	18/9/20 - 30/6/23	**1 (1)**	**2**
Durham	**Anthony Heslop**	1/7/19 - 30/6/22	**1**	**2**
Durham	**Jacci McNulty**	1/7/17 - 30/6/20 1/9/20 - 30/6/23	**0 (1)**	**2**
Durham	**Ian McArdle**	1/7/20 - 16/9/20	**0 (1)**	**0 (0)**
Durham	**Graham Robinson**	1/7/19 - 30/6/22	**1**	**1**
Durham	**Sarah Talbot-Landon**	1/7/19 - 4/1/21	**2(2)**	**2 (2)**
Durham	**Jill Wardle**	1/9/20 - 30/6/23	**1 (1)**	**3**
Hambleton and Richmondshire	**Stanley Stevenson**	1/7/19 - 30/6/20 1/9/20 - 30/6/23	**1(1)**	**1**

Harrogate and Wetherby	**Chris Gibson**	1/7/19 - 30/6/22	**1**	**2**
Harrogate and Wetherby	**Hazel Griffiths**	1/7/19 - 30/6/22	**2**	**1**
Harrogate and Wetherby	**Jules Preston**	4/12/19 - 30/6/22	**2**	**3**
Hartlepool	**Jean Rayment**	4/12/19 - 30/6/22	**1**	**2***
Hartlepool	**Zoe Sherry**	1/7/17 - 30/6/20 1/9/20 - 30/6/23	**0(1)**	**2**
Middlesbrough	**Mary Booth**	1/7/17 - 30/6/20 1/9/20 - 30/6/23	**1 (1)**	**3**
Middlesbrough	**Marie Cunningham**	1/7/19 - 30/6/22	**2**	**1 (1)***
Redcar and Cleveland	**Dr Sara Baxter**	1/9/20 - 30/6/23	**0 (1)**	**3**
Redcar and Cleveland	**Mark Carter**	1/7/19 - 30/6/22	**2**	**3**
Redcar and Cleveland	**Alan Williams**	1/7/17 - 30/6/20	**0 (0)**	**0 (0)**
Rest of England	**Carol Jones**	1/7/19 - 30/6/22	**1**	**0**
Scarborough and Ryedale	**Nasr Emam**	4/2/19 - 25/4/20	**0 (0)**	**0 (0)**
Scarborough and Ryedale	**Janet Goddard**	1/9/20 - 30/6/22	**0 (1)**	**1 (1)***

Scarborough and Ryedale	**Keith Marsden**	1/11/18 - 30/6/20 1/9/20 - 30/6/23	**0 (1)**	**1**
Scarborough and Ryedale	**Judith Webster**	1/7/17 - 30/6/20 1/9/20 - 30/6/23	**1 (1)**	**2**
Selby	**Gemma Birchwood**	1/7/18 - 30/6/20 1/9/20 - 30/6/23	**1 (1)**	**3**
Selby	**Wendy Fleming-Smith**	1/7/17 - 30/6/20	**0(0)**	**0 (0)**
Selby	**John Venable**	1/9/20 - 30/6/23	**1(1)**	**1**
Stockton on Tees	**Mark Eltringham**	1/7/17 - 30/6/20	**0 (0)**	**0 (0)**
Stockton on Tees	**Gary Emerson**	1/7/19 - 30/6/22	**2**	**3**
Stockton on Tees	**Gillian Restall**	1/7/17 - 30/6/20 1/9/20 - 30/6/23	**0 (1)**	**1**
Stockton on Tees	**Dr Mojgan Sani**	1/9/20 - 30/6/23	**1 (1)**	**3**
York	**Stella Davidson**	1/7/18 - 1/9/20	**1 (1)**	**0 (0)**
York	**Christine Hodgson**	1/7/18 - 30/6/21	**2**	**1**
York	**Prof Tom McGuffog MBE**	1/7/18 - 30/6/21	**1**	**1**

Staff Governors

Class	Name	Term of office	Attendance	
			Informal teleconferences (2)	Formal meetings inc AGM (3)
Corporate	**Louis Bell**	1/9/20 - 30/6/23	**0(1)**	**0**
Corporate	**Dr Judith Hurst**	1/7/17 - 30/6/20	**0 (0)**	**0 (0)**
Durham and Darlington	**Philip Boyes**	1/7/17 - 30/06/20	**0 (0)**	**0 (0)**
Forensic	**Glenda Godwin**	1/7/17 - 30/6/20	**0 (0)**	**0 (0)**
Forensic	**Ray Godwin**	1/9/20 - 30/6/23	**0 (1)**	**1**
North Yorkshire and York	**Lynne Taylor**	4/12/19 - 20/8/20	**1 (0)**	**0 (0)**
Teesside	**Emmanuel Chan**	1/9/20 - 30/6/23	**0 (1)**	**2**

Appointed Governors

Clinical Commissioning Groups

Appointing organisation	Name	Term of office	Attendance	
			Informal teleconferences (2)	Formal meetings inc AGM (3)

NHS County Durham	**Mike Brierley**	01/05/20	**1**	**0**
NHS North Yorkshire	**Kirsty Kitching**	5/10/20 - 20/11/20	**0(0)**	**0 (1)**
NHS Tees Valley	**Dr Boleslaw Posmyk**	24/6/20	**1**	**3**
NHS Vale of York	**Dr Ruth Walker**	05/08/20	**1 (1)**	**1**

Local Authorities

Appointing organisation	**Name**	**Term of office**	**Attendance**	
			Informal teleconferences (2)	**Formal meetings inc AGM (3)**
Darlington Borough Council	**Kevin Kelly**	13/08/15	**1**	**0**
Durham County Council	**Lee Alexander**	03/01/17	**1**	**0**
Hartlepool Borough Council	**Cllr Barbara Ward**	24/5/20 - 18/06/20	**0 (0)**	**0 (0)**
Hartlepool Borough Council	**Cllr Stephen Thomas**	18/06/20	**0 (1)**	**1**
Middlesbrough Council	**Erik Scollay**	29/04/20	**1**	**0**
North Yorkshire County Council	**Cllr Helen Swiers**	24/05/16	**1**	**2**

Stockton Borough Council	**Cllr Ann McCoy**	01/07/08	**2**	**2**
City of York Council	**Cllr Derek Wann**	26/06/19	**1**	**2**

Universities

Appointing organisation	**Name**	**Term of office**	**Attendance**	
			Informal teleconferences (2)	**Formal meetings inc AGM (3)**
Newcastle University	**Dr Andrew Fairbairn**	26/11/18	**1**	**1**
Sunderland University	**Sue Brent**	03/07/20	**1**	**1**
Teesside University	**Rachel Morris**	20/10/20	**0 (0)**	**2**
University of York	**Ian Hamilton**	09/03/18	**1**	**0**

Notes: Within the above tables:

The annual elections in 2020 were delayed as a result of COVID-19. This resulted in a break in the tenures of some governors. In these circumstances two terms of office are noted.

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 2020/21

Constituency Name	Date of Election	No of Seats	No. of candidates	No. of Votes cast	No. of eligible voters	Turnout (%)
Staff governors						
Co Durham and Darlington	1/9/20	1	0	-	-	-
Corporate	1/9/20	1	2	162	1253	12%
Forensic	1/9/20	1	2	139	900	15%
Teesside	1/9/20	1	2	121	1493	8%
Public governors						
Darlington	1/9/20	2	4	68	779	8%
Durham	1/9/20	4	8	152	2231	6%
Hartlepool	1/9/20	1	2	41	725	5%
Hambleton and Richmondshire	1/9/20	2	1	-	-	-
Middlesbrough	1/9/20	1	2	69	1192	5%
Redcar and Cleveland	1/9/20	1	2	57	962	5%
Selby	1/9/20	2	3	30	262	11%
Stockton on Tees	1/9/20	2	5	67	1129	5%
Scarborough and Ryedale	1/9/20	3	7	59	583	10%

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

Chaired by the Chairman of the Trust, the Nomination and Remuneration Committee supports the Council of Governors to undertake its duties regarding the appointment and setting the remuneration and terms of service of the Chairman and non-executive directors.

No meetings of the Committee were held during 2020/21, however, the chairman consulted members of the Committee, for example on the appointment of John Maddison as a substantive non-executive director, before seeking a decision from the Council of Governors.

The Members of the Committee as at 31 March 2021 were:

Miriam Harte (chairman of the Trust) – chairman
Mary Booth (public governor - Middlesbrough)
Gary Emerson (public governor - Stockton)
Jules Preston (public governor – Harrogate)
Graham Robinson (public governor – Durham)

Shirley Richardson, as the Senior Independent Director is a member and chairs meetings of the Committee when the appointment and appraisal of the chairman of the Trust is being considered.

Training and Development

A training and development programme is in place to support the Trust meet its duty under the National Health Service Act 2006 to equip governors with the skills and knowledge they need for their role.

The provision of training and development was significantly curtailed due to COVID-19, however, induction courses were offered to all new governors and the Trust participated in the national Governwell programme when this resumed.

Training and development activities will be re-instated as lockdown is eased with the Trust working in partnership with others to increase access.

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 business plan.

In addition to participating in Our Big Conversation governors held a workshop and were formerly consulted on the draft priorities and the key locality service changes to be included in the business plan.

These arrangements enabled governors to be assured that feedback received from their members, during Our Big Conversation had been reflected in both Our Journey to Change our strategic framework, and the draft business plan.

Membership Report

Membership is important to make us more accountable to the people we serve, to raise awareness of mental health and learning disability issues and assist 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 31 March 2021 the Trust's membership was as follows:

- Public members – 9,391
- Staff members – 7,142

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	2	381,192
17-21	347	116,512
22+	8,593	1,533,909
Ethnicity:		
White	8,569	1,897,919
Mixed	56	17,513
Asian or Asian British	162	40,256
Black or Black British	83	7,935
Other	22	5,452
Socio-economic groupings*:		
AB	2,041	164,858
C1	2,578	254,865
C2	2,134	199,502
DE	2,572	258,247
Gender analysis		
Male	3,090	999,181
Female	6,238	1,032,438

Notes:
On application:
449 public members did not provide a date of birth
449 members did not state their ethnicity
63 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.

We have 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.

Member engagement activities were significantly affected by COVID-19, however, during the period:

- Emails were sent to new members to welcome them to the Trust.
- Governor elections were held.

- The Annual General and Members' Meeting was held remotely with over 190 attendees.
- The Trust expanded its use of social media to encourage attendance at meetings of the Board and Council of Governors.
- Members of the Trust received individual invitations to participate in Our Big Conversation.

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.ftmembership@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 Oversight Framework

NHS England and NHS Improvement's NHS 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.

Segmentation

NHS Improvement has placed the Trust in segment 2 (targeted support).

This segmentation information is the Trust's position as at 31 March 2021. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Modern Slavery Act Statement

All staff in clinical or non-clinical roles have a responsibility to consider modern slavery, and incorporates their understanding of this 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 our suppliers adhere to the same ethical principles.

In compliance with the consolidation of offences relating to trafficking and slavery with the Modern Slavery Act 2015 we continue to review our supply chains with a view to confirming that such actions are not taking place.

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/

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, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care 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 and Social Care 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;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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 them 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.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Brent Kilmurray
Chief Executive
24th June 2021

Annual Governance Statement 2020/21

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, while 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 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The chief executive, as the Trust's accounting officer, has overall responsibility for risk management across the organisation.

The Board of Directors has retained responsibility for the approval of risk management policies; setting the risk appetite and risk tolerances; and establishing the tone and culture for risk management in the Trust.

Committees of the Board of Directors are in place both to ensure the effective governance of major operational and strategic processes and systems, and also to provide assurance that risk is effectively managed.

Responsibilities for the delivery of effective risk management are aligned to leadership and governance structures.

Executive, corporate and operational directors support the effective development and application of risk management systems and processes both corporately, as senior leaders of the organisation, and within their portfolios.

Locality Management and Governance Boards (LMGBs) and Directorate Quality Assurance Groups (QuAGS) review and manage risks related to their services.

All staff are expected to have an awareness of risk in the performance of their day to day duties and to escalate situations which present risk to their line manager.

Guidance and training in the risk assessment process is aimed at all levels of staff. This is managed through the inclusion of risk assessment techniques and processes in the Trust Training programme.

The risk and control framework

Following reviews of its governance arrangements, including a leadership and governance review under NHS England/Improvements Well-Led Framework, and the findings of a Care Quality Commission inspection which led to regulatory action, the Trust has recognised that there are significant weaknesses in its risk and control framework. Work is underway to strengthen the Trust's approach. This will be delivered during the first half of 2021/22.

The findings of these reviews and inspections have also contributed to the Board's appraisal of the validity of the Trust's Corporate Governance Statement and the risks and mitigations to deliver effective governance contained within it.

The following section provides details of the arrangements in place during 2021/22.

The Trust's approach to risk management is detailed in its Organisational Risk Management Policy. This was developed with the support of the Trust's internal auditors and in consultation with the Audit Committee and Executive Management Team (now the Senior Leadership Group).

The Policy has the following objectives:

- To support compliance with regulatory requirements and expectations e.g. the Provider Licence.
- To embed a consistent, systematic and standardised approach to the management of risks across the Trust.
- To support understanding of, and competence in, the anticipation, assessment and management of risks amongst all staff.
- To provide clarity on the Trust's risk appetite to support effective decision-making.

Through the development of the Policy, the Board articulated the risk appetite for the organisation.

The Policy also sets out the structures and processes to systematically identify, assess, manage, monitor and review risk and put in place robust plans for mitigation.

Risks facing the organisation will be identified from a number of sources, both internal and external to the organisation, for example:

Internal - though risk assessments, the development of the business plan, consultations with staff and patients, internal inspections and audits and complaints, incidents and claims.

External – through assessments by regulators, consultation with external stakeholders and benchmarking.

The Board has identified the principal risks to the delivery of its strategic direction and these are monitored and managed through the Board Assurance Framework (BAF).

The BAF is reviewed by the Board at each of its meetings. Each risk profile sets out the related controls, gaps in control, assurances, positive assurances, gaps in assurance and mitigation plans.

All risks are scored against set criteria for consequence and likelihood. Each risk also has a target (residual) risk score; the level of risk once all reasonable mitigating actions have been taken.

As at 31 March 2021 the following strategic risks were rated as very high (risk score of 27 to 45):

Risk Name	**Risk Description**
Consultant recruitment	Patient safety, quality and outcomes could be compromised due to difficulties appointing sufficient consultants to meet current and future workforce demands.
Cyber security	Patient care could be compromised and there could be reputational damage if a cyber-attack was successful.
West Lane strategic impact	The events in West Lane Hospital Inpatient services in 2019 could have an adverse strategic impact on the Trust particularly through: ▪ Loss of, or disruption to, service provision with consequential impacts on patient experience and clinical effectiveness. ▪ Loss of reputation with service users, carers, the public. ▪ Being detrimental to staff recruitment and retention. ▪ Reducing the confidence of regulators and commissioners in the Trust leading to increased oversight; lower tolerance; and reduced opportunities. ▪ Creating financial pressures.
Maintaining effective governance	There could be repeated failures, unsafe services, regulatory action and reputational damage if we fail to put in place and maintain effective governance, risk and assurance processes.
Provider collaboratives	The establishment of provider collaboratives might impact on the Trust's ability to deliver services particularly in regard to quality, contracting, case management and finances.
Compliance with national targets and Standards	We could be subject to regulatory action and suffer reputational damage if we fail to comply with national targets and standards.
COVID-19	There could be a significant impact on the Trust's ability to deliver services arising from staff absence and access to supplies due to the Coronavirus.

Note: The risks included in the BAF are subject to review following the approval of the Trust's new Strategy - Our Journey to Change.

The Board is supported in the delivery of its responsibilities through its Committees and the Senior Leadership Group (SLG).

Terms of the reference for the Committee and SLG are in place. Each Committee is also chaired by a non-executive director.

All the Board's Committees have responsibility for providing assurance to the Board on the effectiveness of controls; identifying gaps/weaknesses in control and ensuring these are addressed/escalated as required, and identifying and escalating new risks that could impact significantly on the Trust's ability to deliver its strategic direction, to the Board.

The Audit and Risk Committee has specific responsibilities for:

- Providing assurance to the Board (through its oversight of governance, risk management and internal control) on the effectiveness and robustness of the Trust's risk management arrangements and controls environment).
- Reviewing the adequacy of all risk and control related statements (e.g. the Annual Governance Statement) prior to endorsement by the Board.
- Reviewing the Assurance Framework, prior to its presentation to the Board, to provide assurance on its coverage and comprehensiveness and the appropriateness and effectiveness of the mitigations for each principal risk.

In 2020/21 the BAF was reviewed by the Audit and Risk Committee at each of its meeting.

The Trust's quality governance arrangements are focussed on the Quality Assurance Committee of the Board. It has responsibility for overseeing the Foundation Trust's compliance against the fundamental standards for quality and safety. It also considers statutory and regulatory compliance, in regard to relevant matters (including health and safety, safeguarding and medicines management), clinical audit and research and development.

The Committee receives assurance from:

- Locality based governance arrangements (the LMGBs and QUAGs) mentioned above. Though these arrangements it is intended that there is a clear line for sight from ward to Board.
- Thematic quality groups covering, for example, patient safety, patient experience, drugs and therapeutics.

Organisational risk management is aligned to the Trust's governance arrangements based on the significance of risk. Very high level risks are monitored directly by the Senior Leadership Group supported by sub-groups covering clinical leadership, quality and safety, operational delivery and development workforce and portfolio management.

The Corporate (operational) Risk Register is supported by risk registers which are managed through the LMGBs and QuAGs.

Speciality Development Groups, chaired by Senior Clinical Directors, have also been established with responsibilities for ensuring consistent clinical approaches across the geographical areas of the Trust.

The Trust continues to be registered with the Care Quality Commission; however, this remains conditional on it not providing CAMHS inpatient services at West Lane Hospital (now Acklam Road Hospital).

Risk is embedded in the activities of the organisation in the following ways:

- Equality impact assessments are undertaken for all new initiatives and policies.

- Quality Impact Assessments (QIA), that are required to be signed-off by the Medical Director and Director of Nursing and Governance, are undertaken for all Cash

Releasing Efficiency Savings (CRES) schemes to assess the impact they have on clinical performance, and ultimately, patient care.

- The Trust supports an open reporting culture and encourages its staff to report all incidents through its internal reporting system.

  The Trust's Incident Policy CORP 0043 sets out the arrangements by which all incidents are openly reported within the Trust and where appropriate externally, and that they are systematically reviewed and analysed to prevent/minimise the incident being repeated. These include the involvement of patients and families from the beginning of the incident where appropriate.

- Cyber Security remains a key priority for the Trust and is identified as one of the key strategic risks; which while recognised, is an ever-present threat with potential high impact.

  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 and responsibilities. The network is consulted when there is significant change to information governance process, for example implementing the new requirements under the Data Protection Act 2018 (GDPR).

  The Trusts cyber security activities focus on three key areas; people, processes and technology. The biggest risk is user activity and lack of training and awareness. An ongoing cyber security training e-learning programme (Metacompliance) was launched in August 2020 and distributes regular content to all Trust staff. The development of robust business continuity plans for clinical and corporate services remains a priority and will need to be tested further during the year ahead. Recent investments in the technical infrastructure have provided a strong foundation for the continued work needed to mitigate our potential for an incident; however the threat has increased, due to number of staff working remotely, therefore a need for robust Business Continuity plans within services are needed.

  The Data Protection and Security Toolkit and internal audit provide further assurances on cyber security. A key focus as part of the digital roadmap going forward will be to look at what external assurances and standards we could adopt.

- The Trust actively engages with partners recognising the risks of disruption to patient care from organisational boundaries, recognising that other providers, particularly the voluntary and community have a better understanding of place-based issues and potential solutions; and to ensure as much of the public's money as possible is spent on service-user facing services.

  The creation of Integrated Care Systems, and Primary Care Networks and the focus on integrated, holistic working based on place-based planning and delivery provide both risks and opportunities.

  Feedback has been received that the Trust and its leadership are well regarded; the Trust is building a reputation for strong engagement and being solution; and partners value the Trust's collaborative approach.

Leadership and operational arrangements have been reviewed to maximise the Trust's influence within, and ability to respond to, the new NHS landscape and local systems.

- The Trust's Workforce Strategy is focused upon five key workforce objectives which are:

    - Increasing recruitment.
    - Reducing staff turnover.
    - Enhancing learning and development.
    - Reducing sickness absence.
    - Enhancing staff experience.

    The above objectives support the specific workforce actions within the NHS People Plan which include; growing the workforce, retaining staff, new ways of delivering care (learning and development), health and wellbeing, flexible working, equality and diversity and culture and leadership.

    Our priorities have been reviewed this year in line with the people plan, ICS priorities and the feedback from Our Big Conversation which has led to the development of priorities around living our new values, effective leadership, psychological safety and staff engagement. We are also reviewing all the people and culture policies and procedures in line with our new values and developing new standards for recruitment panels and processes.

    We are undertaking a comprehensive review of our freedom to speak up processes. The associated whistleblowing policy has been updated and we have started a quality improvement process specifically around the way in which the Freedom to speak up concerns sit alongside our other processes through which people can raise concerns and access support. The FTSU guardian is well used and trusted but there is complexity in the system and some lost opportunities to resolve situations more quickly. We are reviewing the disciplinary policy and process in line with national best practice. We are also establishing more formality to the assurance and governance process that the 'raising concerns' group provides, creating a direct link to the workforce subgroup of SLG which will feed into the new people, culture and diversity committee, being established in the summer. And we are establishing regular meetings between our head of temporary staffing and Deputy Director of Nursing and Governance to collate concerns raised by bank and agency staff.

The involvement of public stakeholders in identifying risks and providing assurance that they are mitigated.

A variety of approaches are used including:

- Feedback from governors on concerns raised their members.
- Patient satisfaction surveys including the Friends and Family Test.
- Complaints, claims and Patient Advice and Liaison (PALS) concerns.
- The involvement of patients and the public in the development and evaluation of services.
- Close links with local authorities, Clinical Commissioning Groups and Integrated Care Systems to ensure the delivery of integrated care and treatment.

The Foundation Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance.

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 has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its 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 (outside of current COVID-19 financial arrangements) would involve:

- Agreeing an annual financial plan and longer term strategy.
- 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 localities to better understand and manage their respective income and expenditure, including using service line reporting and benchmarking.
- Disaggregating the Trust's overall reference cost indicator down to specialty/locality.
- Leveraging efficiencies through internal and collaborative procurement initiatives.
- Using benchmarking and nationally published performance metrics to inform plans for improved inpatient and community service efficiency.
- Rationalising the estate.
- Improving workforce productivity, including through innovation and technology
- Benchmarking costs of corporate functions, including reference to national tools including Model Hospital.
- Utilising annualised Business Planning and innovative coaching approaches to generate ideas for cost reductions.
- Embedding the Quality Improvement Systems (QIS) methodology to review how the Trust operates, maximising efficiency and minimising waste.
- Working with partners to improve the overall local health economy in terms of quality and efficiency, including developing non Trust pathways and assuming commissioning functions to improve cost effectiveness and outcomes. The Trust has strategic partnerships with CCGs in both Durham and Tees and North Yorkshire; works collaboratively with NHS England via New Care Models for specialist services and develops new services for people with Learning Disability using PIPS.
- Robust capital planning function locally adopting the NHS England business case approvals process guidance, coordination of prioritisation processes to ensure transparent agreement of relative priorities and impact assessments where resource constraints limit Trust ambitions.

The Board plays an active role by:

- Determining the level of financial performance it requires and the consequent implications (including QIA).

- Reviewing in detail at each meeting financial performance, financial risk and delivery against the detailed CRES, supplemented by more detailed discussion at Resources Committee.
- 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 and Risk 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.
- External audit reports on specific areas of interest.
- The Care Quality Commission reports.

Information governance

There were 13 incidents reported in the Data Security and Protection Toolkit during the period 1 April 2020 to 31 March 2021. Six incidents were privacy breaches (inappropriate staff access to local or national patient information systems) affecting one person–. Seven incidents were confidentiality breaches with a variety of causes. All incidents were investigated by the appropriate Trust team. No cases resulted in regulatory action by the Information Commissioners Office.

Due to the pandemic, NHS Digital has delayed submission of the Data Security and Protection Toolkit 2020-21 until 30 June 2021. Of the 110 mandatory evidence items and 42 assertions, we anticipate publishing the Toolkit with all evidence provided and assertions met.

Data quality and governance

The following steps have been established to ensure that appropriate controls are in place to support the accuracy of data:

- The Trust has in place an internal group which has the responsibility for ensuring data quality within the Trust. This was put on-hold during the COVID-19 response and is to be reinstated as part of the Trust's revised governance structure Furthermore data quality is also discussed at monthly performance meetings between the Director of Finance and Information, the Director of Planning, Commissioning, Performance and Communication and the Chief Operating Officer with each clinical locality.

- 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 has 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.

  In the most recent NHS Digital published results (January 2021) TEWV gained a score of 98.1% for the Data Quality Maturity Index which is a measurement of data quality in the NHS.

- 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.
- Confidentiality and sharing information 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 and other cascade mechanisms.

- 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. The Trust has introduced the use of Statistical Process Control charts this year to enhance decision making.

- 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 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 and Risk 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 England/Improvement.
- The Good Governance Institute.
- 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 and Risk 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 and 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.
- The Resources Committee provides assurance on behalf of the Board of Directors on the availability, sufficiency and deployment of resources (both financial and non-financial) to deliver the Trust's Business Plan and scrutinises major investments, including risks, prior to consideration by the Board.
- 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 and Risk Committee.
- The Annual Report and Accounts are presented to the Board of Directors for approval.

Conclusion

In summary, the Trust has recognised that there are some significant weaknesses in internal control processes.

Although the Trust's overall rating remains "Good", the regulator's latest inspection raised material concerns about clinical risk assessment and risk management processes. The External Auditor has commented on this matter in and has made a value for money recommendation to which the Trust has responded.

The Well-Led review, undertaken by the Good Governance Institute, identified the need for a substantial developmental agenda, some of which was urgent and to be taken forward immediately, to improve governance and internal control and to meet the legitimate expectations of the public, stakeholders, including regulators, and staff.

The Board of Directors is committed to addressing these weaknesses in internal control. Plans are in place to implement the changes required which are being actively monitored.

Brent Kilmurray
Chief Executive
24th June 2021

The auditors' report & opinion

To be inserted

The accounts 2020/21

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

Brent Kilmurray
Chief Executive
24th June 2021

Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	391,456	365,842
Other operating income	4	31,809	19,823
Operating expenses	6, 8	(436,814)	(398,474)
Operating deficit from continuing operations		**(13,549)**	**(12,809)**
Finance income	11	17	562
Finance expenses	12	(1,053)	(1,056)
PDC dividends payable		(2,156)	(2,816)
Net finance costs		**(3,192)**	**(3,310)**
Deficit for the year		**(16,741)**	**(16,119)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(32)	(220)
Revaluations	15	381	2,266
Total comprehensive expense for the period		**(16,392)**	**(14,073)**

The trust's performance against the agreed 2019/20 NHS Improvement control total and agreed 2020/21 financial plan is included in note 2.2

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	14	1,554	1,554
Property, plant and equipment	15	138,833	139,814
Receivables	20	524	498
Total non-current assets		**140,911**	**141,866**
Current assets			
Inventories	19	1,007	746
Receivables	20	17,922	19,400
Non-current assets for sale and assets in disposal groups	22.1	1,080	1,080
Cash and cash equivalents	23	80,936	76,914
Total current assets		**100,945**	**98,140**
Current liabilities			
Trade and other payables	24	(47,011)	(38,950)
Borrowings	26	(890)	(817)
Provisions	29	(7,553)	(499)
Other liabilities	25	(1,595)	(254)
Total current liabilities		**(57,049)**	**(40,520)**
Total assets less current liabilities		**184,807**	**199,486**
Non-current liabilities			
Borrowings	26	(12,304)	(13,194)
Provisions	29	(4,006)	(7,495)
Total non-current liabilities		**(16,310)**	**(20,689)**
Total assets employed		**168,497**	**178,797**
Financed by			
Public dividend capital		153,218	147,126
Revaluation reserve		5,035	4,686
Income and expenditure reserve		10,244	26,985
Total taxpayers' equity		**168,497**	**178,797**

The notes form part of these accounts.

Brent Kilmurray
Chief Executive
Date 24 June 2021

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve*	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**147,126**	**4,686**	**26,985**	**178,797**
Deficit for the year	-	-	(16,741)	**(16,741)**
Impairments	-	(32)	-	**(32)**
Revaluations	-	381	-	**381**
Public dividend capital received	6,092	-	-	**6,092**
Taxpayers' and others' equity at 31 March 2021	**153,218**	**5,035**	**10,244**	**168,497**

*The revaluation reserve is used to record revaluation gains and losses on property, plant and equipment. This reserve is currently used solely for tangible assets only.

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**146,530**	**2,640**	**43,104**	**192,274**
Deficit for the year	-	-	(16,119)	**(16,119)**
Impairments	-	(220)	-	**(220)**
Revaluations	-	2,266	-	**2,266**
Public dividend capital received	596	-	-	**596**
Taxpayers' and others' equity at 31 March 2020	**147,126**	**4,686**	**26,985**	**178,797**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating deficit		(13,549)	(12,809)
Non-cash income and expense:			
Depreciation and amortisation	6.1	3,799	4,779
Net impairments	7	25,841	28,360
Decrease in receivables and other assets		1,881	29,089
Increase in inventories		(261)	(226)
Increase / (decrease) in payables and other liabilities		8,974	(4,663)
Increase in provisions		3,590	2,108
Net cash flows from operating activities		**30,275**	**46,638**
Cash flows from investing activities			
Interest received		17	562
Purchase and sale of financial assets		-	50
Purchase of PPE and investment property		(27,365)	(35,558)
Net cash flows (used in) investing activities		**(27,348)**	**(34,946)**
Cash flows from financing activities			
Public dividend capital received		6,092	596
Movement on loans from DHSC		-	(3,000)
Movement on other loans		(238)	(238)
Capital element of PFI, LIFT and other service concession payments		(580)	(533)
Interest on loans		-	(30)
Interest paid on PFI, LIFT and other service concession obligations		(1,077)	(1,056)
PDC dividend (paid)		(3,102)	(3,245)
Net cash flows from financing activities		**1,095**	**(7,506)**
Increase in cash and cash equivalents		**4,022**	**4,186**
Cash and cash equivalents at 1 April - brought forward		**76,914**	**72,728**
Cash and cash equivalents at 31 March	23.1	**80,936**	**76,914**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts 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.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity’s services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Interests in other entities

Joint operations
Joint operations are arrangements in which the trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The trust includes within its financial statements its share of the assets, liabilities, income and expenses.

The trust is 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. "TEWV Estates and Facilities Management Limited" was made dormant during 2019/20.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the trust accrues income relating to performance obligations satisfied in that year. Where the trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The majority of the trust's revenue from contracts with customers is received from annual contracts with NHS commissioners. Cash is received monthly in 1/12ths, and performance criteria are met as the contracted services are provided.

Revenue from NHS contracts
The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an Integrated Care System level. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

Through national financial arrangement operating to support the NHS in responding to the Coronavirus pandemic, the trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the trust's contracts with NHS commissioners included those where the trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the trust's interim performance does not create an asset with alternative use for the trust, and the trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy 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.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• 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 item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs 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.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust’s Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

A desktop MEA valuation was carried out on the trust's land and buildings at 31 March 2021, and the assets have been treated as prescribed in the Group Accounting Manual. All of the trust's MEA valuations have been completed by Cushman and Wakefield Inc. (independent qualified valuer).

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant 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/grant 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 and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the Coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Private Finance Initiative (PFI) and Local Improvement Finance trust (LIFT) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

PFI 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.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives for Trusts assets are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	90
Dwellings	-	-
Plant & machinery	1	15
Transport equipment	1	7
Information technology	1	7
Furniture & fittings	1	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations, gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits. The trust's intangible assets are licenses that are to be held in perpetuity, as such they do not have a maximum life.

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

In 2020/21, the trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.12 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. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive, or a legal obligation to pay, cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets and liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the trust recognises an allowance for expected credit losses.

The trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are calculated for non government funded organisations only, based on the level of risk attached to individual transactions.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The trust as a lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

		Nominal rate
Short-term	Up to 5 years	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.18%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2021:

	Inflation rate
Year 1	1.20%
Year 2	1.60%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 30.2 but is not recognised in the trust's accounts.

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 NHS Resolution 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 when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 31 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 31 unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 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.

Note 1.19 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 2021.

Note 1.20 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.21 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Note 1.22 Third party assets

Assets belonging to third parties in which the trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.23 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.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.24 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Other standards, amendments and interpretations

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 14 Regulatory Deferral Accounts has not been endorsed by the European Financial Reporting Advisory Group and is not applicable to DHSC bodies.

IFRS 17 Insurance Contracts is planned to be adopted from the 2023/24 financial year.

The trust does not anticipate these changes in accounting standards to have a material impact on the 2021/22 accounts.

Note 1.27 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below), that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

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 to 5 years.

Provisions are, in the main, injury benefits provisions (which are valued using actuarial tables), operating penalties (informed by legal advice) and annual leave pay (informed by national negotiations).

On the grounds of materiality, as per guidance within the group accounting manual, the Trust has not consolidated its Charitable Fund, its subsidiaries for the provision of Positive Individual Proactive Support (PIPS) services, or TEWV Estates and Facilities Management (TEWV EFM, now dormant) service within the main accounts.

Note 1.28 Sources of estimation uncertainty

The trust has made no assumptions about the future and has no other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Note 2.1 Operating Segments

The trust has no elements that require segmental analysis for the period ended 31 March 2021. The chief operating decision maker has been identified as the Chief Operating Officer, an Executive Director post within the trust; and on this basis the trust has identified healthcare as the single operating segment.

Note 2.2 Performance against control total / planned financial position

During 2019/20 NHS Foundation Trusts' financial performance was measured by NHSE/I against an agreed control total (or end of year required surplus or deficit position). For the year ending 31st March 2021 the performance of NHS organisations is measured against delivery of their agreed planned financial position. Certain exceptional and technical revenue streams are excluded from the calculation of 'performance' to ensure true operational performance is measured.

The trust's agreed planned financial position for 2020/21 was a deficit of £1,998k. The trust reported an adjusted financial surplus position (excluding AME impairments) of £9,100k , which was £11,098k ahead of control total i.e. target achieved.

A reconciliation of the trust's performance against the 2019/20 control total and 2020/21 agreed financial plan is shown below:

	2020/21	2019/20
	£000	£000
Deficit for the year from SoCI	(16,741)	(16,119)
Add back net impairments	25,841	27,628
Remove prior year PSF adjustment	-	(125)
Actual surplus for performance assessment	**9,100**	**11,384**
Required / planned surplus / (deficit)	(1,998)	5,485
Performance ahead of required level	**11,098**	**5,899**

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2020/21 £000	2019/20 £000
Mental health services		
Block contract / cost and volume / income under national arrangements*	361,125	339,543
Clinical income for the secondary commissioning of mandatory services	5,580	6,193
Other clinical income from mandatory services	4,156	5,313
All services		
Additional pension contribution central funding**	12,445	11,396
Other clinical income	8,150	3,397
Total income from activities	**391,456**	**365,842**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2020/21 £000	2019/20 £000
NHS England	78,490	74,517
Clinical commissioning groups	302,745	285,352
Other NHS providers	1,417	1,654
NHS other	368	218
Local authorities	1,010	2,101
Non NHS: other	7,426	2,000
Total income from activities	**391,456**	**365,842**
Of which:		
Related to continuing operations	391,456	365,842

Analysis of income from patient care activities (by source) - non NHS other	2020/21 £000	2019/20 £000
Other government departments and agencies	390	429
Other*	7,036	1,571
	7,426	**2,000**

*Other income is mainly from Spectrum Community Health Contract £7,220k (2019/20 £838k).

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

The trust had no income relating to overseas visitors (non-reciprocal, chargeable to the patient) (2019/20 £nil).

Note 4 Other operating income

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,327	-	**1,327**	1,192	-	**1,192**
Education and training	12,925	825	**13,750**	9,663	532	**10,195**
Non-patient care services to other bodies	3,094		**3,094**	3,802		**3,802**
Provider sustainability fund (2019/20 only)			**-**	2,955		**2,955**
Reimbursement and top up funding	7,967		**7,967**			**-**
Income in respect of employee benefits accounted on a gross basis	600		**600**	495		**495**
Contributions to expenditure (items donated from DHSC group bodies)		3,901	**3,901**		-	**-**
Rental revenue from operating leases		692	**692**		692	**692**
Other income*	478	-	**478**	492	-	**492**
Total other operating income	**26,391**	**5,418**	**31,809**	**18,599**	**1,224**	**19,823**
Of which:						
Related to continuing operations			31,809			19,823

*Other income is mainly from contract penalties received £350k.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	245	309

Note 5.2 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2020/21	2019/20
	£000	£000
Income from services designated as commissioner requested services	377,704	353,035
Income from services not designated as commissioner requested services	45,561	32,630
Total	**423,265**	**385,665**

Note 5.3 Non NHS Income

The trust had Non NHS income totalling £29,089k (2019/20, £18,861k).

Note 5.4 Fees and charges

The trust received no income from fees and charges - aggregate of all schemes that, individually, have a cost exceeding £1m (2019/20 £nil).

Note 6.1 Operating expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	3,713	3,455
Purchase of healthcare from non-NHS and non-DHSC bodies	8,145	8,457
Staff and executive directors costs	320,928	288,946
Remuneration of non-executive directors	157	165
Supplies and services - clinical (excluding drugs costs)*	7,122	2,703
Supplies and services - general	6,991	6,469
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	4,761	4,230
Consultancy costs	781	577
Establishment	4,437	4,013
Premises	23,938	21,174
Transport (including patient travel)**	1,961	4,816
Depreciation on property, plant and equipment	3,799	4,779
Net impairments	25,841	28,360
Movement in credit loss allowance: contract receivables	(69)	47
Increase in other provisions	4,535	718
Change in provisions discount rate(s)	139	285
Audit fees payable to the external auditor		
audit services- statutory audit	66	42
other auditor remuneration (external auditor only)	-	2
Internal audit costs	234	233
Clinical negligence	1,113	896
Legal fees	1,938	2,234
Insurance	297	107
Research and development	1,739	1,477
Education and training	5,048	4,362
Rentals under operating leases	7,084	7,716
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	529	462
Hospitality	68	109
Losses, ex gratia & special payments	18	22
Other	1,501	1,618
Total	**436,814**	**398,474**
Of which:		
Related to continuing operations	436,814	398,474

*includes £3,901k of DHSC procured consumables linked to Coronavirus pandemic, the majority being PPE or domestic items

** transport costs have reduced due to lower business travel linked to the Coronavirus pandemic

Analysis of operating expenses - other	2020/21	2019/20
	£000	£000
Services from local authorities	26	342
Other patients' expenses	129	149
National offender health services	146	153
CQC and accreditation fees	257	251
Pension Final Pay Control Charge	385	369
Miscellaneous	558	354
	1,501	**1,618**

Note 6.2 Other auditor remuneration

The trust has not paid its auditors any additional remuneration for the period to 31 March 2021 (31 March 2020, £2k). Auditors remuneration for statutory audit is shown in note 6.1.

Note 6.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2020/21 or 2019/20.

Note 7 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	-	732
Changes in market price	25,841	27,628
Total net impairments charged to operating surplus / deficit	**25,841**	**28,360**
Impairments charged to the revaluation reserve	32	220
Total net impairments	**25,873**	**28,580**

The trust realised impairments totalling £25,873k during 2020/21 following a modern equivalent asset valuation of its sites.

Note 8 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	251,346	224,270
Social security costs	22,374	20,093
Apprenticeship levy	1,181	1,068
Employer's contributions to NHS pensions	41,024	37,463
Pension cost - other	87	77
Temporary staff (including agency)	8,421	8,748
Total staff costs	**324,433**	**291,719**
Of which		
Costs capitalised as part of assets	302	244

Note 8.1 Retirements due to ill-health

During 2020/21 there were 4 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £218k (£102k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 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 for Health and Social Care 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 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 report of the scheme actuary, 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.

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 recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

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.

Note 10 Operating leases

Note 10.1 Tees, Esk and Wear Valleys NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Tees, Esk and Wear Valleys NHS Foundation Trust is the lessor.

Operating lease income is from property rental.

	2020/21 £000	2019/20 £000
Operating lease revenue		
Minimum lease receipts	692	692
Total	**692**	**692**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease receipts due:		
- not later than one year;	692	692
- later than one year and not later than five years;	949	897
- later than five years.	2,100	2,200
Total	**3,741**	**3,789**

Note 10.2 Tees, Esk and Wear Valleys NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Tees, Esk and Wear Valleys NHS Foundation Trust is the lessee.

The trust's operating leases include leased vehicles for staff, property rental and telephony rental.

	2020/21 £000	2019/20 £000
Operating lease expense		
Minimum lease payments	7,084	7,716
Total	**7,084**	**7,716**

Future minimum lease payments due:	31 March 2021 £000	31 March 2020 £000
On buildings		
- not later than one year;	2,699	3,487
- later than one year and not later than five years;	10,269	11,933
- later than five years.	4,881	5,406
Total	**17,849**	**20,826**
On other		
- not later than one year;	3,772	3,690
- later than one year and not later than five years;	2,738	2,270
Total	**6,510**	**5,960**
On all leases		
- not later than one year;	6,471	7,177
- later than one year and not later than five years;	13,007	14,203
- later than five years.	4,881	5,406
Total	**24,359**	**26,786**

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2020/21	2019/20
	£000	£000
Interest on bank accounts	17	562
Total finance income	**17**	**562**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2020/21	2019/20
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	-	12
Main finance costs on PFI and LIFT schemes obligations	620	646
Contingent finance costs on PFI and LIFT scheme obligations	458	410
Total interest expense	**1,078**	**1,068**
Unwinding of discount on provisions	(25)	(12)
Total finance costs	**1,053**	**1,056**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

The trust did not pay any interest payable arising from claims or pay compensation to cover debt recovery costs under this legislation (2019/20, £nil).

Note 13 Discontinued operations

The trust has no discontinued operations at 31 March 2021 (31 March 2020, £nil).

Note 14 Intangible assets

The trust's intangible assets are licenses for a software system that are to be held in perpetuity. Asset balances as at 31 March 2021 were £1,554k (31 March 2020, £1,554k).

Note 15.1 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**10,486**	**111,937**	**15,431**	**2,146**	**84**	**2,283**	**1,347**	**143,714**
Additions	-	6,807	21,380	123	-	-	-	**28,310**
Impairments	(26)	(27,637)	-	-	-	-	-	**(27,663)**
Reversals of impairments	63	1,727	-	-	-	-	-	**1,790**
Revaluations	365	(2,157)	-	-	-	-	-	**(1,792)**
Reclassifications	-	10,112	(10,112)	-	-	-	-	**-**
Valuation/gross cost at 31 March 2021	**10,888**	**100,789**	**26,699**	**2,269**	**84**	**2,283**	**1,347**	**144,359**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**-**	**-**	**774**	**84**	**1,695**	**1,347**	**3,900**
Provided during the year	-	3,476	-	176	-	147	-	**3,799**
Revaluations	-	(2,173)	-	-	-	-	-	**(2,173)**
Accumulated depreciation at 31 March 2021	**-**	**1,303**	**-**	**950**	**84**	**1,842**	**1,347**	**5,526**
Net book value at 31 March 2021	**10,888**	**99,486**	**26,699**	**1,319**	**-**	**441**	**-**	**138,833**
Net book value at 1 April 2020	**10,486**	**111,937**	**15,431**	**1,372**	**-**	**588**	**-**	**139,814**

* Revaluations within both valuation and accumulated depreciation of buildings includes the write out of depreciation amounts following a revaluation exercise.

Note 15.2 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**11,832**	**97,247**	**23,075**	**2,032**	**84**	**1,994**	**1,347**	**137,611**
Additions	-	25,787	11,762	114	-	289	-	**37,952**
Impairments	(2,282)	(31,411)	-	-	-	-	-	**(33,693)**
Reversals of impairments	97	6,117	-	-	-	-	-	**6,214**
Revaluations	20	(2,209)	-	-	-	-	-	**(2,189)**
Reclassifications	3,000	16,406	(19,406)	-	-	-	-	**-**
Transfers to assets held for sale	(2,181)	-	-	-	-	-	-	**(2,181)**
Valuation/gross cost at 31 March 2020	**10,486**	**111,937**	**15,431**	**2,146**	**84**	**2,283**	**1,347**	**143,714**
Accumulated depreciation at 1 April 2019 - as previously stated	**-**	**-**	**-**	**618**	**84**	**1,527**	**1,347**	**3,576**
Provided during the year	-	4,455	-	156	-	168	-	**4,779**
Revaluations	-	(4,455)	-	-	-	-	-	**(4,455)**
Accumulated depreciation at 31 March 2020	**-**	**-**	**-**	**774**	**84**	**1,695**	**1,347**	**3,900**
Net book value at 31 March 2020	**10,486**	**111,937**	**15,431**	**1,372**	**-**	**588**	**-**	**139,814**
Net book value at 1 April 2019	**11,832**	**97,247**	**23,075**	**1,414**	**-**	**467**	**-**	**134,035**

Note 15.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021						
Owned - purchased	10,888	94,131	26,699	1,319	441	**133,478**
On-SoFP PFI contracts and other service concession arrangements	-	5,355	-	-	-	**5,355**
NBV total at 31 March 2021	**10,888**	**99,486**	**26,699**	**1,319**	**441**	**138,833**

Note 15.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020						
Owned - purchased	10,486	106,421	15,431	1,372	588	**134,298**
On-SoFP PFI contracts and other service concession arrangements	-	5,516	-	-	-	**5,516**
NBV total at 31 March 2020	**10,486**	**111,937**	**15,431**	**1,372**	**588**	**139,814**

Note 16 Investment Property

The trust has no investment property (2019/20, £nil).

Note 17 Investments in associates and joint ventures

The trust has no investments in associates or joined controlled operations consolidated in these accounts as at 31 March 2021 (31 March 2020, £nil) on the basis of materiality (as disclosed in note 1).

Note 18 Other investments / financial assets (non-current)

The trust has no other investments / financial assets (non-current) at 31 March 2021, (2019/20, £nil).

Note 18.1 Other investments / financial assets (current)

The trust has no other investments / financial assets (current) at 31 March 2021, (2019/20, £nil).

Note 19 Inventories

	31 March 2021 £000	31 March 2020 £000
Drugs	208	189
Consumables	799	557
Total inventories	**1,007**	**746**

Inventories recognised in expenses for the year were £4,647k (2019/20: £520k). There was no write down of inventories during 2020/21 (2019/20 £nil).

In response to the Coronavirus pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the trust received £3,901k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 20.1 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	15,691	18,207
Allowance for impaired contract receivables	(6,262)	(6,331)
Prepayments (non-PFI)	5,529	4,930
PFI lifecycle prepayments	465	982
PDC dividend receivable	1,359	413
VAT receivable	1,010	1,086
Other receivables	130	113
Total current receivables	**17,922**	**19,400**
Non-current		
Other receivables	524	498
Total non-current receivables	**524**	**498**
Of which receivable from NHS and DHSC group bodies:		
Current	6,569	9,954
Non-current	491	462

Note 20.2 Allowances for credit losses

	2020/21 Contract receivables and contract assets £000	2019/20 Contract receivables and contract assets £000
Allowances as at 1 April - brought forward	**6,331**	**6,284**
New allowances arising	50	47
Reversals of allowances	(119)	-
Allowances as at 31 Mar 2021	**6,262**	**6,331**

Note 20.3 Exposure to credit risk

	2020/21 receivables £000	2019/20 receivables £000
Non-impaired receivable past their due date by:		
0 - 30 days	870	979
30-60 Days	159	395
60-90 days	34	429
90- 180 days	46	666
over 180 days	1,442	1,003
Total	**2,551**	**3,472**

Note 21 Other assets

The trust has no other assets as at 31 March 2021 (31 March 2020, £nil).

Note 22.1 Non-current assets held for sale and assets in disposal groups

	2020/21	2019/20
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**1,080**	**-**
Assets classified as available for sale in the year	-	2,181
Impairment of assets held for sale	-	(1,101)
NBV of non-current assets for sale and assets in disposal groups at 31 March	**1,080**	**1,080**

Cardale Park land was classified as an asset held for sale in 2019/20 and the trust anticipates it will be sold during the 2021/22 financial year.

The sale of this asset does not impact on the trust's ability to meet its obligation to provide commissioner requested services as no sales are authorised without full consideration of the impact on service provision.

Note 22.2 Liabilities in disposal groups

The trust has no liabilities in disposal groups as at 31 March 2021 (31 March 2020, £nil).

Note 23.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2020/21	2019/20
	£000	£000
At 1 April	**76,914**	**72,728**
Net change in year	4,022	4,186
At 31 March	**80,936**	**76,914**
Broken down into:		
Cash at commercial banks and in hand	179	275
Cash with the Government Banking Service	80,757	76,639
Total cash and cash equivalents as in SoCF	**80,936**	**76,914**

Note 23.2 Third party assets held by the trust

Tees, Esk and Wear Valleys NHS Foundation Trust held cash and cash equivalents which relate to monies held by the trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2021	31 March 2020
	£000	£000
Bank balances	850	778
Total third party assets	**850**	**778**

Note 24.1 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	8,778	7,536
Capital payables	4,213	3,785
Accruals	26,362	20,663
Social security costs	3,604	3,192
VAT payables	1,283	1,253
Other taxes payable	2,771	2,521
Total current trade and other payables	**47,011**	**38,950**
Of which payables from NHS and DHSC group bodies:		
Current	3,951	3,937

The trust has no non current trade and other payables (2019/20 £nil).
The Directors consider that the carrying amount of trade payables approximates to their fair value.

Note 24.2 Early retirements in NHS payables above
There were no early retirement costs in the NHS payables balance at 31 March 2021 (2019/20, £nil).

Note 25 Other liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	1,595	254
Total other current liabilities	**1,595**	**254**

Non-current

The trust has no other non current liabilities (2019/20, £nil)

Note 26.1 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Other loans	238	238
Obligations under PFI, LIFT or other service concession contracts	652	579
Total current borrowings	**890**	**817**
Non-current		
Other loans	238	476
Obligations under PFI, LIFT or other service concession contracts	12,066	12,718
Total non-current borrowings	**12,304**	**13,194**

PFI borrowings are in relation to Lanchester Road Hospital which operates under a standard form PFI contract i.e. unitary payments are payable from the date of construction completion and are not subject to re-pricing. Inflation linked to RPI is applied annually. Final settlement is expected in May 2038.

Note 26.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Other loans	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**-**	**714**	**13,297**	**14,011**
Cash movements:				
Financing cash flows - payments and receipts of principal	-	(238)	(580)	**(818)**
Financing cash flows - payments of interest	-	-	(619)	**(619)**
Non-cash movements:				
Application of effective interest rate	-	-	620	**620**
Carrying value at 31 March 2021	**-**	**476**	**12,718**	**13,194**

Note 26.3 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Other loans	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2019	**3,018**	**952**	**13,829**	**17,799**
Cash movements:				
Financing cash flows - payments and receipts of principal	(3,000)	(238)	(533)	**(3,771)**
Financing cash flows - payments of interest	(30)	-	(645)	**(675)**
Non-cash movements:				
Application of effective interest rate	12	-	646	**658**
Carrying value at 31 March 2020	**-**	**714**	**13,297**	**14,011**

Note 27 Other financial liabilities

The trust has no other financial liabilities at 31 March 2021 (31 March 2020, £nil).

Note 28 Finance leases

The trust does not have any finance lease obligations other than PFI commitments (2019/20, £nil).

Note 29.1 Provisions for liabilities and charges analysis

	Pensions: injury benefits	Legal claims*	Other**	Total
	£000	£000	£000	£000
At 1 April 2020	**3,355**	**204**	**4,435**	**7,994**
Change in the discount rate	139	-	-	**139**
Arising during the year	113	90	4,980	**5,183**
Utilised during the year	(144)	(69)	-	**(213)**
Reversed unused	(559)	(43)	(917)	**(1,519)**
Unwinding of discount	(25)	-	-	**(25)**
At 31 March 2021	**2,879**	**182**	**8,498**	**11,559**
Expected timing of cash flows:				
- not later than one year;	158	182	7,213	**7,553**
- later than one year and not later than five years;	632	-	924	**1,556**
- later than five years.	2,089	-	361	**2,450**
Total	**2,879**	**182**	**8,498**	**11,559**

*Legal claims relate to employer / public liability claims notified by the NHS Litigation Authority.

**Other provisions relate to potential clinical penalties, an employment tribunal linked to holiday pay, potential contract refunds and a provision for clinical pensions tax reimbursement. No provision has been made relating to the 2018 PFI Termination; this is disclosed under Note 30 - Contingent Liabilities.

Note 29.2 Clinical negligence liabilities

At 31 March 2021, £1,854k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Tees, Esk and Wear Valleys NHS Foundation Trust (31 March 2020: £1,514k).

Note 30 Contingent assets and liabilities

	31 March 2021 £000	31 March 2020 £000
Value of contingent liabilities		
NHS Resolution legal claims	(116)	(152)
Net value of contingent liabilities	**(116)**	**(152)**

The contingencies relate to employer liability legal cases, all cases relate to NHS Resolution and are due within 1 year.

The trust has a potential liability linked to a prior year PFI Contract termination. The trust is currently engaged in seeking to agree a pre-action protocol type process under the terms of a court order in order to rebut any related liability. This is with Three Valleys Healthcare Limited (in liquidation – the former PFI provider) and the liquidators of that company. Any resultant mediation process will take some months to complete. If the mediation process does not secure an agreement then further legal proceedings will follow.

It is the trust's opinion that disclosure of any potential (or range of) liability may prejudice this process, and it is applying the disclosure exemption available under IAS 37.

Note 31 Contractual capital commitments

	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	2,981	20,903
Total	**2,981**	**20,903**

Note 32 Other financial commitments

The trust has no other financial commitments as at 31 March 2021 (31 March 2020, £nil).

Note 33 Defined benefit pension schemes

The trust does not operate an on-statement of financial position pension scheme.

Note 34 On-SoFP PFI, LIFT or other service concession arrangements

The trust has full control of clinical services provided from its PFI funded hospital (Lanchester Road), and full access and use of the buildings, which are maintained by the PFI project company as part of the PFI procurement contract.

The PFI project company provides services for “hard” facilities management including building maintenance and life cycle replacement programmes. A contractual commitment exists for the PFI project company to maintain the building at “category b” status for the contract life (30 years from commencement for Lanchester Road).

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 34.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2021 £000	31 March 2020 £000
Gross PFI, LIFT or other service concession liabilities	**31,597**	**33,604**
Of which liabilities are due		
- not later than one year;	1,742	1,658
- later than one year and not later than five years;	6,229	6,497
- later than five years.	23,626	25,449
Finance charges allocated to future periods	(18,879)	(20,307)
Net PFI, LIFT or other service concession arrangement obligation	**12,718**	**13,297**
- not later than one year;	652	579
- later than one year and not later than five years;	2,091	2,232
- later than five years.	9,975	10,486

Note 34.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2021 £000	31 March 2020 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**49,768**	**50,389**
Of which payments are due:		
- not later than one year;	2,333	2,214
- later than one year and not later than five years;	9,929	9,423
- later than five years.	37,506	38,752

Note 34.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2020/21	2019/20
	£000	£000
Unitary payment payable to service concession operator	**2,270**	**2,161**
Consisting of:		
- Interest charge	620	646
- Repayment of balance sheet obligation	580	533
- Service element and other charges to operating expenditure	529	462
- Capital lifecycle maintenance	83	75
- Contingent rent	458	410
- Addition to lifecycle prepayment	-	35
Total amount paid to service concession operator	**2,270**	**2,161**

Note 35 Off-SoFP PFI, LIFT and other service concession arrangements

The trust has no off-SoFP PFIs as at 31 March 2021 (31 March 2020, £nil).

Note 36 Financial instruments

Note 36.1 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 and 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 and NHS England Commissioners, both of 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.

Note 36.2 Carrying values of financial assets

All of the trust's financial assets are carried at amortised cost. Fair value is not considered to be significantly different from book value.

Carrying values of financial assets as at 31 March 2021	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non financial assets	9,462	**9,462**
Cash and cash equivalents	80,936	**80,936**
Total at 31 March 2021	**90,398**	**90,398**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non financial assets	11,912	**11,912**
Cash and cash equivalents	76,914	**76,914**
Total at 31 March 2020	**88,826**	**88,826**

Note 36.3 Carrying values of financial liabilities

All of the trust's other financial liabilities are carried at amortised cost. Fair value is not considered significantly different from book value

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost £000	Total book value £000
Obligations under PFI, LIFT and other service concession contracts	12,718	**12,718**
Other borrowings	476	**476**
Trade and other payables excluding non financial liabilities	39,353	**39,353**
Provisions under contract	182	**182**
Total at 31 March 2021	**52,729**	**52,729**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost £000	Total book value £000
Obligations under PFI, LIFT and other service concession contracts	13,297	**13,297**
Other borrowings	714	**714**
Trade and other payables excluding non financial liabilities	31,984	**31,984**
Provisions under contract	204	**204**
Total at 31 March 2020	**46,199**	**46,199**

Note 36.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021 £000	31 March 2020 restated* £000
In one year or less	41,515	34,084
In more than one year but not more than five years	6,467	6,973
In more than five years	23,626	25,449
Total	**71,608**	**66,506**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 37 Losses and special payments

	2020/21		2019/20	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	1	-	2	1
Total losses	**1**	**-**	**3**	**1**
Special payments				
Ex-gratia payments	13	3	43	14
Total special payments	**13**	**3**	**43**	**14**
Total losses and special payments	**14**	**3**	**46**	**15**

The trust received no compensation payments (2019/20 £45k)

Note 38 Related parties

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 and Social Care is regarded as the parent department, and a related party. During the period Tees, Esk and Wear Valleys NHS Foundation trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department, or a related party. The trust also has a non consolidated charity, for which it acts as the sole corporate trustee.

The main entities that the trust has dealings with are its commissioners, namely;

NHS England
NHS Tees Valley CCG
NHS County Durham CCG
NHS North Yorkshire CCG
NHS Vale of York CCG
Health Education England

The trust also has material expenditure with the following:

NHS Pension Scheme
HM Revenue & Customs

The related parties disclosure below includes organisations the trust has a joint venture, subsidiary or other partnership arrangement with. The trust is not required to report other public bodies as related parties.

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.

2020/21 Entity	Income £000	Expenditure £000	Receivables £000	Payables £000
Non-consolidated subsidiaries and associates / joint ventures	74	-	765	2
Other bodies or persons outside of the whole of government accounting boundary	100	74	98	-
Value of provisions for doubtful debts held against related parties (excludes salaries)	-	-	(98)	-
Total balances with related parties	**174**	**74**	**765**	**2**

2019/20 Entity	Income £000	Expenditure £000	Receivables £000	Payables £000
Non-consolidated subsidiaries and associates / joint ventures	25	65	793	-
Other bodies or persons outside of the whole of government accounting boundary	-	1,320	217	-
Value of provisions for doubtful debts held against related parties (excludes salaries)	-	-	(217)	-
Total balances with related parties	**25**	**1,385**	**793**	**-**

Note 39 Events after the reporting date

The trust has no events after the reporting period to disclose.

If you would like additional copies of this report please contact:

The communications team
Tees, Esk and Wear Valleys NHS Foundation Trust
West Park Hospital
Edward Pease Way
Darlington
DL2 2TS
Email: tewv.enquiries@nhs.net
Tel: 01325 552223

Our Chairman, Directors and Governors can be contacted via the Trust Secretary's office at West Park Hospital (see above address).
Tel: 01325 552314
Email:tewv.ftmembership@nhs.net

For more information about the Trust and how you can get involved visit our website www.tewv.nhs.uk

Tees, Esk and Wear Valleys
NHS Foundation Trust

Office of the Chief Executivet
West Park Hospital
Edward Pease Way
Darlington
DL2 2TS

Telephone: 01325 552077

24 June 2021

Cameron Waddell
The Corner
Bank Chambers
26 Mosley Street
Newcastle upon Tyne
NE1 1DF

Dear Cameron

Tees, Esk and Wear Valleys NHS Foundation Trust, including group - audit for year ended 31 March 2021

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 2021 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with the DHSC 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 Accountable 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 or Group 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 Accountable 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 or Group 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 and intangible assets below their carrying value at the statement of financial position date. An impairment review is therefore not considered necessary.

Charges on assets

All the Trust's assets are free from any charges exercisable by third parties except as disclosed within the financial statements.

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.

Service Concession Arrangements

I am not aware of any material contract variations, payment deductions or additional service charges in 2020/21 in relation to the Trust PFI schemes that you have not been made aware of.

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.

Other matters

I can confirm in relation to the following matters that:

- Brexit - we have assessed the potential impact of the United Kingdom leaving the European Union and that any disclosure in the Annual Report fairly reflects that assessment.
- COVID-19 - we have assessed the impact of the COVID-19 Virus pandemic on the Trust and the financial statements, including the impact of mitigation measures and uncertainties, and are satisfied that the financial statements and supporting notes fairly reflect that assessment.

Going concern

I confirm that I have carried out an assessment of the potential impact of the COVID-19 Virus pandemic on the Trust, including the impact of mitigation measures and uncertainties and am satisfied the going concern assumption remains appropriate and that no material uncertainty has been identified.

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.

Annual Governance Statement

I am satisfied that the Annual Governance Statement (AGS) fairly reflects the Trust's risk assurance and governance framework and I confirm that I am not aware of any significant risks that are not disclosed within the AGS.

Annual Report

The disclosures within the Annual Report and Remuneration Report fairly reflect my understanding of the Trust's financial and operating performance over the period covered by the financial statements

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

Unadjusted misstatements

I confirm that there are no unadjusted misstatements.

Yours faithfully

Brent Kilmurray
Accounting Officer

Contact: Andrea Petty
Direct Tel: 03000 267312
email: andrea.petty@durham.gov.uk
Your ref:
Our ref:

Sharon Pickering
Director of Planning, Performance and Communications
Tees, Esk and Wear Valleys NHS Foundation Trust
Tarncroft
Lanchester Road Hospital
Durham
DH1 5RD

23 June 2021

Dear Sharon

Re: Tees, Esk & Wear Valleys NHS Foundation Trust Quality Account 2020-21

Thank you for the opportunity to comment on the Tees, Esk and Wear Valleys NHS Foundation Trust Quality Account 2020-21. The County Durham Health and Wellbeing Board appreciate this transparency and have taken account of the impact of Covid-19 on the Quality Accounts, as well as the delays and changes brought about by this and as such would like to provide the following comments on the document.

We acknowledge performance against the following four priority areas of improvement for 2020-21 and wish to provide feedback against these:

Priority 1: Improve the clinical effectiveness and patient experience in times of transition from child to adult services
Priority 2: Reduce the number of preventable deaths
Priority 3: Making care plans more personal
Priority 4: Increasing the proportion of inpatients who feel safe on wards

Moving forward the Board note that there will be three priority areas for 2021-22:

Priority 1: Making care planning more personal
Priority 2: Safer care
Priority 3: Compassionate care

The Health and Wellbeing Board supports the Trust's 2021-22 priorities for improvement and notes that the two priorities *Reduce the number of preventable deaths* and *Increasing the proportion of inpatients who feel safe on wards* have been amalgamated into a new 'safer care' priority.

It is also noted that the priority to *Improve the clinical effectiveness and patient experience in times of transition from child to adult services* will not be carried forward to 2021-22, and as such, actions in relation to this priority have been removed from the quality account.

The Board note that *Compassionate Care* is a new priority for 2021-22 and are aware of the actions identified under this priority area.

It is important that the Quality Account aligns, where appropriate to the County Durham Joint Health and Wellbeing Strategy 2021-25, and the County Durham Place Based Commissioning Plan which have been agreed through the County Durham Health and Wellbeing Board.

The Health and Wellbeing Board adopts a life course approach to its priorities, recognising the importance of mental health, wellbeing and the social determinants of health cutting across our priorities. The three TEWV priorities for improvement align with our three strategic priorities of Starting Well, Living Well and Ageing Well.

As part of the development of the Joint Health and Wellbeing Strategy 2021-25 we worked with young people through Investing in Children and Durham Youth Council to gather their views. Young People agreed that mental health should be a priority, especially given the impact of the pandemic as it has been difficult throughout the pandemic for young people to maintain routines and enjoy aspects of normal life. The restrictions have made accessing help and support more problematic and have made young people feel isolated from friends and family, whether this is physical isolation or due to restricted access to technology. Young people feel that Mental Health services should be more accessible and should be in an open and comfortable environment.

Positive partnership working in County Durham is evidenced through a number of different partnership boards including the Mental Health Strategic Partnership Board, Children, Young People and Families Partnership Board and the Resilient Communities Group.

The Health and Wellbeing Board shared the TEWV “Big Conversation” widely with partners to ensure the opportunity was available to share views to help further develop areas of focus which will influence part of the TEWV business plan for the next three years.

The Health and Wellbeing Board note that the establishment of the Child and Adolescent Mental Health Services (CAMHS) single point of access for referrals and self-referrals to CAMHS services as a positive development. The Board also welcome the introduction of a new freephone line, available 24 hours a day, seven days a week, which will make it easier for people in mental health distress to access urgent help.

Although the priority to ‘Improve the clinical effectiveness and patient experience in times of transition from child to adult services has not been identified as a priority in the Quality Account for 2021-22, we are pleased to hear that this work has been superseded by the ‘Improving transitions and service provision for people aged 16 to 25 years in TEWV NHS Foundation Trust’ and that this is linked to the wider work around the NHS England CAMHS whole pathway commissioning. As part of the overall integration work for County Durham our transitions pathway for 14-25 year olds will work with local partners across children and adult services to develop and implement new ways of working to provide better and more integrated support for 14-25 year olds with their education, health, care and housing needs. It is important that we ensure these pathways work in harmony. The Board would welcome updates on these developments as the progress of this work is integral to the overall integration work for County Durham.

Making care plans more personal
The Board acknowledge that the impact of Covid has had a significant impact on this area during the last year and note that the lead for this work has been redeployed to support the work around the Covid response.

It is positive that some training courses have been delivered to trainee and newly qualified nurses, albeit at a lesser extent than anticipated. The continued emphasis on workforce development is recognised, to ensure the workforce has the right skills to enable them to undertake their roles safely and effectively. Continued training and development provides assurance that care planning will be meaningful and undertaken in a timely way by experienced professionals to minimise the need to do this when an individual is in distress.

It is noted that none of the performance indicator targets have been achieved, and although the Board acknowledges that service users are more likely to provide feedback should they have a negative experience of the service, which will be reflected in the performance indicators, we would encourage the Trust to continue to work towards gathering feedback from service users across the board to ensure that a range of views are reflected.

The Health and Wellbeing Board are keen to ensure that moving forward care planning is based on shared decision making, and co-production which focuses on meeting the needs of individual patients rather than the needs of the service. It is reassuring to see that a steering group will be established to oversee the development and implementation of this, and that co-created guidance on writing good care plans will be developed.

Improve the clinical effectiveness and patient experience in times of transition from CYP to AMH services
It is noted that the majority of actions under this priority were suspended due to the pandemic and moving forward will be superseded by the work to implement 'Improving transitions and service provision for people aged 16 to 25 years in TEWV NHS Foundation Trust' which is linked to the wider work around the NHS England CAMHS whole pathway commissioning.

However, it is acknowledged that TEWV maintained improvement targets in terms of actual numbers and saw an extra 703 young people through their transition period and that transition plans were completed for an extra 784 young people during 2020-21 (compared to 2018-19). The Board recognise this achievement given the challenges of the ongoing pandemic, alongside extremely high caseloads.

Moving forward, the Board would encourage the use of modern technology to support young people as they often tell us this is their preferred method of communication, however caution must be taken not to exclude those who are not able to access this.

Reduce the number of preventable deaths
The plans to review and investigate deaths and involve families and carers in the process is welcomed as this will offer wider perspective on the whole pathway of care received which will inform learning and shape practice improvements.

The Board acknowledges that 11 patient safety briefings have taken place to support early learning from incidents, and that staff awareness of these briefings has been enhanced.

It is unfortunate that the Family Conference engagement events were unable to go ahead due to the pandemic, but it is hoped this can be re-established following the success of the 2019 event, as these can provide valuable service user feedback which plays a crucial part in shaping services as we move forward.

It is positive that the 48 hours follow up for all patients discharged from AMH services is now fully introduced.

Whilst it is acknowledged that TEWV are working to eliminate preventable deaths through a range of improvement programmes, it is noted that sadly one patient's review indicates that their death may have been preventable, and we understand that another inpatient death review is due to be completed by August 2021. The Board works closely with the Safeguarding Partnerships and we continue to promote that safeguarding is everyone's business and advocate for improvements in this area.

Increasing the proportion of inpatients who feel safe on wards
It is assuring to know that there is a renewed and concentrated focus to increase the proportion of inpatients who feel safe on wards, and that this is a priority for the Trust.

It is concerning that the deep dive indicated that the main reason patients do not feel safe on wards is due to the environment, their illness, other patients and staffing and the Board would strongly advocate an improvement in this area.

It is promising to see the innovative ways of technology being used in care settings, and that the Oxehealth Digital Health Care Assistant has been trialled in three wards, and that approval has been given to roll this out to a further 12 wards. It is noted that the body camera KPIs have not been monitored during 2020-21 due to the pandemic, but that this pilot will continue into 2021-22 and will be rolled out to a further five wards.

The Health and Wellbeing Board understands that liaison with the Police is now embedded across the Trust as business as usual.

The Board support the evidence based 'Safe Wards' intervention model which has been implemented, and would welcome feedback on the review of local interventions, as consideration could be given to implementing some of these ideas when mental health support is being provided in other areas e.g. calm down boxes.

It is noted that across 2021-22 TEWV will work towards implementing the safer care priority by implementing a range of actions, for example to share the agreed patient safety priorities, benchmarking patient experience data, implement an organisational learning group and implementing mechanisms to assess the impact of organisational learning.

Serious Incidents
The number of serious incidents increased in 2019-20 and has not reduced during 2020-21, which is concerning. The Board were informed by TEWV that the Care Quality Commission (CQC) took enforcement action against them during 2020-21, however it is noted that since the inspection TEWV have invested £5.4 million in staffing, with a specific focus on inpatient services, seven day capacity and quality governance. The Board note that a Quality Improvement Board has been put in place to oversee quality assurance

standards and to provide assurance to the Trust Board that actions are being taken to address patient safety.

We look forward to continuing to work with TEWV as an important partner around the Health and Wellbeing Board to achieve our vision of being “a healthy place, where people live well for longer”.

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 Paul Sexton
Chair of the County Durham Health and Wellbeing Board
Cabinet Portfolio Holder for Adult and Health Services

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24 June 2021**
TITLE:	**Approval of accounts for the financial year ended 31 March 2021**
REPORT OF:	**Liz Romaniak, Director of Finance and Information**
REPORT FOR:	**Approval**

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

Executive Summary:

The Board is required to approve and formally adopt the accounts for the period ended 31 March 2021 for submission to NHS Improvement.

The Trust reported a **deficit** for the financial year of £16,741k. After deducting impairments the Trust has a **surplus** of £9,100k.

This was higher than planned mainly due to receipt of unplanned non-recurrent income streams (see section 3.1 for more detail).

Recommendations:

The Board of Directors is requested to adopt the accounts and authorise the auditors to submit them as the audited accounts of the Trust for the period ended 31 March 2021 to NHS Improvement.

The Board of Directors has previously supported a recommendation from the Audit & Risk Committee that the Trust should be considered as a going concern and that the year-end accounts should be prepared on that basis.

The Board of Directors is asked to confirm that by approving the annual report they are confirming as far as they are aware, there is no relevant information of which the Trust's auditors are unaware.

The Board of Directors is asked to confirm that in approving the annual report they agree to the Modern Slavery Act 2015 statements included in the annual report.

MEETING OF:	**Board of Directors**
DATE:	**24 June 2021**
TITLE:	**Approval of accounts for the financial year ended 31 March 2021**

1. PURPOSE OF REPORT

1.1 The purpose of this report is to ask the Board of Directors to approve the accounts for the period ended 31 March 2021.

2. BACKGROUND

2.1 In line with statutory requirements the Board is required to approve and formally adopt the accounts for the period ended 31 March 2021 for submission to NHS England / Improvement, the Independent Regulator for NHS Foundation Trusts.

2.2 Mazars LLP has carried out an audit of the accounts and they presented the outcome of the audit to the Audit & Risk Committee on the 18 June 2021.

3. KEY ISSUES

3.1 Key areas of Performance

The Audit & Risk Committee (ARC) received a copy of the unaudited accounts on 13 May 2021. A copy of the latest unaudited accounts for 2020-21 is enclosed within Appendix 1 (please note at time of delivery these are not signed off by Audit, however the planned audit has completed, with an unqualified opinion provided by Mazars – any updates will be tabled); these were shared with the ARC on 18 June 2021. The highlights are summarised below;

Income
Total operating income for the financial year ended 31 March 2021 was £423.3m which was higher than the previous year. There were variations within headings, as per below:

Income from activities increased by £25.6m, mainly due to:

- £9.6m non-recurrent national income to support the NHS response to the Covid-19 pandemic.
- £5.5m contract and sub-contract changes for specialised and prison services.
- £6.6m non-recurrent national income to offset elevated untaken annual leave costs, holiday pay (Flowers) provisions and the 6.3% increase in employer pension contributions.
- Remaining movements reflect additional investment in mental health services and inflation.

Other operating income increased by £12.0m, mainly due to:

- £8.9m non-recurrent funding received through national financial top up arrangements in the first 6 months of the year and to account for supplies including personal protective equipment.
- £3.3m increase in training income linked to additional placements within IAPT and of student nurses

Operating Expenses

Total operating expenses increased during 2020-21, mainly due to the reasons detailed below.

Pay Expenditure increased £32.7m, mainly due to:

- Increased staffing levels (average increase of 557 WTE, or around 8%) during the year to support the Covid response and to progress mental health investments including those linked to the Long Term Plan; £17m.
- Elevated annual leave accruals, an increase in the Trust's holiday pay (Flowers) provisions, the impact of the 6.3% uplift on employer contributions on NHS pensions and the impact of nationally negotiated pay awards £12.3m.

Non Pay Expenditure increased £5.7m, mainly due to:

- £3.9m accounting for Covid supplies procured through national DHSC arrangements.
- £0.9m increased statement of financial position provisions, offset by reductions in travel expenditure arising due to pandemic lockdown restrictions.

Surplus / Deficit for the year

The Trust reported a **deficit** for the year of £16,741k. When adjusted to exclude impairments (the basis on which financial performance is assessed); the Trust achieved an adjusted **surplus** of £9,100k; which was higher than planned mainly due to higher than planned non-recurrent income streams.

This adjusted surplus was in excess of the Trust's agreed financial target as detailed below;

	£000
(Deficit) for the year	(16,741)
Remove impact of impairments	25,841
Surplus for control total performance	**9,100**
(Deficit) Opening Plan Requirement*	(1,998)
Ahead of control total by	**11,098**

*Note – whilst the Trust's original plan for the second half of 2020/21 was a deficit of £1.998m, the Trust received £2.6m unplanned NHSE income in that period and agreed with regional NHSE/I leads to deliver an improved financial outturn of at least £0.6m. This was therefore the adjusted financial target against which financial performance was reported by the Trust.

Statement of Financial Position

Property, Plant and Equipment have decreased over the year by £981k, as follows:

	£000
Property, Plant and Equipment NBV 31 March 2020	**139,814**
Additions	28,310
Depreciation	(3,799)
Impairments - Operating expenses	(25,841)
Revaluation gains - Revaluation reserve	349
Property, Plant and Equipment NBV 31 March 2021	**138,833**

Cash at bank and in hand has increased by £4.02m to £80.9m. The increase reflects the operating surplus offset by in-year capital investment (costs of which were offset due to bids to secure national capital funding and from VAT recovery) as well as working capital variations, including provision increases and an elevated untaken leave accrual.

3.2 Items of note in the accounts

There are items of special note in the accounts for 2020-21 which have been discussed with the Trust's auditors.

- The property valuation movements of £25.5m.
- A contingent liability linked to the termination of the Roseberry Park Hospital Private Finance Initiative (PFI).
- All provisions, including one held for the Flowers legal case linked to holiday pay on overtime and additional hours worked.
- Technical entries to account for DHSC procured supplies to support the pandemic response.

3.3 Explanations to some notes in the accounts

Some of the notes contained in the accounts require some guidance and the following explanation may be of assistance;

- After the main financial statements in the accounts there are notes on accounting policy (commencing page 8) which describe the basis on which the accounts have been completed. It summarises the methodology used and highlights any change in policy from last year.
- The 'financed by' section of the statement of financial position is predominately supported by the Statement of Changes in Taxpayers' Equity (page 5) and details the changes in the year.
- The supporting note to property, plant and equipment (note 17.1) shows a column headed 'assets under construction'. This relates to schemes in the capital programme that were not completed at 31 March 2021 and in line with capital accounting policy these cannot be capitalised. The £26.7m at the end of 2020-21 related largely to developments at Roseberry Park and Kings Park.
- Details of the Trust's PFI schemes in operation are shown under note 34, page 47.

- Note 2.2 demonstrates how the Trust's performance is measured against the agreed financial plan. A reference to this note is included on the SoCI. The plan target of (£1,998k deficit) is different to that reported to Board during 2020/21 as the Trust agreed an improved target of £0.6m with its ICS during the year, this did not change the NHSE/I plan.

3.4 Annual Governance Statement

The Annual Governance Statement included in the annual report (agenda item 10) has been reviewed by Mazars LLP and the Audit & Risk Committee.

3.5 Annual Report

The disclosure to auditors' statement is also included within the annual report (agenda item 10). This disclosure states the Board of Directors confirm as far as members are aware, there is no relevant information of which the Trust's auditors are unaware.

3.6 Going Concern

NHS Foundation Trusts are required to prepare their accounts in accordance with relevant accounting rules. One of the requirements is to prepare the accounts on a going concern basis unless an organisation is to cease trading or there are significant doubts on the organisations ability to continue as a going concern.

Those charged with governance (i.e. the Board) need to consider whether this Trust is clearly a going concern. A Trust is considered a Going Concern provided it meets the following criteria:

"The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern."

The Audit & Risk Committee previously recommended to Board, who agreed that the Trust should be considered as a going concern and that the year end accounts should be prepared on that basis.

3.7 Audit

The audit of the Trust's Annual Accounts has largely completed and was reported to ARC 18th June 2021 with an unqualified opinion, and there were no unadjusted misstatements.

3.8 Submission

The Trust agreed the options for an extended submission date for the audited accounts to ensure that the annual report reflects the most up to date position regarding governance of the Trust. The accounts and annual report will both be submitted to NHSE/I on 29th June 2021.

4. IMPLICATIONS

4.1 There are no direct financial implications associated with this paper.

4.2 The Trust is required within the terms of its authorisation as a Foundation Trust to submit accounts to Parliament by 29 June 2020 (the Trust was granted the extended submission date to ensure its annual report reflected most recent governance information).

5. RISKS

5.1 There are no risks associated with this paper.

6. CONCLUSION

6.1 The Trust has prepared accounts in line with the requirements of NHSE/I and the Group Accounting Manual, with the audit process only making minor changes from the accounts submitted on the 27 April 2021.

7. RECOMMENDATIONS

7.1 The Board of Directors is requested to adopt the accounts and authorise the auditors to submit them as the audited accounts of the Trust for the period ended 31 March 2021 to NHS England / Improvement.

7.2 The Board of Directors previously agreed to adopt the recommendation of the Audit & Risk Committee that the Trust should be considered as a going concern and that the year-end accounts should be prepared on that basis.

7.3 The Board of Directors is asked to confirm that by approving the annual report they are confirming as far as they are aware, there is no relevant information of which the Trust's auditors are unaware.

7.4 The Board of Directors is asked to confirm that in approving the annual report they agree to the Modern Slavery Act 2015 statements included in the annual report.

Liz Romaniak
Director of Finance and Information

Associated Papers:
Audit & Risk Committee item 15 (Going Concern) (18th March 2021)
Audit & Risk Committee item 10 (Draft Annual Governance Statement) (13th May 2020)
Audit & Risk Committee item 5 (Draft Annual Report and Accounts) (18th June 2021)

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO.11

CONFIDENTIAL

BOARD OF DIRECTORS

DATE:	25th June 2021
TITLE:	Quality Account 2020/21
REPORT OF:	Sharon Pickering, Director of Planning, Commissioning, Performance & Communications Elizabeth Moody, Director of Nursing & Governance
REPORT FOR:	Assurance

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

Executive Summary:

The 20/21 Quality Account is attached. This includes a number of Board Statements of Assurance for sign off.

The development process for this year's Quality Account has been impacted upon by the ongoing impact of Covid-19 and its consequences for both national guidance and local capacity. The Trust has complied with as many of the requirements as possible, but some aspects of our normal process have been impacted on by Covid. However, we are intending to publish by the legal deadline and have given all stakeholders an opportunity to comment (although with a shortened time for consideration). All Stakeholder comments will be circulated to Board Members by email between 21st and 24th June and added as received in the relevant appendix to the published version of the document.

Some of the normally required data is not in the document because collection systems were suspended during the first wave of Covid-19. Nevertheless, the document paints a full picture of our performance on quality issues during 20/21.

In addition, the 3 quality improvement priorities for 21/22 are clearly linked to what our data is telling us, fully support Our Journey to Change and have been developed with significant clinical input. QuAC has discussed and approved the priority themes. The detailed actions have been developed by the appropriate leads. These will be added to the Trust Business Plan 2021/22-2023/24 at its next quarterly review.

As required by the statutory regulations, the document includes a number of Board Statements of Assurance (contained in part 2), and a range of statutory content in Part 3. This Committee and the Board of Directors can be assured that the content of these sections has been developed by the Head of Planning and Director of Quality Governance, drawing upon existing assurance discussed in the appropriate governance meeting.

Recommendations:

The Board of Directors are recommended to approve the submission / publication of the Quality Account, including the BoD Statements of Assurance

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**25th June 2021**
TITLE:	**Quality Account 2020/21**

1 INTRODUCTION AND PURPOSE

1.1 This report seeks Board of Directors' approval for the submission and publication of the 2020/21 Quality Account.

2 BACKGROUND INFORMATION AND CONTEXT

2.1 Historically, all organisations in receipt of significant NHS funding must produce a Quality Account. Foundation Trusts must incorporate this "Quality Report" into their Annual Report. There is an independent audit of the document and some of the indicator data within it.

2.2 In recognition of the pressure on NHS providers' capacity due to Covid 19, NHSE have waived some of their requirements for this year. This includes the independent audit requirement and the stipulation to include the Quality Account within the Annual report. The minimal guidance issued by NHSE is contained at **Appendix 1**

2.3 In 2019/20 the date for submission of the Quality Accounts was extended as a consequence of the pandemic and we were led to believe that there would be an extension for this year. We therefore agreed to work to an end of July deadline, in acknowledgment of the continuing pressures on some of the clinical staff involved in developing the document and the improvement priorities within it.

2.4 Unfortunately the Department of Health announced on 30th April that it was retaining the legal publication deadline of June 30th. Therefore we had to rapidly develop a revised timetable.

2.5 Our approach, in light of the legal uncertainties and formal detailed guidance around this year's document has been to

a) Include all of the content that has been legally required in the past, except where data collection systems were temporarily stood down during the first wave of the pandemic and hence that data is not available. We make clear in the document where this is the case
b) To utilise the Big Conversation feedback which took place during 20/21 as a substitute for the normal engagement on potential quality improvement priorities with commissioners, healthwatch and governors
c) To continue engagement with Overview and Scrutiny committees on request (Darlington and Tees Valley)
d) To give stakeholders a slightly reduced timescale to return comment to us (20 calendar days rather than the normal 30)
e) Publish in advance of the 30th June legal deadline, once the Board of Directors has approved the document

3 KEY ISSUES

3.1 The final draft of the Quality Account 2020/2021 is attached in **Appendix 2.**

3.2 As normal, the report includes "backwards looking" elements which give a picture of our quality performance in 20/21, and our quality improvement priorities which look forward to 2021/22. Our 3 Quality Improvement priorities are:

- Priority One: Making Care Plans more personal
- Priority Two: Safer Care
- Priority Three: Compassionate Care

3.3 There are some data gaps in 20/21 where data collection and reporting was stood down during the pandemic period. Other foundation trusts' quality account documents are likely to have similar gaps.

3.4 The quality improvement priorities were included in draft form in the Trust Business Plan which was approved by the Board of Directors in March 2021. These priorities are now more fully developed, but when the final version is approved by the Board the Trust's Business Plan will be changed in accordance to align with the newly agreed detail for the 3 2021/22 Quality Account priorities.

3.5 The following stakeholders were sent draft copies of the document on 1st June.

- Clinical Commissioning Groups (x4)
- Health & Wellbeing Boards (x9)
- Local Authority Overview & Scrutiny Committees (x8)
- Local Healthwatch organisations (x8)

We will be able to accept their responses up to 21st June, which will be circulated by email to all members of the Board of Directors and included, verbatim in appendix 4 of the document when it is published. We have agreed with Tees Valley overview and scrutiny committee that we will brief them on the document on 22nd June and they will provide a response on 23rd June. This will also be circulated to our Board of Directors by email.

3.6 The draft Quality Account has been considered by the QuAC and the Audit and Risk Committee and amendments made in light of comments received.

4 IMPLICATIONS

4.1. Compliance with the CQC Fundamental Standards

This is a key document which will help CQC build up a picture of the Trust's record on quality.

4.2. Financial/Value for Money

There are no direct financial implications associated with this report, however there may be some financial implications associated with improving performance where necessary. These will be identified as part of the action plans as appropriate.

4.3. Legal and Constitutional (including the NHS Constitution)

As discussed in section 2, the elements of the normal requirements under NHSE control have been waived, but the requirement to publish by 30th June (a legal issue under DH control) remains in place.

4.4. Equality and Diversity

In developing and implementing plans, the leads of each priority must take steps to consider whether any "protected group" will be disadvantaged and if so, consider mitigations.

4.5. Risks

By publishing the Quality Account before the legal deadline of 30th June the Trust should eliminate any risk of any regulatory action relating to this document. Where the Trust has not fully complied with past requirements, this can be linked to Covid. It will also be clear that the Trust has done the best that it can to adhere to the spirit of statutory requirements.

The risk of the content of the statutory assurance statements being incorrect is small because reporting mechanisms which are part of established Trust governance systems were used. In addition the document was fully reviewed by the Director of Quality Governance.

5.0 CONCLUSIONS

5.1 The development process for this year's Quality Account has been impacted upon by the ongoing impact of Covid-19 and its consequences for both national guidance and local capacity.

5.2 However, the document does paint a full picture of our performance on quality issues during 20/21. We have been able to use engagement with stakeholders through the Big Conversation to substitute for our normal engagement processes. We are on track to publish before the statutory deadline.

5.3 The 3 quality improvement priorities are clearly linked to what our data is telling us, fully support Our Journey to Change and have been developed with significant clinical input.

6. RECOMMENDATIONS

6.1 The Board of Directors are recommended to approve the submission / publication of the Quality Account, including the BoD Statements of Assurance

Chris Lanigan
Head of Planning and Business Development

Appendix 1 – NHSE Guidance

https://www.england.nhs.uk/financial-accounting-and-reporting/quality-accounts-requirements-2020-21/

Quality accounts requirements 2020/21

The Department of Health and Social Care (DHSC) has confirmed that the deadline to publish 2020/21 Quality Accounts remains **Wednesday 30 June 2021**. Where activities envisaged by the quality accounts regulations did not take place, owing to the exceptional challenges of 2020/21, trusts can disclose this was the case and their plans to reinstate them. Providers should continue to publish their Quality Accounts online. The functionality to upload accounts onto the NHS.uk website is no longer available. As an interim measure, trusts should also send reports to england.quality-accounts@nhs.net to be uploaded to their individual pages on the NHS England and NHS Improvement website.
NHS foundation trusts are not required to include a quality report in their annual report for 2020/21. For more information NHS foundation trusts should see NHS foundation trust annual reporting manual (FT ARM).

Tees, Esk and Wear Valleys
NHS Foundation Trust

2020 - 2021

Quality Account

Part One: Introduction and About Us

What is a Quality Account?

A Quality Account is an annual report around the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. Our Quality Account looks back on how well we have done in the past year at our achieving our goals. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

What are the aims of the Quality Account?

1. To help patients and their carers make informed choices about their healthcare providers
2. To empower the public to hold providers to account for the quality of their services
3. To engage the leaders of the organisation in their quality improvement agenda

Who reads the Quality Account?

Lots of different people read the Quality Account. Some are people who use our services, their carers, staff, commissioners and regulating bodies. We produce our report for anyone who wants to know more about the quality of our services, and how we plan to maintain and improve them.

What information can be found in the Quality Account?

In this report, you will find information about how we measure and review the quality of services that we provide. You will also find our priorities for improvements for the year ahead. Like all NHS healthcare providers, we measure the quality of our services by looking at:

- Patient Safety
- The effectiveness of treatments that patients receive
- How patients experienced the care provided

Structure of this Quality Account document

The structure of this Quality Account is in accordance with guidance that has been published by the Department of Health and 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 2020/21, our priorities for improvement in 2021/22 and the required statements of assurance from the Board and
- **Part 3:** Further information on how we have performed in 2020/21 against our key quality metrics and national targets and the national quality agenda

A profile of the Trust

The Trust provides a range of Mental Health, Learning Disability and Autism services for around two million people from Stanley and Seaham in the north to Selby and Wetherby in the south, and from Hartlepool and Whitby in the east to Harrogate and Weardale in the west The area we serve incudes the cities of York, Durham and Ripon, and the towns such as Middlesbrough, Darlington, Stockton, Northallerton, Bishop Auckland, Whitby, Hartlepool, Redcar, Harrogate and Scarborough.

The area covers 4,000 square miles (approximately 10,000 square kilometres). The Trust also provides some regional specialist services (for example, Forensic Services and Specialist Eating Disorder Services to the North East and North Cumbria 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 also in parts of the North West.

Services commissioned by Clinical Commissioning Groups (CCGs) are managed within the Trust on a geographical basis. This is through three geographic Locality based services; Durham and Darlington, Teesside and North Yorkshire and York. There is also a non-geographic 'Locality' which manages Forensic and Offender Health services. Each is led by a Director of Operations, Deputy Medical Director, Head of Nursing and Professional Lead for Psychology, who report to the Chief Operating Officer, Medical Director, Director of Nursing and Governance and Director of Therapies respectively.

Our Quality Account and Quality Governance

The Department of Health and NHS Improvement (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 2020/21.

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 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 contact with the Trust's patient advice and liaison service (PALS)
- **Care Quality Commission:** 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 Trust Board's Quality Assurance Committee (QuAC).

The QuAC receives formal reports from each of the LMGBs on a monthly basis.

We have recently developed a Quality Assurance Framework focusing upon the patient's clinical risk assessment and management. Our assurance programme utilises a range of methods such as Matron Walkabouts and clinical audit and leadership visits, involving a range of personnel. We will continue to build on this and broaden our focus.

We also normally 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 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 Trust's Clinical Assurance Framework.

Unfortunately we have been unable to undertake peer review inspections during 2020/21 due to the Covid-19 pandemic, however we plan to resume these as soon as restrictions allow.

In addition, each month members of the Executive Management Team (EMT) and 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. As above, we have been able to only hold these visits virtually instead of in person due to the Covid-19 pandemic, however plan to resume face-to-face as soon as we are able to do so.

The Trust also continues to develop its Integrated Information Centre (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 we review key information on quality that we provide, with a particular emphasis on providing assurance on the quality of our services. At these meetings, we also provide information on any thematic analyses or quality improvement activities we have undertaken and on our responses to national reports that have been published.

Whilst we are proud of our achievements over the past year, we are also aware that we have not always got it right; however we believe that by truly listening and working together we can make changes and improve the experience of TEWV for everyone.

Earlier this year, following an unannounced inspection from the Care Quality Commission (CQC), our acute wards for adults and psychiatric intensive care units were rated as 'inadequate' for both safe and well-led. The Trust is currently working on our improvement plans for the CQC and have given assurance that patients are safe on our wards.

We acknowledge that there is still work to do and that it is important to continue to take time for deeper reflection to ensure we take the right course of action and that the changes made are meaningful.

The challenges the Trust has faced over the last couple of years continued into 2020/21. The ongoing Covid-19 pandemic created risks and impacted the Trust's performance. Whilst it did not initially cause the extreme pressures felt elsewhere within the NHS, there were challenges in maintaining our service delivery due to increased infection prevention and control measures and social distancing.

During the second half of 2021/22, we started to experience the expected surge in demand and acuity relating to Covid-19, as social isolation and anxiety arising from the pandemic impacted the mental health of the population. This is expected to continue into 2021/22.

During the year, the findings of inspections and other reviews have given greater insight and clarity on the improvements required. Rapid progress has already been made in response to concerns raised by our regulators and in strengthening our governance processes. However, we do not underestimate the size of the task ahead.

The information contained within this report is accurate, to the best of my knowledge.

A full statement of Director's responsibilities in respect of the Quality Account is included in **Appendix 1.** 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:

- Elizabeth Moody (Director of Nursing & Governance) at: elizabeth.moody1@nhs.net
- Sharon Pickering (Director of Planning, Performance, Commissioning and Communications) at: sharon.pickering1@nhs.net
- Avril Lowery (Director of Quality Governance) at a.lowery1@nhs.net

This document has been shared for comment with Trust Governors, local Clinical Commissioning Groups (CCGs), Healthwatch Organisations and Health Overview and Scrutiny Committees. Responses to this consultation are included in **Appendix 4**.

Brent Kilmurray
Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust

What we have achieved in 2020/21

Although we faced the challenges outlined in the previous section, there were some notable quality achievements during the year:

- We have opened Foss Park Hospital, our new 72-bed hospital located on Haxby Road in York. It provides two adult single-sex wards (Ebor Ward – female adult beds and Minster Ward – male adult beds) and two older people's wards (Wold View for people with dementia and Moor Croft for people with Mental Health conditions such as psychosis, severe depression or anxiety)
- The York Crisis Home Treatment team was accredited as providing an excellent service by the Royal College of Psychiatrists Home Treatment Accreditation Scheme (HTAS)
- The Tees CAMHS Single Point of Contact (SPoC) went live in 2020; SPoC provides a single telephone line (or email) for children and young people, their parents/carers, and professionals to talk to expert CAMHS trained staff about concerns regarding a child or young person's mental health. It provides an initial point of contact, triage, clinical decision making, access to mental health expertise, advice on self-help, signposting, referral and emotional containment for parents/professionals
- The Trust's care home liaison staff have been working closely with care homes in Teesside and County Durham to support the wellbeing of their residents and staff during the COVID-19 pandemic. In addition to providing telephone, video and face-to-face consultations, the teams have shared resources and guidance on supporting wellbeing
- The Trust has launched a new free-phone service for those in mental or emotional distress. The service, which has been developed as part of our long term ambition to transform mental health crisis services, is available 24 hours a day, seven days a week, providing an alternative to traditional crisis care and offering local people the opportunity to talk to trained mental health support workers
- Adult Learning Disabilities services in Durham & Darlington have secured additional funding to assist primary care colleagues to complete Annual Health Checks for people with a learning disability. The agreed protocol and model is being shared with colleagues in Tees Locality as they have been asked to provide similar support by commissioners
- TEWV's forecasting model, which was designed by TEWV clinicians and planners with the help of our CCG colleagues and our Director of Public Health has been recognised as one of the four best practice models nationally. It identifies the main drivers of increased need (direct impact of Covid 19, impact of the lockdown, and impact of the economic recession on a range of segments in our population). It also estimates how much of the additional mental health needs will translate into demand for secondary care services. TEWV staff will explain how the model works at a forthcoming national NHS England webinar. We will be refining our model in the light of recent research and the learning from the other models. This work has helped the Trust prepare for the expected Covid-related surge in mental health needs and informed our current surge-recruitment campaign

- Within Durham & Darlington Mental Health Services for Older People, work has commenced within the Care Home Liaison Wellbeing Service. This has made significant positive impact and feedback. Due to the extent of the demand and the continuing pandemic, we would hope to extend this service post-March 2021
- Michael Taylor, associate nurse consultant and Dr Paul Tiffin, consultant psychiatrist, have been supporting scriptwriters from the television soap Emmerdale on a storyline featuring a character's relapse in mental health following a traumatic episode. Working closely with scriptwriters the team have reviewed scripts and offered advice and guidance on symptoms, treatment and presentation to ensure an accurate representation is portrayed
- As part of Black History Month the North East regional BAME staff networks, including TEWV, held a virtual event in October called 'Action, allyship and antiracism – what do these mean for everyone?'
- Construction work is underway on the new community mental health hub being built on North Moor Road in Northallerton. North Moor House will provide state of the art facilities for local mental health and learning disability services and will accommodate outpatient services for people of all ages across Northallerton and the surrounding areas
- The Trust has purchased rights to DadPad, a free app that provides dads with advice on caring for a new baby as well as information on various topics including mental health
- The rollout of Attend Anywhere across all services during the Covid-19 pandemic, to enable remote virtual appointments to continue has been largely successful

National Awards – Won or Shortlisted

Awards where TEWV as an organisation, or one of our teams/staff members were shortlisted for an award but did not win that award during 2020/21 were:

Awarding Body	Award Status	Name/Category of Award	Team/Individual
Health Service Journal	Shortlisted	Transformation Category – Mental Health Service Redesign Initiative	North Yorkshire & York Community Learning Disability Service – initial assessments: more co-production, timely clinical documentation and improved staff wellbeing

Nursing Times	Shortlisted	Nursing in Mental Health	Health & Justice Mental Health Inreach Team: HMP Holme House
Healthcare Quality Improvement Partnership	Shortlisted	Clinical Audit Professional of the Year	Robert Redfern
Northern Echo Health & Care Awards	Shortlisted	Mental Health Award	Chris Oakes
Northern Echo Health & Care Awards	Shortlisted	Mental Health Award	Unforgettable Experiences

In 2020/21 the Trust was proud to be recognised externally in a number of national awards. Awards won or highly commended by TEWV teams or staff members are shown in the following table:

Awarding Body	**Award Status**	**Name/Category of Award**	**Team/Individual**
TheraNorth	Won	TheraNorth Award - October	Karen Cartmell
Royal College of Psychiatrists	Won	Psychiatric Team of the Year: Working Age Adults	Redcar & Cleveland Community Affective Disorders Service

Annual Medical Education Awards	Won	Clinical Supervisor of the Year	Steve Wright
Royal College of Psychiatrists: Northern & Yorkshire	Won	25 Women in Psychiatry	Kim Barkas
The Irene Taylor Trust	Won	Koestler Award	Health & Justice PIPE and Primrose Services
Literati Award 2020	Won	Literati Award	Sarah Dexter-Smith Abi Tarran-Jones

Our Big Conversation

In July 2020, our Board of Directors considered a report about revising our overarching strategy. The Board agreed that we needed to review the Strategic Framework but that this needed to be informed by significant engagement with our service users, carers, staff and stakeholders. As a result of this we launched 'Our Big Conversation' as a means of gathering intelligence to inform our new Strategic Framework but also for testing the key messages that we heard from that intelligence.

Our Big Conversation has been undertaken and engaged a total of **2,183** staff, service users, carers and partners, who together shared over **35,800** ideas, comments and votes. This provided an ideal opportunity for the Board to listen to what people are saying about the organisation. The thoughts and ideas provided have been analysed. This analysis was then used to inform an emerging Strategic Framework.

Three Board planning workshops were held between October 2020 and January 2021 to discuss and develop 'Our Journey to Change' (our draft Strategic Framework) and that led to the identification of key areas of focus for the 2021/22-2023/24 Business Plan and the actions for each of these key areas.

'Our Journey to Change' will enable actions to be planned and implemented to address the issues revealed by the conversations.

Quality Priorities

We have identified our three Quality Improvement priorities for 2021/22, based on our assessment of the quality data and intelligence available to us and feedback from service users and carers. The priorities are:

1. Making Care Planning more Personal (this is a continuation of our previous Quality Improvement priority)
2. Safer Care (this is an amalgamation of two of our previous Quality Improvement priorities – Reducing the number of Preventable Deaths and Increasing the percentage of our inpatients who feel safe on the wards)
3. Compassionate Care

The following section includes our proposed actions for these priorities during 2021/22

Part Two: Priorities for Improvement and Statements of Assurance from the Board

2020/21 and 2021/22 Priorities for Improvement – How did we do and our future plans

In this section, we share our quality priorities for the year ahead. Following initial discussion and a review of quality data, risks and future innovation, we developed our priorities in collaboration with our staff, service users and carers. Our priorities will support the Trust as we continue with our mission to make sure that safe, quality care is at the heart of all we do.

Due to the ongoing Covid-19 pandemic, it was not possible to undertake our normal Quality Account stakeholder engagement events. Consideration was given as to whether it would be possible to hold stakeholder engagement activities virtually, for example, via Microsoft Teams. It was however agreed that as the original priorities for 2019/20 were developed by our stakeholders during previous engagement sessions, and the fact that there has been little progress against the actions identified for these priorities during the previous year because of the pandemic, it would not be necessary to undertake further engagement at this time.

The three Quality priorities for 2021/22 which we have identified also sit within TEWV's 2021/22–2023/24 Business Plan.

One of our priorities for 2020/21 – **Improve the Clinical Effectiveness and Patient Experience in times of Transition from CYP to AMH Services** – has not been carried forward to 2021/22 due to the work of this priority being superseded by the Trust-wide project 'Improving Transitions and Service Provision for People aged 16 to 25 years in Tees, Esk and Wear Valleys NHS Foundation Trust' which is linked to the Trust's wider work around the NHS England CAMHS Whole Pathway Commissioning. This means that many of the actions in relation to this Quality Improvement priority were removed from our Quality Account to ensure there was no duplication or divergence.

Priority 1 – **Making Care Planning more Personal -** has been a priority for the Trust several years; however whilst some improvement has been made we still have some way to go to truly co-create care plans in line with our new goals and service user and regulator's expectations. **Priority 2 –Safer Care** this is an amalgamation of - priorities from the Trust Quality Account – Reducing Preventable Deaths and Increasing the Percentage of Inpatients who feel Safe on our Wards (now known as Safer Care). For these priorities, the section below including information on what we have done during 2020/21 and what we will do in 2021/22. **Priority 3 – Compassionate Care** – is a new priority which we have developed for 2021/22.

Our Progress during 2020/21

Making 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, hence this being identified as a priority in 2020/21.

The benefits/outcomes we aimed to deliver for our patients and their carers were:

- To have their personal circumstances viewed as a priority when planning care and treatment
- To have an accessible, understandable and personalised care plan (including a 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 personal circumstances, and what is most important to the person and those closest, viewed as a priority when planning care and treatment

What we did in 2020/21:

What we said we would do:	What we did:
• Re-audit and report as per Q4 2017/18 • Compare and contrast review of Patient Experience • Develop and implement a communications and engagement plan to ensure all relevant stakeholders are aware of changes to the CPA and introduction of DIALOG (a clinical tool that allows for more personalised Care Planning) and review this plan with key stakeholders (staff, service users, carers, local authorities and GPs) • Continue User Acceptance Testing (UAT) of DIALOG and wider CITO developments (moving from artificial to real-life testing) • Work with TEWV Information Technology team to ensure a finalised, working version of DIALOG is embedded within CITO • Develop guidance to support the implementation of revised CPA processes including DIALOG • Develop training and supporting materials in relation to the implementation of revised CPA processes including CITO pilot (this may not include the final version of DIALOG) • Pilot training to support staff to implement the revised CPA processes • Evaluate the pilot CPA training, making revisions where necessary • Roll out the revised CPA training across the Trust	• The Covid-19 pandemic has severely impacted progress against this priority over the past year. The lead for this piece of work has been redeployed for much of this time to support the patient and staff swabbing, antibody clinics, outbreak response and vaccination programme. However, aspects of the work have continued, for example, training has been delivered for trainee and newly qualified nurses on a variety of courses, but this has been to a much lesser extent than during previous years. Links have been maintained with the development group for Cito (a system which overlays the Trust's patient record to make it easier to record and view the patient's records), although this has also been impacted by the redeployment of the lead for this piece of work and key others within the group due to the Covid-19 pandemic. These actions have been rolled over into 2021/22

How do 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 2020/21:	Actual 2020/21:	Timescale:
• Do you know who to contact out of office hours if you have a crisis?	85%	74%	Q4 2020/21
• Were you involved as much as you wanted to be in deciding what treatments or therapies to use?	81%	75%	Q4 2020/21
• 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? *This was added as a performance indicator as it was anticipated, when this part of the Quality Account was developed, that the Peer Support project would be well-established and would be supporting a different way of approaching care planning. It has been established more recently that this development opportunity will be progressed during 2021/22 with a Trust Lead overseeing recruitment and induction. Patient Experience Surveys will be expanded to include this measure from Q3 2021/22*	42%	N/A	Q4 2020/21
• Do the people you see through NHS mental health services help you with what is important to you? *This is at the heart of care planning; the future state will place this front and centre of the approach to care planning. The use of DIALOG within Cito makes this very explicit, as it asks the questions 'do you need more help in this area' across 11 quality of life domains that will have been self-rated. Communications and basic introductory training and question/answer sessions have been running since November 2020 with support from the Cito team* *This also links to current work that is underway to make sure that plans are 'needs led' and not being written because people feel that they have to. As such, the intervention plans, safety plans and care plans are being reviewed to establish what needs to remain and what can be moved to other parts of the system and processes (i.e. are the plans written because there is a personal need – needs-led)* *The measurement of this indicator will be considered in future Patient Experience Surveys and DIALOG and is fully dependent on the new ways of working following the implementation of Cito in August 2022*	87%	N/A	Q4 2020/21
• Were you involved as much as you wanted to be in agreeing what care you will receive?	82%	75%	Q4 2020/21
• Were you involved as much as you wanted to be in discussing how your care is working?	89%	79%	Q4 2020/21
• Does the agreement on what care you will receive take your personal circumstances into account? *This is linked to the questions above. Again, our intended future state addresses this directly, as there are parts of the process and systems that highlight what is important to the person and describes the context of the care planning. The measurement of this indicator will be considered in future Patient Experience Surveys and DIALOG and is fully dependent on the new ways of working following the implementation of Cito in August 2022*	87%	N/A	Q4 2020/21

The measures for the above come from the NHS Community Mental Health Survey which is administered by the CQC. The targets we have set are very aspirational targets, and the experience that our service users report relates to their experiences in the Trust as a whole, rather than in relation to their CPA alone. Evidence also suggests that service users are more likely to complete this questionnaire if they have had a negative rather than a positive experience.

Improve the Clinical Effectiveness and Patient Experience in times of Transition from CYP to AMH Services

Why this is important:

We define Transition in this Quality Account priority as a *purposeful and planned process of supporting Young People to move from Children's to Adult's Mental Health Services*.

Young people with ongoing or long-term health or social care needs may be required to transition into adult 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 transfer into, and evidence that young people may fail to engage with services without proper support.

This transition takes place at a pivotal time in the life of young person. It is often at a time of cultural and developmental changes that lead them into adulthood. Individuals may experience several transitions simultaneously. A loss of continuity in care can be a disruptive experience, particularly during adolescence, when young people are at enhanced risk of psychosocial problems.

The particular importance of improving the transition from Children and Young People's Services to Adult Services has been recognised for a number of years. We initially agreed to put a two-year Quality Improvement priority in place, focusing on this specific transition. We have extended this as the full extent of the work required has become apparent. The paragraphs below show what we achieved in 2020/21.

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 evidence-based guidelines, which will result in better clinical outcomes

What we did in 2020/21:

What we said we would do:	What we did:
• Extend the work of the NHSI Transitions Collaborative project into an internal 3-year project that oversees the development and delivery of key quality improvements – learning from the original pilot and the SI review undertaken in February 2020, taking the work forward. Including the learning form the thematic review – CPA/Process/Caseload Management/Escalation; Reasonable Adjustments & Assertive Engagement in complex cases • Develop an action plan with this 'Preparing for Adulthood Collective' to implement key learning in the first year of the project, and will establish strategies and targets for Year Two and Year Three • Instigate Quality Improvement plans for the effectiveness of the panel process following the evaluations of transition panels which has taken place in Quarter 4 2019/20 • Sustain and maintain improvements in the clinical effectiveness and patient experience at times of transition from CAMHS to AMH throughout the year; this will be informed by the collaborative work and 'plan, do, study, act' cycle via the Steering Group and audit activities	• The majority of these actions were suspended due to the ongoing Covid-19 pandemic. Towards the end of 2020-21 the Trust began to implement the project 'Improving Transitions and Service Provision for People aged 16 to 25 years in Tees, Esk and Wear Valleys NHS Foundation Trust' which is linked to the Trust's wider work around the NHS England CAMHS Whole Pathway Commissioning. This means that many of the actions in relation to our Transitions Quality Improvement priority were superseded by this work and so were removed from our Quality Account to ensure there was no duplication or divergence • We have however managed to maintain our improvement targets over this time period in terms of actual numbers; we saw an extra 703 young people through their transition period and completed a transition plan for an extra 784 during 2020/21 compared to 2018/19. This is positive especially against the backdrop of Covid-19 and extremely high caseload numbers

How do 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 CYP who have a transition plan by age 17 years and 4 months *This remains a high priority within clinical services; further work will be undertaken to better understand why all young people don't have a transition plan in place, and the actions required to ensure that a transitions plan is in place*	100%	87.4%	Q4 2020/21
• Percentage of CYP who have their transition plan discussed at Panel *This metric requires further review; at present we have been unable to extract the information required*	100%	N/A	Q4 2020/21
• Percentage of CYP who have completed transitions questionnaire on leaving CAMHS Services *During the pandemic it has been more challenging to achieve feedback from young people; the service plans to expand the cohort of young people who they approach to complete the questionnaire to the 16-25 service. This will enable a greater number of questionnaires to be completed, providing more detailed feedback to improve services*	90%	N/A	Q4 2020/21
• Percentage of CYP who have a positive transitions experience *Again during the pandemic it has been more challenging to achieve feedback from young people; the service plans to expand the cohort of young people who they approach to complete the questionnaire to the 16-25 service. This will enable a greater number of questionnaires to be completed providing more detailed feedback to improve services*	100%	N/A	Q4 2020/21
• Percentage of CYP who have an unplanned discharge from AMH within 3-6 months	0%	N/A	Q4 2020/21
• Percentage of people who have a '6P*' Formulation when presented at transitions panel *Due to the Covid-19 pandemic, the audit that would encompass these two metrics has been delayed. It is now planned to publish this report during Quarter 3 2021/22*	100%	N/A	Q4 2020/21

*A '6P' formulation (also known as a Rethink formulation) uses a visual approach to organising information for formulation using the '6Ps' as follows: presenting problem(s), predisposing factors which made the individual vulnerable to the problem, precipitating factors which triggered the problem, perpetuating factors such as mechanisms which keep a problem going or unintended consequences of an attempt to cope with the problem, protective factors and predictive factors

Reduce the number of Preventable Deaths

Why this is important:

It is recognised that people with a mental health problem, autism and/or a learning disability are likely to experience a much earlier death than the general population; therefore a key focus for the Trust will be on mortality review processes. Not all deaths of people receiving mental health services from the Trust will represent a failing or a problem in the way that person received care. However, sometimes healthcare teams can make mistakes, or parts of the system do not work as well 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 that we carry these out.

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 by involving them further in incident reviews.

There have been 11 Patient Safety Briefings disseminated to wards and teams from January to April 2021 to support early learning from incidents. These have covered issues and information including: Assessment and management of risks including updates on clinical risk management improvements to record keeping and environmental risk awareness; management of ligature risks in assisted bathrooms and toilet areas; defibrillation battery indicators; and keeping patients safe through carrying out of care rounds and supportive observations. Staff awareness of these briefings has been enhanced through improved ward communication structures and the inpatient practice development team.

The benefits/outcomes we aimed to deliver for our patients and their carers were:

- 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 the reviews of deaths, including identifying any themes early so that actions can be taken to prevent future harm
- That our process reflect national guidance and best practice which will support the delivery of 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
- Patients and families feel listened to during serious incident investigations are consistently treated with kindness, openness and honesty

What we did in 2020/21:

What we said we would do:	What we did:
• Fully introduce 48-hour follow up for all AMH patients after discharge from inpatient wards	• We have fully introduced 48-hour follow-up processes for all AMH patients after discharge from inpatient wards (previously 72 hours)
• Produce report, recommendations and evaluation from Family Conference • Produce action plan from Family Conference and implement these actions	• The Family Conference held in March 2019 was to be followed on by March 28th 2020 by a second event. However the Covid-19 lockdown prevented this from going ahead. This was a disappointment for families who wanted to be part of the event but they were appreciative of why it was cancelled. Due to the sensitive nature of the Family Conference it was not the type of event that could be held remotely. One of the reasons for the success of the 2019 event was due to the support that was in place for the families that attended who were still grieving and distressed about the loss of their loved one
• Involve a lived experience Service User/Carer Representative in the Environmental Risk Group	• We have invited a Service User/Carer Representative with lived experience to be a member of the Trust's Environmental Risk Group and they have attended one meeting so far. The Environmental Risk Group have overseen a comprehensive programme to reduce the risk of ligatures across inpatient services; this has included the fitting of new, safer, ensuite showers, toilets and hand basins as well as the pilot of the Oxehealth Digital Care Assistant in three wards. This is a system that detects movement in bedroom areas and seclusion rooms through the measurement of a patient's vital signs and can send alerts to staff where risks to the patient may be arising
• Implement actions from the external review of unexpected deaths of Adult, Forensic and Older Person's Services inpatients	• We have implemented the actions from the external review of unexpected deaths of Adult, Forensic and Older Person's Services inpatients
• Review the Trust Zero Suicide Plan in view of the Family Involvement Event and Safety Summit in Quarter 2 2020/21; set up a task and finish group to be an umbrella Steering Group around preventing harm and deaths, chaired by the Trust Medical Director	• The Suicide Prevention and Self Harm Reduction Group, chaired by the Medical Director, was established as planned. The group continues to develop a framework to ensure that the Trust is supported in coordinating activities designed to reduce the risk of suicide and frequency of suicide attempts. The group also focuses on dissemination of learning and good practice around suicide prevention and self-harm

How do 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
• Increase the number of mortality reviews in relation to deaths (this is in addition to the existing Serious Incident Process) and identify actionable learning	400	326	Q4 2020/21
• Eliminate Preventable Deaths of inpatients (including during periods of leave)	0	1*	Q4 2020/21
• Reduce the number of Serious Incidents where it was identified that the Trust contributed to the incident	<30	55	Q4 2020/21

**There is one other inpatient death in the process of review, which will not be complete until August 2021*

The purpose of reviews of deaths is to understand where problems in care might have contributed to that death. The mortality review process remains under review and is focusing on proportionate investigations to ensure that learning and themes are identified and acted upon Trust-wide and wider. A more robust multi-disciplinary mortality review panel has been established and there has been an event looking at key themes relating to physical health deaths. We have started to share these themes with external stakeholders in keeping with the Community Mental Health Framework which focuses on how we can improve the physical health of people who also experience difficulties with mental health.

In 2020/21 there was 1***** patient where on review of their care it was considered that their death may have been potentially preventable. This means that it was more likely than not to have resulted from problems in healthcare. The Trust is committed to eliminating such preventable deaths and continues to work hard to achieve this through a range of improvement programmes. These programmes have been developed based on the learning identified from reviewing patient care at both a local and national level. This work ranges from a focus on clinical risk assessment, environmental risk reduction, revision of Trust policies and procedures to ensure they are informed by a contemporary evidence base. Implementation of revised practices are supported by the development of competence based training and assessment. Our work on eliminating harm and preventable deaths will continue to develop over the coming year. Following the CQC focussed inspection in January 2021, the Trust held a Quality Improvement event to ensure that robust systems were in place to comprehensively assess and mitigate patient risk. This improvement work has encompassed and enhanced ongoing actions to address the four most common root cause or contributory findings as detailed above. Work has included providing detailed guidance on clinical risk assessment and management to clinical staff to support practice in line with the Trusts Harm Minimisation policy as well as simplifying related documentation on the electronic patient record in the form of the safety summary and safety plan, leave and observation care plan. Harm minimisation training and suicide prevention training content and delivery has also been reviewed to bring greater clarity on standards and expectations as well as more detailed focus on clinical risk assessment aligned to particular patient needs.

Unfortunately the number of serious incidents where it was identified that the Trust contributed to the incident has not reduced during 2020/21. However, each of these incidents has a robust action plan in place for service improvement with the aim of reducing similar incidents during 2021/22.

Increasing the proportion of inpatients who feel safe on our wards

Why this is important:

A known theme among mental health inpatients is that they do not feel safe whilst on our wards; this is identified as a priority for Trusts in the NHS Long-Term Plan (2019). Feedback from our stakeholders in 2019/20 indicated awareness of this as an issue and we therefore agreed to include this as one of our priority areas for improvement within the Quality Account 2020/1 with the aim to increasing the proportion of inpatients who feel safe on our wards.

To enable us to measure this, the question *'during your stay, did you feel safe?'* has been included in a suite of questions within the trust wide Friends and Family Test patient experience survey for some time. The survey is offered to patients and carers at each touch point throughout their journey i.e. at a review meeting or a discharge planning meeting or as a minimum every three months, Patients also have the opportunity to expand on their answers through providing additional narrative.

The Trust is committed to improving this area of our patients' experience. Work has been ongoing for some time to continually review the patient experience survey results and to better understand the reasons why some of our patients do not feel safe on our wards.

The benefits/outcomes we aim to deliver for our patients and their carers are:

- An overall improved patient and family experience
- An increase in the percentage of our service users feeling safe when they are in a Trust inpatient setting
- Increased collaboration between service users, staff and peers
- A reduction in incidents e.g. violence and aggression, absence without leave, drug misuse
- Improved understanding of ward environments and why service users feel unsafe
- Increased opportunity to use digital technology to support the delivery of care

What we did in 2020/21:

What we said we would do:	What we did:
• Use existing data to identify priority wards and actions; collate existing Friends and Family Test and other data	• We undertook a deep dive into the patient survey narrative provided by patients to further understand the reasons why our patients might not feel safe. The key themes identified were due to the environment, due to their illness, other patients and staffing.
• People with lived experience to talk to people currently on the TEWV inpatient wards with the highest and lowest current FFT scores, produce a 'lessons learned' report, develop a plan for each ward identified as a priority and deliver actions from this plan	• This action has been rolled over to our Quality Improvement Business Plan for 2021/22
• Undertake work to improve liaison with the Police	• We have undertaken work to improve liaison with the Police over the past year; this has now been embedded as 'business as usual'. This includes working together to address the issues of violence affecting staff and patients, including developing an action plan to introduce an improved method of recording non-urgent crimes to ensure that when NHS staff need police to attend they are available. This had led to a significant improvement in feedback on incidents reported. There are also regular urgent care interface meetings with the Police to address any issues between both partners. We also have an ongoing safe community work stream with Police and Substance Misuse Services to share community intelligence, think strategically about our approach to care and how we can work collaboratively to overcome criminal activity and risks associated with substance misuse
• Continue monitoring of Key Performance Indicators (KPIs) during the pilot phase of body cameras and develop a Business Case for further roll-out of these cameras (if supported by monitoring of benefit KPIs)	• Although the pilot phase of body cameras has continued during 2020/21, there has been no monitoring of KPIs undertaken due to the Covid-19 pandemic. It is planned to continue the pilot during 2021/22 by rolling out to a further 5 wards. Further consideration will be given to further implementation based on an evaluation/benefits realisation
• Install the technology required for sensor technology in five wards and develop required governance in relation to this pilot work; a benefits realisation of the pilot will be undertaken	• We have tested the Oxehealth Digital Care Assistant in three wards across the Trust. Approval has been given to extend this to a further 12 wards including some seclusion and Section 136 areas – the approach will include three workstreams, overseen by an Implementation Steering Group

	chaired by the Director of Nursing & Governance that will meet every three to four weeks until three months post 'go-live' when the ongoing project and partnership working is then overseen by a Partnership Board. The Partnership Board will report key information into our Senior Leadership Group meeting. We see this initiative as being key to our plans for keeping patients safe

How do 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
• Percentage of inpatients who report feeling safe on our wards	88%	65%
• Percentage of inpatients who report that they were supported by staff to feel safe	65%	68%

Across all of our inpatient wards we have introduced the Safe Wards model. The model is evidenced based and provides approximately 300 ideas for interventions that could be helpful to reduce levels of conflict and containment to make the wards a safer place. A number of interventions have been introduced since its launch including, mutual help meetings between staff and patients, calm down boxes that contain items to lower the level of arousal and agitation and the implementation of bad news mitigation plans when a patient may receive unwelcoming information. Individual wards are required to take ownership of these initiatives and evaluate progress. The wards have been asked to review their local interventions by the end of March 2021 and to consider any additional interventions that could be introduced onto the ward. This will be done in collaboration with the service users where possible and each ward will provide feedback to the Quality Assurance Groups.

Our Quality Improvement Priorities for 2021/22

A summary of our plans for 2021/22 can be found in *Appendix 5: Our Quality Account Plan on a Page*

Priority One: Making Care Plans more personal

What we will do in 2021/22:

- Establish a Steering Group to oversee the development and implementation of high quality, collaborative care planning
- Agree principles and format (inpatients and community) of what constitutes a personalised care plan as opposed to a treatment or intervention plan
- Produce a plan to inform the communication, introduction and safe transition of DIALOG into the patient record and other Cito developments and policy amendments required
- Co-create guidance on 'writing good care plans'
- Co-create updated Care Planning training and agree roll-out plan
- Audit the percentage of service users within inpatient and community services with a personalised care plan and agree an improved target
- Co-create patient reported measures of personalised care plans
- Undertake patient reported evaluation of personalised care plans
- Review Cito plan and produce update on progress
- Undertake service user experience evaluation
- Evaluate embeddedness and make recommendations for sustainability

How will we know we are making things better?

To demonstrate that we are making progress against this priority we will measure and report on the following metrics

Indicator:	Target 21/22:	Timescale:
• Do you know who to contact out of office hours if you have a crisis?	85%	All Q4 2020/21
• Were you involved as much as you wanted to be in deciding what treatments or therapies to use?	85%	
• 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?	42%	
• Do the people you see through NHS mental health services help you with what is important to you?	87%	
• Were you involved as much as you wanted to be in agreeing what care you will receive?	85%	
• Were you involved as much as you wanted to be in discussing how your care is working?	89%	
• Does the agreement on what care you will receive take your personal circumstances into account?	87%	

Priority Two: Safer Care

This priority builds on previous priorities related to improving patient safety, learning from patient safety events and deaths and how this drives improvement as well as increasing the percentage of patients who feel safe on our wards.

Why this is important:

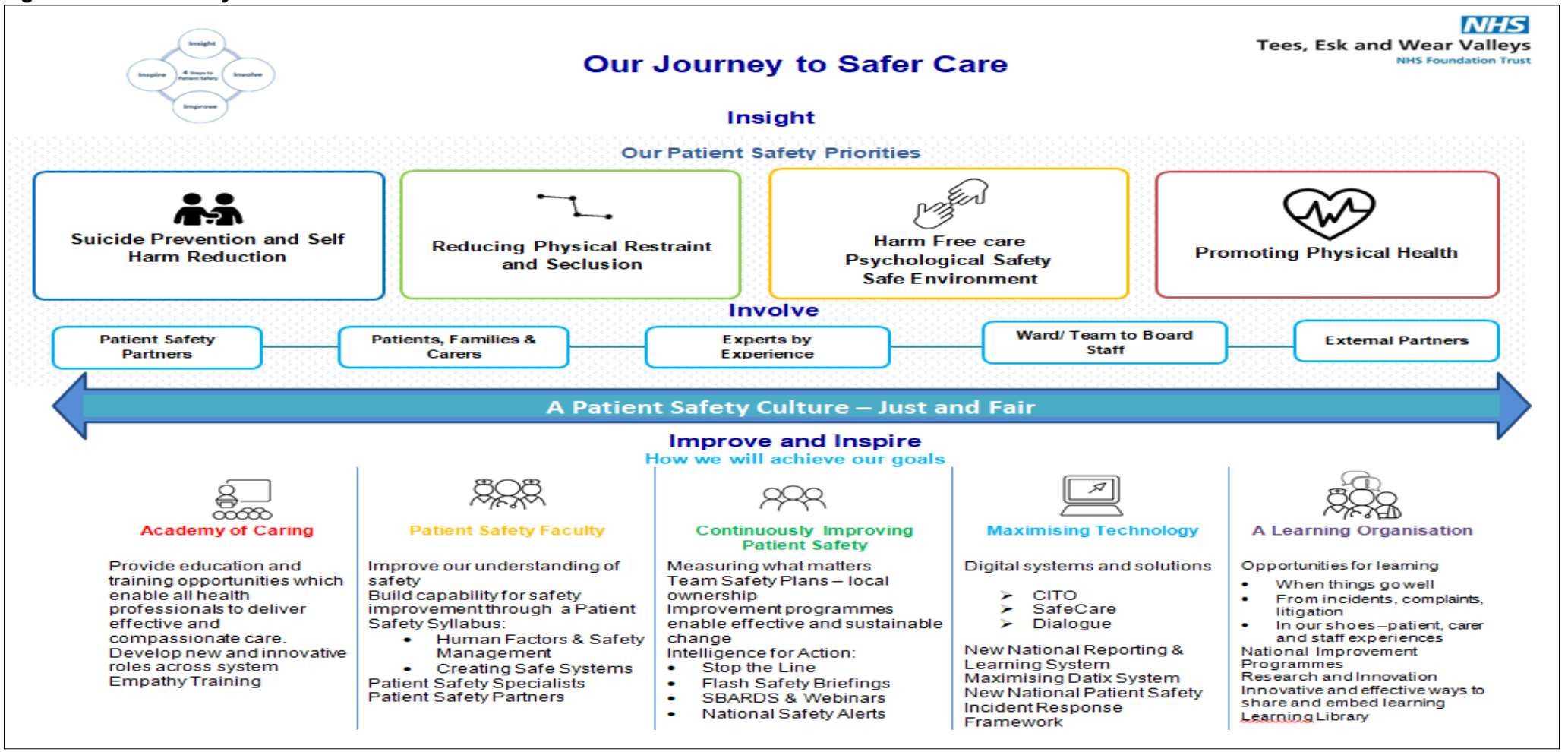
Patient Safety continues to be a key priority for the Trust and we have already identified four Patient Safety priority areas that we will focus upon over the next three years:

- Suicide prevention and self-harm reduction
- Reducing physical restraint and seclusion

- Harm-free care, psychological safety (allowing staff and patients to speak out safely by fostering an open and transparent culture), safe environment
- Promoting physical health

These are illustrated in Figure 1 - 'Our Journey to Safer Care.' This provides an overview of our approaches and key enablers.

Figure 1: Our Journey to Safer Care



The benefits/outcomes we aim to deliver for our patients and their carers were:

- Improved patient safety and reduction of patient harm
- Increased capability for patient safety improvement
- Increased confidence that investigations are being carried out in accordance with best-practice guidelines and in a way that is likely to optimise learning opportunities
- An increase in the percentage of our service users feeling safe when they are in a Trust inpatient setting
- Increased collaboration between service users, staff and peers
- A reduction in incidents e.g. violence and aggression, absence without leave, drug misuse
- Improved understanding of ward environments and why service users feel unsafe
- Increased opportunity to use digital technology to support the delivery of care

What we will do in 2021/22:

We will implement 'Our Journey to Safer Care'

- Communicate and share the agreed patient safety priorities across defined internal and external stakeholders using a range of mediums and mechanisms as part of the trust patient safety campaign
- Determine the programmes of work for each of the four patient safety priorities
- Identify process and outcome KPIs for each of the four patient safety priorities
- Assess current baseline for each performance indicator identified and set incremental targets for improvement throughout 2022/23
- Promote the role of the Trusts Patient Safety Specialist
- Work in collaboration with the ISC 'Better Tomorrow programme: learning from deaths, learning from lives' to improve our processes for identifying lessons learned using information to improve future care and to develop support networks in undertaking mortality reviews within a wider community of practice
- Review and update Learning from Deaths Policy

We will increase the percentage of our inpatients who feel safe on our wards:

- Work proactively within the newly formed Regional Patient Experience Network , maximise opportunities for benchmarking patient experience data
- Use existing data to identify priority wards/teams and actions: collating existing Friends and Family Test (FFT) and other data
- People with lived experience to talk to people currently on wards with highest and lowest current FFT scores

- Develop a plan for each ward/team identified as a priority, with involvement from clinical staff, management and service users and deliver actions throughout the year
- Further review information from patient experience surveys and concerns raised from patients and carers through PALS contact and complaints and use this to feed into report and action plan, and deliver actions throughout the year
- Seek ideas as part of the 'mutual help' meetings that take place on the wards on what we can do to make patients feel safe - roll out across the Trust
- Review current 'ward orientation' process for patients being admitted onto our wards and incorporate into personal safety plans - roll out across the Trust (currently in Tees only)
- Continue existing pilot of body cameras to a further six wards and an additional 60 cameras
- Develop a business case for further roll-out of body cameras (if supported by monitoring of benefit Key Performance Indicators)

We will strengthen organisational learning, including learning from deaths:

- Implement an Organisational Learning Group (OLG)
- Deliver the four organisational learning work programmes that aim to strengthen and embed robust systems for the identification and sharing of learning (infrastructure and governance, systems for communication of immediate patient safety concerns, development and launch of a Learning Library and share learning from West Lane Hospital
- Have in place an Integrated Organisational Learning Report with an initial focus on learning from patient safety issues
- Have in place a mechanism assessing the impact of organisational learning

How will we know we are making things better?

Indicator:	Target 2021/22:	Timescale:
Expand the pilot use of staff body cameras to include a further five wards	Body cameras in place in a further five wards	Q1 2021/22
Percentage of inpatients who report feeling safe on our wards	88%	Q4 2021/22
Percentage of inpatients who report that they were supported by staff to feel safe	65%	Q4 2021/22

Priority Three: Compassionate Care

Why this is important:

The Trusts new strategic framework describes the kind of organisation we want to be:

We will co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism, involving them and their carers as equal partners. We will listen, learn, improve and innovate together with our communities and will always be respectful, compassionate, and responsible.

Fundamental to achieving this is by living these three values, one of which is Compassion, and through ensuring our systems and processes support these.

The benefits/outcomes we aim to deliver for our patients and their carers are:

- Personalised, compassionate care
- Co creation of care that optimises and improves life experiences
- Feeling involved and listened to when there is a serious incident investigation
- Responses to complaints and concerns that are underpinned by an empathetic and compassionate approach

What we will do in 2021/22

- Develop the Serious Incident review process to take account of feedback from patients and families regarding a more collaborative and informed approach
- Undertake an evaluation of the new process
- Refresh current improvement plan related to responses to complaints

We will embed the new Trust Values and Behaviours within the Trust:

- Hold engagement events with staff at all levels to develop our new ways of working together, with involvement of service users and carers
- Share outputs of initial engagement events so all staff, service users and carers can access tools and resources which help to describe our new ways of working
- Further roll-out of engagement events, to be attended by all staff
- Work with staff, service users and carers to identify work which has already been developed which supports the new values. Agree how we will learn from and build on this work

- All teams to co-create their ways of working and development plans

We will roll out empathy and compassion training across locality and corporate services:

- Establish a baseline of those requiring training
- Undertake a formal evaluation of training

How will we know we are making things better?

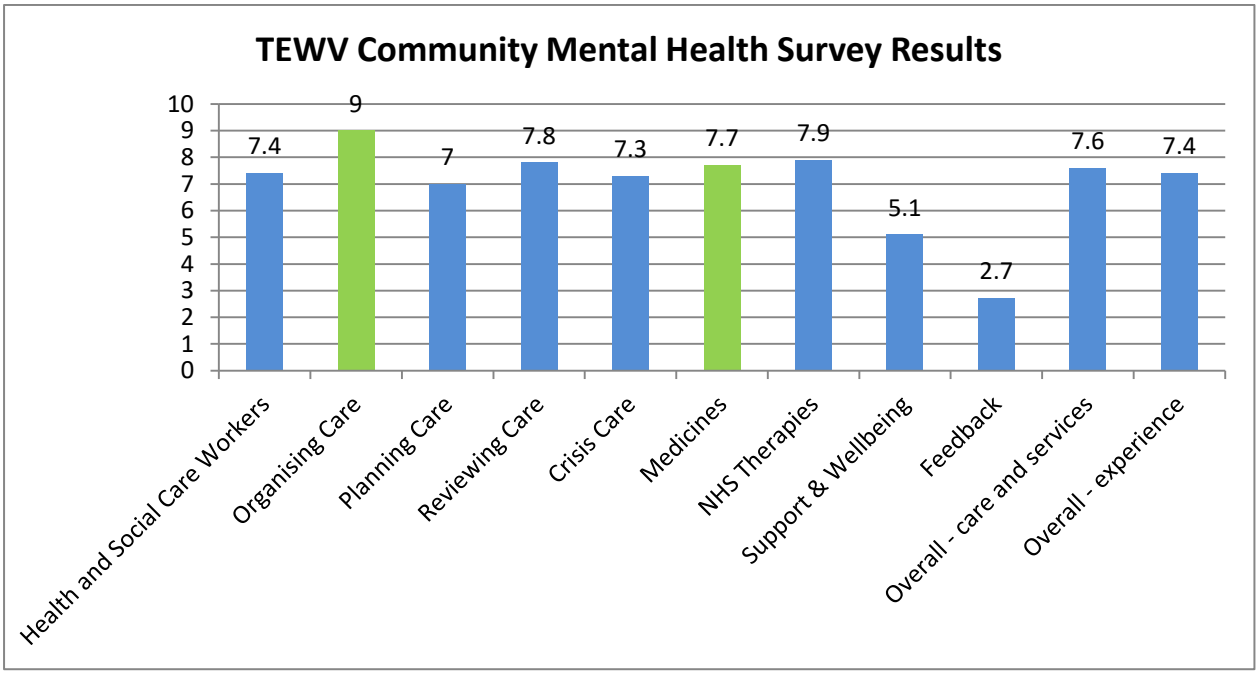
Indicator:	Target 21/22:	Timescale:
• Percentage of patients reporting that they felt treated with dignity and respect	94%	All Q4 2021/22
• Percentage of patients who were involved as much as they wanted to be in the planning of their care	70%	
• Percentage of patients who report being listened to and heard by staff	76%	
• Reduction in the number of complaints that request a further local resolution	18%	

Monitoring Progress

The Trust will monitor its progress in implementing these priorities at the end of each quarter and will report to our Quality Assurance Committee, our Council of Governors and our wider Stakeholders.

TEWV's 2020 Community Mental Health Survey Results

- There were 340 responses from people about the Trust
- The Trust's score for 'Overall Experience' was 74% compared to 71% in 2019, 66% in 2018 and 71% in 2017, demonstrating a steady improvement over the past few years
- The Trust performed 'Better' than most other Trusts that took part in the survey in the following categories: Organising care and Medicines
- The Trust performed 'About the same' as most other Trusts that took part in the survey in the following categories: Health and social care workers, Planning care, Reviewing care, Crisis care, NHS therapies, Support and wellbeing, Feedback, Overall views of care and services and Overall experience
- The Trust did not perform 'Worse' than most other Trusts that took part in the survey in any of the categories.



Full results of the Survey for the Trust can be found at:

https://www.cqc.org.uk/provider/RX3/survey/6

In order to take forward these results in relation to improving our patient experience, we will:

- Improve communication between services, patients and GPs by focusing on the sharing of information between the Trust, Partners, Patients and Carers
- Aim to reduce waiting times for therapy and appointments through a recruitment programme of additional clinical staff
- Hold a scoping/improvement event to review and agree future Crisis Operational Models Trust-wide. This follows on from the implementation of the all-age single

central crisis line in May 2020 and subsequent evaluation undertake alongside the review of the telephony system requirements and demand and capacity predications
- Allow the patient to be included more in consultations and decision-making by recording of attendance at CPA meetings and reviews on PARIS and undertaking further Patient Experience Surveys
- Circulate the National Community Mental Health Survey report and findings across the Trust for discussion at local governance groups and add this report to the agendas for discussion at patient and service user involvement groups
- Develop a further action plan in relation to the issues raised by the survey

TEWV's 2020 National NHS Staff Survey Results

The National NHS Staff Survey is commissioned by the Picker Institute on behalf of TEWV and 26 other Mental Health and Learning Disabilities Trusts.

- TEWV were ranked 11th out of 27 Trusts
- All TEWV Staff were invited to participate
- The response rate decreased from 45% in 2019 to 38% in 2020 – there were 2,785 participants in total which is a decrease of 186 staff from 2019
- The median response rate across all Mental Health Trusts was 45%
- Overall staff engagement remained at 7 (out of ten)

The following table shows the categories where the Trust scored 'Better', 'Worse' or 'About the Same' as other Mental Health Trusts:

Better	• Equality, Diversity and Inclusion
Worse	• Immediate Managers • Quality of Care • Safe Environment – Violence • Staff Engagement • Team Working
About the Same	• Health and Wellbeing • Morale • Safe Environment – Bullying and Harassment • Safe Culture

Benchmarking

Below are the questions where the Trust scored above or below average when benchmarked against the other organisations, along with the percentage difference from the average score:

- Have adequate materials, supplies and equipment to do my work (+6%)
- Satisfied with level of pay (+6%)
- In last 12 months, have not experienced musculoskeletal problems as a result of work activities (+5%)
- Organisation acts fairly: career progression (+6%)

- Not experienced discrimination from patients/service users, their relatives or other members of the public (+5%)
- Organisation treats staff involved in errors/near misses/incidents fairly (-5%)

Top Five Scores

- Have adequate materials, supplies and equipment to do my work (69%)
- In last 12 months, have not experienced musculoskeletal problems as a result of work activities (78%)
- Organisation acts fairly: career progression (89%)
- Satisfied with level of pay (45%)
- Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public (76%)

Bottom Five Scores

- Organisation treats staff involved in errors/near misses/incidents fairly (54%)
- Last experience of physical violence reported (87%)
- Immediate manager values my work (76%)
- Satisfied with opportunities for flexible working patterns (63%)
- Not felt pressure from manager to come to work when not feeling well enough (76%)

An overview of these results have been shared with the Trust's Senior Leadership Groups/Committees and the locality-specific free text comments have also been shared with the leadership teams within each locality. We have identified locality representatives and an initial meeting will be scheduled to discuss the approach the Trust will take in order to take forward these results in relation to improving our staff experience and what assurance this approach will offer. Our journey to safer care goals will also help us to address our staff feeling safer to raise errors and incidents and violence reduction within our inpatient settings. We will focus on themes and 'bite-size' improvements, so as not to overwhelm staff with more actions/targets and to ensure that we implement improvements which will really make a difference to our staff.

TEWV's Staff Friends and Family Test Results

Due to the ongoing Covid-19 pandemic, data collection for the Staff Friends and Family Test was stood down during 2020/21

Review of Services

During 2020/21 the Trust provided and/or subcontracted **20** relevant health services. The Trust 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 2020/21 represents **100%** of the total income generated from the provision of relevant health services by the Trust for 2020/21.

Participation in clinical audits and national confidential inquiries

A clinical audit is the process by which the quality of care and services provided are measured against agreed standards. Where services do not meet the agreed standard, the audit provides a framework where suggestions for improvements can be made. A third party conducts national audits. Participating in these audits gives organisations the opportunity to compare their results with other organisations. Local audits are conducted by the organisation itself. Here they evaluate aspects of care that the healthcare professionals themselves have selected as being important to their team. The statements on a clinical audit demonstrate the healthcare provider is concerned with monitoring the quality of their services and improving the healthcare provided.

During 2020/21, **four** national clinical audits and **two** national confidential inquiries covered the health services that TEWV provides.

During 2020/21, TEWV participated in **100% (four out of four)** of the national clinical audits and **100% (two out of two)** 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 2020/21 were as follows

- POMH Topic 20a: Improving the Quality of Valproate Prescribing in Adult Mental Health Services
- POMH Topic 18b: Use of Clozapine
- National Clinical Audit of Psychosis (NCAP): Spotlight re-audit in EIP
- National Audit of Inpatient Falls (NAIF)
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

The national clinical audits and national confidential inquiries that TEWV was **participated in** during 2020/21 were as follows:

- POMH Topic 20a: Improving the Quality of Valproate Prescribing in Adult Mental Health Services
- POMH Topic 18b: Use of Clozapine
- National Clinical Audit of Psychosis (NCAP): Spotlight re-audit in EIP
- National Audit of Inpatient Falls (NAIF)
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (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 2020/21** 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 number of registered cases required
POMH Topic 20a: Improving the Quality of Valproate Prescribing in Adult Mental Health Services	Sample provided: 203	100%
POMH Topic 18b: Use of Clozapine	Sample provided: 120	100%
National Clinical Audit of Psychosis (NCAP): Spotlight re-audit in EIP	Sample provided: 440	100%
National Audit of Inpatient Falls (NAIF)	Sample provided: 3	100%
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	22 questionnaires sent to the Trust; 12 returned	55%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	*	*

** The Trust was eligible to participate in this confidential enquiry during 2020/21; data collection, however, continued into 2021/22 therefore figures will be reported within the 2021/22 Quality Account*

Due to the timings of the national audits, the Trust had not received and reviewed the reports for all 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 them and agree actions to improve the quality of healthcare provided.

The reports of **130** local clinical audits were reviewed by the Trust in 2020/21 and TEWV intends to take actions to improve the quality of healthcare provided. **Appendix 3** includes the actions the Trust is planning to take against the **ten** key themes from these local clinical audits reviewed in 2020/21

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 **36** clinical audits in 2020/21 which include clinical effectiveness projects undertaken by Trainee 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 and were reviewed by the Specialty Clinical Audit Subgroups. Over the next year the Trust will explore the use of audit apps to make audits quicker and more efficient and to make it easier for teams to understand their information and make the changes needed.

Participation in Clinical Research

The Trust participates in research activity to help provide new knowledge that has the potential to be valuable in managing and treating patients. It is important that such research is open to critical examination and open to all that would benefit from it.

The number of patients receiving relevant health service provided or sub-contracted by TEWV in 2020/2021 that were recruited during that period to participate in research approved by a Research Ethics Committee was **836**. Of the **836** participants, **826** were recruited to **20** National Institute for Health Research (NIHR) portfolio studies. This compares with **658** patients involved as participants in NIHR research studies during 2019/20.

Examples of how we have continued our participation in clinical research include:

- We were involved in conducting **52** clinical research studies during 2020/21; **43** of these studies were supported by the NIHR through its networks
- **36** members of our clinical staff participated as researchers in studies approved by a Research Ethics Committee, with **27** of these in the role of Principal Investigator for NIHR supported studies
- **2921** members of our staff were also recruited as participants to NIHR portfolio studies
- We continue to collaborate with a wide range of universities and other NHS providers to deliver large multi-site research studies for the benefit of our service users, carers and staff
- Many studies have adapted recruitment methods to accommodate over the phone and video calls to ensure participants can still consent to and have access to research opportunities. The ability to receive feedback from research participants through the Participant in Research Experience Survey has been impacted upon by Covid-19.
- **2293** TEWV staff took part in NHS CHECK which is a major study of the impact of the COVID-19 pandemic on the short and long-term health and wellbeing of all staff working within 18 partner NHS Trusts.

Key achievements:

The emergence of Covid-19 has seen research in the global spotlight to develop solutions swiftly. Our staff and service users have been taking part in research that is finding effective vaccines, developing treatments and informing government policy. The Department of Health gave Urgent Public Health status to a variety of studies where research is essential and deemed to have an important effect on the progress and outcome of the pandemic. TEWV is sponsor for the only interventional mental health research study badged as Urgent Public Health, the Basil C19 study, which examines the use of behavioural activation in older adults with low mood or loneliness and long term health conditions during Covid-19.

We are looking forward to welcoming our first research participant to Foss Park Clinical Research Facility with the opening of a new commercial research study to compare two medications as add-on treatment to anti-depressant therapy for adults with depression and sleep problems.

The ComBAT study (Community Based Behavioural Activation Training for depression in adolescents) has now opened. It is a 5-year programme grant that commenced in January 2021 and aims to develop and deliver a standardised community based behavioural activation training programme in consultation with adolescents, their parents and professionals from the NHS, schools and charities. The partnership with the University of York continues to thrive with new emerging grant applications in progress.

The Trust is proud to have a Consultant Nurse who is funded by the NIHR through the '70@70 Senior Nurse and Midwife Research Leader Programme'. We are committed to increasing the visibility of nursing research and nurses' contribution to research delivery. Our Consultant Nurse has worked collaboratively to overcome challenges and drive changes in this area.

The programme is now in its final year and key objectives for 2020/21 are:

- Complete Care Covid Study – data collection, analysis, write-up, presentation and feedback to relevant groups
- Complete dissemination and agreed actions on recommendations from Nurse Consultant research activity audit
- Complete job planning work for TEWV Nurse Consultants
- Continue supporting preceptor programme in TEWV
- Complete the podcasts we are currently making with the Local Clinical Research Network: North East & North Cumbria
- Undertake a three-year survey in TEWV of what nurses want in terms of required support etc. to become more involved in research
- Work with the TEWV Research & Development Team and Nursing & Governance Directorate to ensure actions from the research strategy and nursing strategy are met as planned
- Prepare abstract and poster for end of year three as per '70@70' three-year plan
- Final Year three report as per '70@70' three-year plan
- Continue supporting individual nurses for NIHR Clinical Academic Pathways and PhD preparation

- Agree arrangements for follow up to the role in the Trust with the Director of Nursing & Governance for TEWV

Use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework

Due to the ongoing Covid-19 pandemic NHS England and NHS Improvement stood down all CQUIN requirements

What the Care Quality Commission (CQC) says about us

The Care Quality Commission (CQC) is the independent regulator for health and social care in England. It ensures that services such as hospitals, care homes, dentists and GP surgeries provide people with safe, effective, compassionate and high-quality care, and encourages these services to improve. The CQC monitors and inspects these services, and then publishes its findings and ratings to help people make choices about their care.

Tees, Esk and Wear Valley NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is **registered without conditions for services being delivered by the Trust**. The Trust is therefore licensed to provide services.

The CQC **has** taken enforcement action against TEWV during 2020/21. TEWV **has** participated in a special review/investigation by the CQC during the reporting period.

In January 2021, the CQC carried out an unannounced, focussed inspection of five of our Acute Wards of Adults of Working Age and Psychiatric Intensive Care Units (PICU) and observed that some risk assessment and management processes were not fully effective to support the delivery of safe patient care. A number of urgent and immediate actions were taken across the core service and a quality improvement event was held to address standards around risk assessment and organisational learning across all services.

In March 2021, due to enforcement action taken in the safe and well-led dimensions, the CQC inspection report rated the Acute Wards for Adults of Working Age and PICUs as inadequate in these areas. The Trust was required to complete an improvement plan addressing all the requirements in the inspection report and the Section 29A Warning Notice with actions to be completed by 3rd May 2021.

In addition to clearly evidencing delivery of the required actions, the Trust acknowledges that a wider programme of change and improvement is required beyond this date. It is recognised that increasing multidisciplinary involvement and oversight, improving staffing establishments, building in appropriate training, expertise, sustainable support, clinical supervision and leadership to our clinical teams is critical to prioritising a culture of patient safety and continuous quality

improvement. In addition, work is underway to enhance and embed organisational learning from a range of internal and external sources. This includes reviewing, strengthening and developing mechanisms for capturing and communicating learning and importantly gaining assurance of the impact of our actions to improve care for services users and their families.

Since the inspection, we have invested £5.4 m in staffing, with a focus on inpatient services, seven-day capacity and quality governance. An improved assurance schedule that includes a review of care documentation has been put in place to provide assurance that patients risks are assessed and that they have a safety plan in line with their needs.

A 'Quality Improvement Board', chaired by the Chief Executive with executive team attendance with responsibility for ward/team to board reporting on implementation has been put in place to oversee quality assurance standards including regular audit and direct observation on wards and to provide assurance to the Trust Board that actions being taken to address patient safety are improving. Community assurance processes have included the development of a dashboard to support community caseload reporting and improved clinical supervision.

Improvement Plan

A Regional Quality Board has been set up where TEWV is reporting on progress to other partners such as NHSE and ICSs as well as the CQC. We are also accessing expert support from outside the Trust to support with rapid improvement and embedding actions.

In addition to the attainment of all CQC recommendations and conditions related to the Section 29a warning notice issued by CQC in March 2021, an umbrella improvement plan has been developed with overarching work-streams which include:

- Implementation of the trust's new strategy-'Our journey to change'
- Board development
- Strengthening 'ward/team to Board governance flow' and focus on the Board Assurance Framework/Risk Registers
- Embedding organisational learning including reviewing the involvement of families and carers in Serious Incident reviews
- Simplification of management and governance structures to support the line of sight, communication and flow of information
- Development of new Board integrated assurance performance report and strengthening capacity and capability in corporate and locality/specialist governance roles
- Training and professional development for clinical staff
- Sustainability of improvements including leadership development and strengthening lines of accountability
- Technological improvements including the development of a new electronic patient record system

We are confident that we will continue to improve services and will work with staff, service users, carers, volunteers, governors, commissioners and partners to address the areas where standards were not as expected.

Although we have retained a 'Good' rating for the well-led domain, we now have an overall rating of 'Requires Improvement' with a number of actions having been taken to improve the quality and safety of our services.

The CQC's current rating for the Trust for each key domain overall is:

Further information can be found at: https://www.cqc.org.uk/provider/RX3

Quality of Data

It is important that data used by NHS services is of a high quality so that it can be best used to inform decisions on the management of patients. In addition, data must be of a high quality to help inform organisational decision-making and planning. For example, it is also important that the General Medical Practice Code is recorded so information about the patient's health and any hospital treatment received is sent back to their GP, who should be able to treat the patient appropriately.

The Trust did not submit records during 2020/21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics; these were stopped by the 'reducing the burden team at NHS Digital, as the Trust submits to the Mental Health Services Data Set it is no longer required to make these submissions.

Information Governance

Information Governance requires the Trust to set a high standard for the handling of information. The aim is to demonstrate that it can be trusted to maintain the confidentiality and security of personal information, by helping individuals to practice good information governance.

Due to the ongoing Covid-19 pandemic, NHS Digital has delayed submission of the Data Security and Protection Toolkit 2020-21 until 30th June 2021. Of the **110** mandatory evidence items and **42** assertions, we anticipate publishing the Toolkit with all evidence provided and assertions met.

In the most recent NHS Digital published results (January 2021) TEWV gained a score of 98.1% for the Data Quality Maturity Index which is a measurement of data quality in the NHS

The following steps have been put in place to ensure that appropriate controls are in place to ensure the accuracy of data:

- The Trust has in place an internal group which has the responsibility for ensuring data quality within the Trust; this was put on-hold during the COVID-19 response but is set to be reinstated as part of the Trust's revised governance structure

- 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 has a Data Quality Strategy which provides a framework for improvements in this important area

- 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
  - Confidentiality and Sharing Information Policy

  These policies incorporate national standards where available and are regularly reviewed. All the policies are held on the staff 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' and other cascade mechanisms.

- A significant amount of training is provided to support staff using 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, real-time data is used to forecast future positions thus improving the decision-making process. The Trust has introduced the use of Statistical Process Control (SPC) charts this year to enhance decision making

- All data returns are submitted in line with agreed timescales

Freedom to Speak Up

Following a review by Sir Robert Francis in 2015, a national standard 'Freedom to Speak Up' policy was published by NHS Improvement and NHS England. This policy has the aim of developing a more open and supportive culture for staff to raise any issues of patient care, quality or safety. The Trust has subsequently adopted this standard policy in its own policy.

The Trust has a policy which details how staff can speak up about risk, malpractice, or wrongdoing. Most of the time staff will choose to raise their concerns with their line manager. However sometimes they may feel this is inappropriate. They then have the option to 'Speak Up' anonymously using our Raising Concerns email address (which can be found on the Trust Intranet) or by contacting the Trust's Freedom to Speak Up Guardian via mobile telephone or dedicated email address.

Part of the role of the Freedom to Speak Up Guardian is to ensure that staff receive feedback on how their concerns are being addressed e.g. who is conducting the service review or investigation, what they found and what, if any, subsequent actions are being taken. Depending on the case, this feedback can be verbal or written. It often forms part of regular feedback aimed at developing a trusting relationship.

Ensuring that people who speak up do not experience detriment is a central commitment of the Guardian's role. It is also clearly stated within the Trust policy. Staff are also regularly reminded that they should not tolerate any negative consequences of their speaking up. At the end of their involvement, staff are asked to answer two questions – "Would you feel confident to speak up in the future?" and "Did you feel you experienced any detriment?"

The Trust has little evidence of overt actions leading to detriment. However, some staff have felt a loss of trust in the organisation to keep them safe. This loss of trust has on some occasions resulted in staff feeling unable to remain in their current post. Many have moved to another post within the organisation and have reported their satisfaction with this outcome.

The Freedom to Speak Up guardian attends the Trust Board on a twice-yearly basis to deliver their report. This report contains numbers of new cases taken on, the number closed, the broad category of the concern, and any feedback. It also contains anonymised case studies/examples and any lessons learnt.

During 2020/21, there were **51** cases referred to the Freedom to Speak Up Guardian. Of these, **20** were submitted anonymously. **21** of the concerns related to culture of bullying, and **9** related to patient safety and **11** to staff safety. The remainder related to other issues such as culture or systems/processes. We are committed to creating an open and transparent culture where every member of staff can speak out safely. Over the next year we will continue to raise the profile of the Freedom to Speak Up Guardian and triangulate the information we have with other sources to ensure the best and safest care for our service users.

Reducing Gaps in Rotas

The Guardian of Safe Working for Junior Doctors within the Trust produces quarterly reports to the Trust Board that focus on gaps in medical rotas and safety issues. The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The work of the Guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission and by the continued scrutiny of the quality of training by Health Education England.

The Guardian is required to levy a fine against a department(s) if a Junior Doctor:

- Works on average over 48 hours/week
- Works over 72 hours in seven days
- Misses more than 25% of required rest breaks
- On non-residential on call (NROC) does not have a minimum of continuous rest for five hours between 22:00 and 07:00
- Does not have the minimum eight hours total rest per 24-hour NROC shift
- Has more than the maximum 13-hour residential shift length
- Does not have the minimum 11 hours rest between resident shifts

The Guardian of Safe Working for Junior Doctors within the Trust produces quarterly and annual reports to the Trust Board that focus on gaps in medical rotas and safety issues.

The Trust's Board received the Guardian's annual report for 2020/21 at its meeting of 29th April 2021. During the year, the most common reasons for needing short-term/locum cover was due to vacancies on the rotas, staff sickness (short/long term) and COVID 19 related absences (sickness or self-isolation).

Exception reports received related mostly to not having five hours continuous rest while working between 10pm and 7am on a Non-Residential On-Call rota, having to stay later than normal working hours or shift end time or missing teaching/training due to staff shortages. Discussions on these issues have taken place where appropriate and additional staffing put in place where possible.

Bolstering staffing in adult and older adult community mental health services

The Trust through its Commissioners, national transformation investment and Covid Surge monies has increased its staffing across all clinical services to include CYP and Learning Disability Services. The table below shows the additional staffing in post in March 2021.These staff were recruited across a range of clinical services, in particular to respond to demand with in urgent care services, enhancing community and inpatient teams in particular to improve skills in responding to complex presentations

Examples include Structured Clinical Management Practitioners in County Durham, which is a nationally recognised model to support patients with a Personality Disorder.

We have also enhanced our GP-aligned Mental Health services to provide additional capacity to support practice-based nurses and the Access Service – their focus will be on people with lower level needs who require a level of intervention that does not need to be provided in secondary care.

Within North Yorkshire and York MHSOP Services have increased capacity with dedicated roles to improve Physical Health Monitoring, which is a recognised area of need. A Social Worker as also been introduced to this team, who will be facilitating a virtual 'Steps to Recovery' group in addition to working with individuals and families in the community and providing discharge liaison support where inpatient treatment is appropriate

The North Yorkshire and York AMH integrated teams will also begin working six days a week (two members of the team to work on Saturday) and will be joined by support workers from the Crisis Team. Due to the recent changes in the Urgent Care Service at the Friarage Hospital, overnight crisis services in this area have been reviewed. There has been additional funding for additional Senior Crisis Practitioners to enable provision of the All Age Crisis Helpline.

In North Yorkshire and York MHSOP Services staff have been trained in non-governed psychological therapies to increase skills within the Community Teams, and physiotherapy, pharmacy and dietetics have also all been incorporated into the community model. Physiotherapy staff have also developed a virtual group around physical health interventions.

The Trust is currently agreeing with Commissioners their investment plans for 2021/22, which it is anticipated will be mobilised to implement a range of roles in both Inpatient and Community based-Services

	Additional Staff 2021/22
AMH Durham & Darlington North Yorkshire & York Teesside **Total**	 168 239 153 **560**
CYPS Durham & Darlington North Yorkshire & York Teesside **Total**	 97 88 48 **233**
Forensic Services	**176**

Learning Disabilities Durham & Darlington North Yorkshire & York Teesside **Total**	 64 9 43 **116**
MHSOP Durham & Darlington North Yorkshire & York Teesside **Total**	 29 143 22 **194**
TOTAL	**1278**

Learning from Deaths

Following publication of the Southern Health report in 2015 there has been enhanced national scrutiny on how all NHS organisations respond to deaths of service users in their care. This culminated in the release of a 'Learning from Deaths Framework' which was published by the National Quality Board in 2017. The Trust collects data on all known deaths and has processes in place to determine the scope of deaths which require further review or investigation. The Board of Directors (meeting in public) receive a quarterly Learning from Deaths dashboard and report summarising learning. As well as being included in this Quality Account, information is also included in the annual Patient Safety report.

In Mental Health and Learning Disability Services we have a number of older people who are cared for in the community and their needs are such they only require minimal contact with us. We have undertaken some analysis of the average age of service users who died during 2020/21, which was found to be **79** years old. Many of these people, who die, do so through natural causes as happens in the wider population. This explains the difference between the total number of deaths (from all causes including natural causes) and the numbers we go on to investigate further. To support staff in their decision making regarding the investigation of deaths, staff have clear policy guidance, setting out criteria for categories and types of review.

Despite the pressures of COVID-19, good progress has been made to improve both the quality and the number of Serious Incident and Mortality reviews completed over the year, notably the number of Learning Disability Deaths that have been reviewed internally and reported to LeDeR (Learning Disabilities Mortality Review).

It is recognised that team development and skilled staff are key to the delivery of high quality, safe care and high functioning teams to minimise the risk of incidents occurring. Progress is being made to enhance senior clinical leadership with recruitment to new Community Matron Roles, Practice Development Practitioners and Peer Workers to support co-creation, recovery and involvement.

In 2019, a family conference was held with bereaved families who had experienced the serious incident process. One of the aims of the conference was to identify how

we could improve the way we engage with families. An action from this event was to appoint a Family Liaison Officer. This role is now well established and has received positive feedback from both families and staff. In May 2021, an improvement event is planned to consider how we can further improve involvement with families to facilitate a more equal partnership in the Serious Incident Investigation process. The Trust was due to hold its second annual family conference in March 2020; this has been put on hold due to COVID-19 and is regularly under review.

Any death of a person open to Trust services, which is reported through our Incident Management System, is subject to an initial review by the Central Approvals Team. During 2020/21 **2,315** TEWV patients died; this comprised the following number of deaths which occurred in each quarter of that reporting period:

- **926** in the first quarter
- **375** in the second quarter
- **481** in the third quarter
- **533** in the fourth quarter

From the **2,315** deaths, **2,033** were expected/physical health deaths in the community; many of these patients, as alluded to above, had minimal contact with services. Please see above paragraphs for further narrative

There were **249** unexpected deaths (this figure includes community and inpatients). Of these **249** deaths, **four** were deaths in inpatient services. Two of the four were unexpected physical health deaths. All four cases were reviewed as a serious incident.

There were also **32** expected, physical health deaths in inpatient services

By 31st March 2021, in relation to unexpected and expected physical health deaths **286** mortality reviews and **40** structured judgement reviews had either been carried out or requested.

The number of deaths in each quarter that were identified as requiring a serious incident investigation are as follows:

- **24** in the first quarter
- **23** in the second quarter
- **17** in the third quarter
- **27** in the fourth quarter

Out of cases that have been completed during 2020/2021 (126), **44** cases had either a root cause or contributory finding. There is no agreed or validated tool to determine whether problems in the care of the patient contributed to their death within Mental Health or Learning Disability Service. This means that Mental Health and Learning Disability organisations are using different ways of assessing this.

The definitions used by the Trust are as follows:

- **Root Cause** - The prime reason(s) why an incident occurred: A root cause is a fundamental factor, an act or omission that had a direct effect on the incident occurring. Removal of these will either prevent, or reduce the chances of a similar type of incident from happening in similar circumstances in the future**.**
- **Contributory Factor/Influencing Factor -** An act or omission that influences the likelihood of the incident occurring and hence contributed to the incident

Root and/or contributory findings from serious incident reviews undertaken in 2020/21 have highlighted the following areas for learning and improvement:

- Record keeping
- Communication
- Patient risk assessments
- Non-compliance with some elements of Trust policy

The Trust has seen a decrease of over 30% in the number of serious incidents resulting in deaths in 2020/21 (133 in 2019/20)

Detailed below are some of the actions we have already taken, or will take during 2021/22 in response to what we have learned from reviews of deaths:

The Trust is undertaking an extensive programme of estates works to reduce potential ligature points within inpatient services to address learning from inpatient deaths and an increase in fixed ligature incidents. Phase one of the programme has focused on the replacement of sinks, taps, toilets, shower controls and soap dispensers to standardise these with anti-ligature fittings in ensuite bathrooms and agreed standards for assisted bathrooms which are recognised as high risk areas for patients. Phase two of this work will be completed during 2021/22 and will enhance the safety of bedroom doors and replace windows.

In addition, 11 wards have now been prioritised for installation of Oxehealth Digital Care Assistant, which is assistive technology that has been proven to reduce harm within in-patient services. The Environmental Risk Group, chaired by the Director of Nursing and Governance, has oversight of these safety measures and receives monthly incident reports involving ligatures and other risks where environmental factors may have contributed to harm as well as progression of initiatives to reduce harm.

A Rapid Patient Safety Review Meeting has been introduced for unexpected inpatient deaths, usually to be held within 48 hours of the incident occurring. This is to ensure that all immediate identified actions have been put in place to maintain patient safety and to share any early learning identified.

The Suicide Prevention and Self Harm Reduction Group, chaired by the Medical Director continues to develop a framework to ensure that the Trust is supported in coordinating activities designed to reduce the risk of suicide and frequency of suicide attempts.

The group is also focusing on dissemination of learning and good practice around suicide prevention and self-harm. Trust Suicide Prevention Leads continue to build up and maintain effective partnership working with the suicide prevention taskforces/alliances and other agencies

In line with the North Cumbria and North East Integrated Care System (ICS) priorities around physical health and learning from deaths, the Trust has identified 'Making Every Contact Count' leads within services and is incorporating the principles of this. These include making healthy changes such as, stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption into daily practice. These can help people to reduce their risk of poor health significantly.

The Trust is strengthening its arrangements for organisational learning with the establishment of the Organisational Learning Group, chaired by the Director of Quality Governance. Workstreams include the development of effective systems for rapid dissemination of urgent safety messages, sharing early learning and establishing and maintaining a Learning Library.

In January 2021, following the CQC focused inspection, the Trust held a Quality Improvement Event to ensure that robust systems were in place to comprehensively assess and mitigate patient risk. This improvement work has encompassed and enhanced ongoing actions to address the four most common root cause or contributory findings from serious incident investigations. Work has included providing detailed guidance on clinical risk assessment and management to clinical staff to support practice in line with the Trust's Harm Minimisation policy (clinical risk assessment and management) as well as simplifying related documentation on the electronic patient record in the form of the safety summary and safety plan, leave and observation care plan.

Harm minimisation training (clinical risk assessment and management) and suicide prevention training content and delivery has also been reviewed to bring greater clarity on standards and expectations as well as more detailed focus on clinical risk assessment aligned to particular patient needs.

As an organisation, the decision was made to provide Suicide Prevention training to staff. To progress this, 26 staff members have been trained to date by Connecting with People (4 Mental Health). These staff will then deliver the training to all TEWV registered staff – as at 28th May 2021 there had been 139 staff trained, with another 316 places already booked on future training. The training provides a whole organisational approach to embed best practice and governance, with training designed for real impact and improvement of individual and organisational working practices. The training reflects the latest evidence-based principles and best practice, and provides individuals the opportunity to reflect on their own practice and how they can utilise the skills they have refreshed or learnt in their practice. We have also recently introduced Suicide Awareness training for all non-registered staff; as at 28th May 2021 there have been 113 placed booked on this training.

PALS and Complaints

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.

The Trust's Policy and Procedure for the Management of Compliments, Comments, Concerns and Complaints outlines the Trust's approach to receiving valuable feedback and information from patients and their carers about the services provided by the Trust. When people raise concerns they are given options by the Patient Advice and Liaison Service (PALS)/Complaints Team for taking their concerns forward. They may opt to have their concerns addressed by PALS staff liaising on their behalf with clinical staff or through meetings with the Clinicians.

People may also choose at any point to have their concerns registered under the NHS Complaints Regulations (2009) with a more formal investigation and a written response letter from the Chief Executive.

During 2020/21 PALS dealt with **2,127** concerns or issues from patients and carers, a decrease of **244** when compared to 2019/20. **1,102 (52%)** of the concerns raised were around AMH services across the Trust.

1,972 of the PALS concerns (**85%**) were closed within 15 working days (although no formal target is set for this). Non-compliance was largely as a result of the Covid-19 pandemic where it has not always been possible to obtain timely feedback from operational services.

265 formal complaints were received and registered during 2020/21 compared to 296 for the same period last year.

Complaints across services: **172** in AMH services, **41** in CYPS, **23** in MHSOP, **11** in Secure Inpatient Services, **2** in Health and Justice, **6** in ALD services and **10** in Corporate Services.

The most common cause for complaints across the Trust related to aspects of clinical care (154) followed by communication (61) and attitude (28). Complaints have also been received relating to discharge arrangements (11), environment (5), medical records (3), waiting Times (1), General Advice (1) and Bereavement (1).

175 responses were sent out during 2020/21, **134** (**78%**) were within timescales (60 working days).The number of complaints received and closed are published on the Trust's website.

The Trust has commissioned specific training to support and empower a wide range of our staff to develop reasoned empathy, emotional awareness, intelligent compassion and resilience in order to promote wellbeing and a just, caring culture. Learning is applied within the context of duty of candour, ensuring a person-centred approach to complaints, resilience and leadership culture. The training is supporting our staff to understand vulnerability in themselves and others and prevent psychological harm. It does this in a thought-provoking, honest and supportive learning environment. Learning the science and reality behind meaningful, empathic communication, as well as self-care and to build confidence in why empathy and emotional awareness is a key and important focus.

An example is the session of experimental learning; it not only identifies what empathy is, but enables those attending to ‘feel’ empathy, analyse and understand it on a deeper level, and why it is so important within complaints. The session takes empathy out of the text book and into real life as delegates go on a journey of empathy and emotional awareness and the importance of both these things when an incident occurs, to support patients, loved ones and themselves.

Part Three: Other Information on Quality Performance 2020/21

Mandatory Quality Indicators

Since 2012/13, all NHS Foundation Trusts have been required to report performance against a core set of indicators. Normally the Trust is required to present a mandatory statement and the data on NHS Digital for the most recent and the previous reporting period available. However, due to the ongoing Covid-19 pandemic, this mandatory collection was stood down by NHS Digital

Care Programme Approach Seven-Day follow-up

In March 2020, the national collection of this measure by NHS Digital was suspended due to the Covid-19 pandemic and the need to release capacity across the NHS to support the pandemic response. Subsequently, a consultation on the Quarterly Mental Health Community Teams Activity return opened and the outcome was published on 15th April 2021 announcing the decision to retire this collection as the measure has effectively been replaced by the new 72-hour follow-up standard.

109 people were not followed up within seven days during 2020/21. Given the unprecedented times, it has not been possible to gather the level of intelligence in terms of this area of underperformance that would normally be included within the report, as all efforts have been diverted to manage the Covid-19 situation and the need to ensure that the Trust's focus remains on this clinical priority. However this figure should be considered within the context that **95.91% were followed up within seven days.**

The Trust intends to take/has taken the following actions to improve this percentage and so the quality of its services, by:

- Adding a dedicated item on this measure to the agendas for Service Business Meetings/Huddles and Quality Assurance and Improvement Boards
- Ensuring that all relevant teams regularly review their performance against this metric

Crisis Resolution Home Treatment team acted as gatekeeper

In March 2020, the national collection of this measure by NHS Digital was suspended due to the Covid-19 pandemic and the need to release capacity across the NHS to support the response. Subsequently, a consultation on the Quarterly Mental Health Community Teams Activity return opened and the outcome was published on 15th April 2021 announcing the decision to retire this collection. A replacement for this measure will not be introduced immediately; time will be taken to

explore developing an alternative indicator(s) to help measure meaningful contact with Crisis Resolution & Home Treatment Teams before admission.

220 people during 2020/21 were not assessed by the Crisis Team prior to admission. Given the unprecedented times, it has not been possible to gather the level of intelligence in terms of this area of underperformance that would normally be included within the report, as all efforts have been diverted to manage the COVID-19 situation and the need to ensure that the Trust's focus remain on this clinical priority. This number needs to be considered within the context that **86.50% of individuals were assessed by a Crisis Team prior to admission**.

TEWV **has taken** the following actions to improve the percentage, and so the quality of its services:

- Implemented additional capacity to Mental Health Support Teams to respond to calls from people who are in distress but do not require a crisis assessment
- Added a review of this metric to daily huddles
- Implemented Business Continuity Plans during the Covid-19 pandemic to ensure liaison psychiatry teams and CRHTs worked jointly to address gatekeeping
- Amended and updated the Crisis Operational Policy for AMH Services to clarify roles and responsibility of professionals acting on behalf of the CRHT services (out of hours) in a gatekeeping capacity
- Reviewed the Quality Standards Work for AMH Crisis Teams
- Reviewed and introduced a Safety Summary and Safety Plan for all urgent care services to improve risk recording/documentation and collaborative working with patients, improving quality of information, care and safety

TEWV **intends to take** the following actions to improve the percentage, and so the quality of its services:

- Undertake a scoping event to review urgent care/crisis services during 2021/22, considering the Trust-wide central crisis line, and explore potential opportunities for future development and operational models for the delivery of services, working with patients, staff, partners and stakeholders
- Use NHS England Transformation Funding to continue to support options for alternatives to crisis, working with the voluntary sector and ensuring services meet core fidelity. Work is continuing to implement innovative approaches within the localities

Patients' experience of contact with a health or social care worker

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 2020, we have reported the Health and

Social Care Workers section score which compiles the results from the questions used from the survey detailed below in the table.

TEWV Actual 2020	*National benchmarks in 2020*	*TEWV Actual 2019*	*TEWV Actual 2018*	*TEWV Actual 2017*
Overall section score: 7.4 **(sample size 340)**	Highest/Best MH Trust: **7.8** Lowest/Worst MH Trust: **6.4**	Overall section score: **7.3** (sample size 209)	Overall section score: **7.3** (sample size 209)	Overall section score:**7.7** (sample size 232)

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.

TEWV Actual Q3 20/21	*National Benchmark in Q1 & Q2 20/21*	*TEWV Actual Q1 & Q2 20/21*	*TEWV Actual Q3 19/20*
Trust reported to NRLS: **3,105** incidents reported of which **27 (0.9%)** resulted in severe harm or death* * **10** Severe Harm and **17** Death	Not available	Trust reported to NRLS: **6,207** incidents reported of which **80 (1.3%)** resulted in severe harm or death* * **22** Severe Harm and **58** Death	Trust reported to NRLS: **3,312** incidents reported of which **40 (1.2%)** resulted in severe harm or death

Although this may seem like a large number of total incidents, this is in line with expected numbers for a Trust with a caseload the size of TEWV; the Trust is one of the largest Mental Health Trusts in the country.

TEWV considers that this data is as described for the following reasons:

- The number of incidents reported by TEWV to the NRLS for Quarter three 2020/21 was slightly less than the same period in 2019/20. 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

- 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 2020/21 TEWV reported **141** incidents as Serious Incidents, of which **94** were deaths due to unexpected causes. This compares with **119** (from a total of **159** in 2019/20) and **126** (from a total of **142**) in 2018/19**.**

- TEWV is one of the largest Mental Health Trusts in England in terms of population served and caseload

TEWV **has taken** the following actions to improve this indicator, and so the quality of our services by:

- Analysing all patient safety incidents; these are reported and reviewed by the Quality Assurance and Improvement Group which is a sub-group of the Trust's Senior Leadership Group. A monthly report is circulated to the Trust's Quality Assurance Committee and are reported to commissioners via the Clinical Quality Review Process

- Implementing a consistent approach to the grading of incidents and to improve the overall quality of reporting via the Trust's Central Approval Team who review all reported incidents

- 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

- Undertaking mortality reviews on those deaths that are classed as physical health expected/unexpected deaths. Mortality reviews are completed in line with guidance from the Royal College of Psychiatrist and peer organisations across the region. The mortality review tool used consists of a Part One and Part One review. Part One is a review of the care records, if any concerns are noted a Part Two (more in-depth Structured Judgement Review) will be carried out

- The identification of learning themes from incidents helps the Trust to identify key areas for improvement and this is built into our quality improvement work plans. Many examples are given within this report including the development of the suicide and self-harm reduction strategy, environmental ligature reduction, harm from falls reduction, and reducing restrictive practices

- We now have an Organisational Learning Group, chaired by the Director of Quality Governance. The group is responsible for developing robust and effective

systems for sharing learning and ensuring the actions identified have the desired impact

- The official statistics publishing schedule is changing; NRLS are now publishing the Organisation and National level patient safety incident reports once a year rather than every six months, with the next publication due in September 2021. This has resulted in the Trust not being able to benchmark their data with other Mental Health Trusts

Our performance against our quality metrics

The Quality Account 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 Report.

Quality Metrics

Quality Metrics		2020/21		2019/20	2018/19	2017/18	2016/17
		Target	Actual	Actual	Actual	Actual	Actual
Patient Safety Metrics							
1	Percentage of patients reported 'yes always' to the question 'do you feel safe on the ward'?	88%	67.54%	62.39%	61.50%	62.30%	N/A
2	Number of incidents of falls (level 3 and above) per 1000 occupied bed days (for inpatients)	0.35	0.18	0.15	0.18	0.12	0.37
3	Number of incidents of physical intervention/restraint per 1,000 occupied bed days	19.25	26.27	30.45	33.81	30.65	20.26
Clinical Effectiveness Measures							
4	Existing Percentage of patients on Care Program Approach who were followed up within seven days after discharge from psychiatric inpatient care	>95.00%	96.14%	97.13%	96.49%	94.78%	98.35%
5	Percentage of Quality Account audits of NICE guidance completed	100%	100%	100%	100%	100%	100%

6a	Average length of stay for patients in Adult Mental Health (days)	**<30.2**	**23.25**	**25.55**	**24.70**	**27.64**	**30.08**
6b	Average length of stay for patients in Mental Health Services for Older People (days)	**<52**	**59.80**	**66.84**	**66.53**	**67.42**	**78.06**
Patient Experience Measures							
7	Percentage of patients who reported their overall experience as excellent or good	**94%**	**90.32%**	**91.65%**	**91.41%**	**90.50%**	**90.53%**
8	Percentage of patients that report that staff treated them with dignity and respect	**94%**	**84.59%**	**85.80%**	**85.70%**	**85.90%**	**N/A**
9	Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	**94%**	**89.94%**	**86.70%**	**86.90%**	**87.20%**	**86.58%**

Notes on selected Metrics

1. Data for CPA seven day follow-up is taken from the Trust's patient systems and is aligned to the national definition
2. The percentage of Quality Account 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
3. 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 **2020/21** position was **67.54%** which relates to **1864** out of **2760** surveyed. This is **20.46%** below the Trust target of **88.00%.** All localities underperformed this year. **Forensic Services** was closest to the target with 72.5**%** and **North Yorkshire and York** was furthest away with **62.43%**

When brief analysis has been undertaken of why patients do not feel safe in a ward environment, the most often cited cause has been due to the behaviour of other patients. It has also been noted that due to the acuity levels of patients who are admitted, they are likely to feel unsafe due to the fact that they are acutely unwell. As there is a persistent significant gap between our target and performance on this

metric, improving the percentage of patients who feel safe on wards has been identified as a Quality Improvement priority for 2020/21 (see page 25).

Metric 3: Number of incidents of physical intervention/restraint per 1,000 occupied bed days (OBDs)

The end of **2020/21** position was **26.27;** which relates to **5727** interventions and **217,975** OBDs; this is **7.02** worse than the Trust target of **19.25**

Durham and Darlington were the only locality achieving the target with a rate of **16.74**. Of the underperforming localities, **Tees** had the highest number of incidents per 1000 OBD with **43.64**

A large proportion of restrictive intervention usage across the Trust occurs in a small number of wards and is more likely to occur with a small group of patients with complex needs. Severe forms of physical restraint i.e. prone (face-down) have significantly reduced in recent years.

The Trust continues to work towards the long-term reduction of all forms of restrictive intervention. A range of actions are in progress across the Trust via our Restrictive Intervention Reduction Plan; our recent improvements include:

- Feasibility testing of the use of Body-worn cameras in a number of our inpatient wards to help reduce the use of restrictive interventions
- Our mandatory training for all clinical staff in the prevention and management of violence and aggression is now accredited via the national standards for reducing restrictive interventions
  We have developed new procedures for the safe use of segregation and are currently working to train staff across the Trust
- We have increased the availability of training for Advanced Practitioners in Positive Behaviour Support in collaboration with Northumbria University
- In conjunction with Cumbria, Northumberland Tyne and Wear NHS Foundation Trust and Cumbria University we have developed graduate training for staff in reducing the use of restrictive interventions, which is now available nationally

TEWV is aware that our patient satisfaction rate as measured in our ongoing data collection has gently risen from 90% to 92% during 2018/19. Despite being one of the highest reporting Trusts nationally we have aspirations to further improve and have set a target of 94%. We are also aware that only around 60% of inpatients who have been surveyed feel safe, and only approximately 87% of surveyed service users feel they have been treated with dignity and respect. More detailed data discussed by our Patient Experience Group and reported to our Quality Assurance also notes that staff availability and environment stands out as issues most often mentioned in negative comments by patients are carers.

In 2019/20 we have a number of actions in our Quality Account and wider Business Plan which we believe will improve our patient experience results. These include:

- Our continuing commitments to Recovery oriented services that focus on wider personal wellbeing
- Our Making Care Plans More Personal priority, which should see more service users able to co-produce their care plans, and able to access these electronically. To support this work we are training clinical staff in shared-decision making principles and practices
- Our Dual Diagnosis priority which should improve the Trust's approach to treating people with substance misuse issues who are also mentally unwell. These improvements may reduce the number of people who feel unsafe in our hospitals
- Our Urgent Care priority should see further incremental improvements in crisis care delivered in 2019/20, while principles for long-term changes in urgent care mental health services as a whole are developed to drive future improvement
- Our Right Staffing business plan priority which through reviewing ward establishments and rostering systems should ensure that we have the right staff, with the right skills available at the right time to support service users' recovery
- Our Making a Difference Together priority will work on preserving what is good in our current culture, while promoting culture change where this is required in order to improve service user experience
- Our commitment to reducing admission rates and phasing out dormitory inpatient accommodation in Harrogate as part of our service transformation plans
- Opening a new mental health hospital in York (by end 2020)
- Continuing to rectify the construction and maintenance defects at Roseberry Park Hospital in Teesside
- Our digital transformation plans which will make it possible, where clinically appropriate and in line with service user preferences, for service users to interact with clinicians via Skype rather than travelling long distances to clinics

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 3 2013/14 reporting **59.80** days as at end of **2020/21**. This is **7.8** worse than target but is an improvement on the position reported in 2019/20. The pie chart below shows the breakdown for the various lengths of stay during 2020/21.

The median length of stay was **46** days, which is 4 days better than the target of 52 days and demonstrates that the small number of patients who had very long lengths of stay have a significant impact on the mean figures reported.

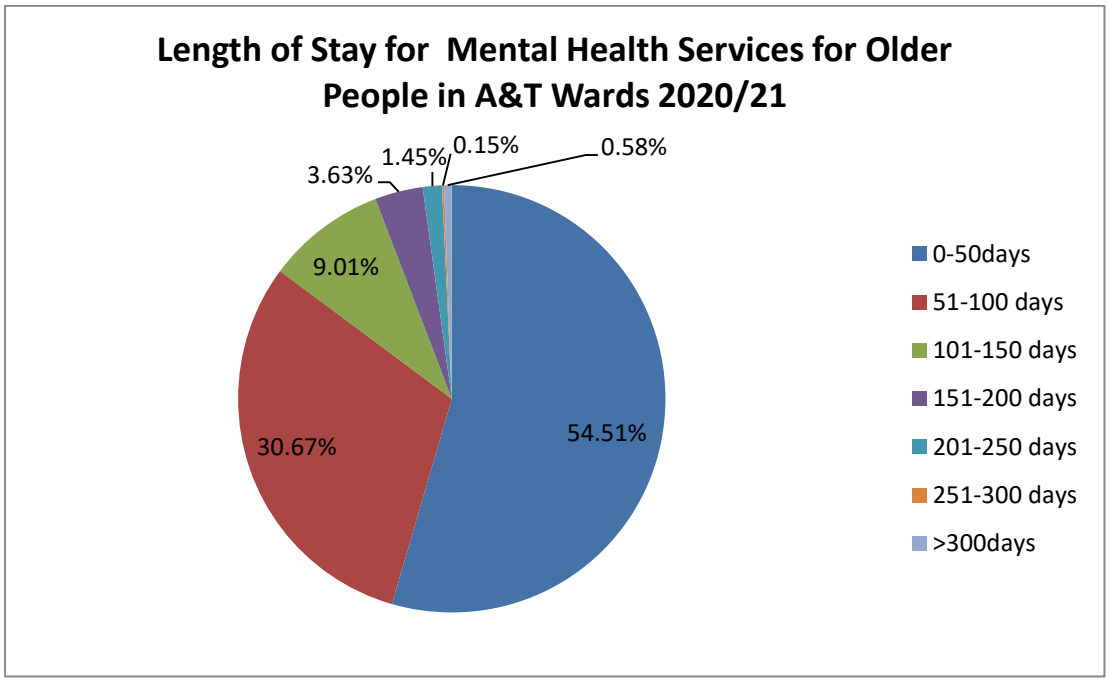


Figure 2: Average length of stay for MHSOP during 2020/21

The length of stay of patients (for both adults and older people) is closely monitored by all services within the Trust. The reasons for the increase in 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 skewed the overall average. In total (Adults and MHSOP) **82.63%** of lengths of stay were between 0-50 days, with **12.52%** between 51-100 days. There were 26 patients who had a length of stay greater than 200 days. Given the unprecedented times, it has not been possible to gather the level of intelligence in terms of this area of underperformance that would normally be included within this report.

Metric 7: Percentage of patients who reported their overall experience as excellent or good

The end of **2020/21** position was **90.32%** which relates to **10,109** out of **11,192** surveyed. Whilst we have not reached our target of 94% we are very pleased to see that over 90% of our patients reported their overall experience as excellent or good

All localities underperformed against the target in 2019/20. **Teesside** were closest to the target with **93.42%** and **Forensic Services** was performing furthest away from the target at **86.21%.**

Metric 8: Percentage of patients that report that staff treated them with dignity and respect

The end of **2020/21** position was **84.59%** which relates to **9363** out of **11,069** surveyed. This is **9.41%** below the Trust target of **94.00%.**

All localities underperformed in 2020/21. **Teesside** were closest to the target with **88.62%** and **Forensic Services** were furthest away from the target with **81.23%.**

We continue to focus on this important area of patient experience; our patients tell us that treating people with dignity and respect includes staff treating people in a caring and compassionate way which will be strengthened by the work we are doing on our Trust values and empathy training for staff. It is also about involving people in decisions around their care which will be supported by the ongoing quality priority around personalised care planning and our goal of co-creation. Having an environment that respects privacy and dignity is important and we are proud that we have eliminated all dormitory accommodation and all patient bedrooms are now single, many with ensuite facilities.

Metric 9: Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment

The end of **2020/21** position was **89.94%** which relates to **9521** out of **10,586** surveyed. This is **4.06%** below the Trust target of **94.00%.**

Whilst the Trust has not met its own target, we are pleased that almost 90% of our patients would recommend our services and we continue to focus on a range of improvement work focused on providing high quality and responsive services that provide a good patient experience. Examples are given throughout this report.

All localities underperformed in 2020/21. **Teesside** were closest to the target with **93.55%** and **Forensic Services** were furthest away from the target with **85.43%.**

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 the NHS Oversight Framework 2019/20 Annex 2, released in August 2019.

Single Oversight Framework

Indicators		2020/21		2019/20	2018/19	2017/18	2016/17	2015/16
		Threshold	Actual	Actual	Actual	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	56%	77.58%	77.53%	64.89%	73.32%	70.04%	55.91%
B	IAPT/Talking Therapies – proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	50%	50.89%	48.83%	51.29%	50.44%	48.32%	N/A
C	Percentage of people referred to the IAPT programme that were treated within six weeks of referral	75%	98.70%	96.49%	97.91%	95.49%	95.44%	84.01%
D	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral	95%	99.93%	99.84%	99.73%	99.89%	99.14%	95.93%
E	Percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care	>95.00%	96.14%	97.56%	97.31%	96.52%	98.35%	97.75%
F	Admissions to adult facilities of patients who are under 16 years old	N/A	1	0	0	1	N/A	N/A
G	Inappropriate out of area placements (OAPs) for adult mental health services	N/A	2061	2367	874	1913	N/A	N/A
H	Data Quality Maturity Index (DQMI) – Mental Health Services Data Set Data Score	N/A	98.20	98.2	N/A	N/A	N/A	N/A

Notes on the Single Oversight Framework Targets and Indicators

The data represents the Trust's position as monitored through internal processes and reports.

Metric F: Admissions to adult facilities of patients who are under 16 years old

There was one Tees Valley CCG patient under the age of 16 admitted to an adult ward in February 2021. The patient was admitted under section because no CAMHS

PICU beds were available nationally; they spent one night in a Trust AMH unit but in a specific area separated from the main adult ward under 2:1 observations. The child did not therefore come into contact with any of the AMH service users on the main part of the ward.

Metric G: Inappropriate out of area placements for Adult Mental Health Services

The national standard we agreed with NHS England has been largely impacted by an ongoing concern in Durham & Darlington Locality. Adult Mental Health Services have reported an increase in acuity that has particularly affected female wards, resulting in increased lengths of stay and higher bed occupancy, which has led to more female patients requiring placement out of area. This has been further impacted by Covid-19 outbreaks on wards, which necessitated temporary closures to new admissions and beds having to be sourced within other areas of the Trust. The Service does not have the facility to utilise swing beds, so are not able to flex AMH female and male bed capacity to respond to demand. Pressure remains on AMH female beds and admissions continue to be coordinated proactively across the locality and repatriated where possible.

Within Mental Health Services for Older People the increase has been primarily attributable to a Covid-19 outbreak on a ward, which prevented new patients from being admitted to the ward and beds having to be sourced within other areas of the Trust.

Metric H: Data Quality Maturity Index (DQMI) – Mental Health Services Data Set Data Score

The latest available published data is at December 2020.

External Audit

Due to the COVID-19 pandemic, the external audit of the 2020/21 Quality Account was stood down.

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. Due to the Covid-19 pandemic we have been unable to hold our usual Stakeholder engagement events; however we have sought views from our Stakeholders, service users, carers and staff through a variety of other means throughout the year, including Our Big Conversation (see Page 12). We have used this feedback when formulating our priorities and actions for 2021/22.

In line with national guidance, we have circulated our draft Quality Account for 2020/21 to the following stakeholders:

- NHS England
- North East Commissioning Support
- Clinical Commissioning Groups (County Durham, Tees Valley, North Yorkshire, Vale of York)
- Local Authority Overview & Scrutiny Committees (x9 inc. Tees Valley Joint Committee)
- Local Authority Health & Wellbeing Boards (x7)
- Local Healthwatch Organisations (x8)

All the comments we have received from our stakeholders are included verbatim in **Appendix 4.**

The following are the general themes received from stakeholders in reviewing our Quality Account for 2020/21:

The Trust will write to each stakeholder addressing each comment made following publication of the Quality Account 2020/21 and use the feedback as part of the annual lessons learnt exercise in preparation for the Quality Account 2021/22.

APPENDICES

Appendix 1: 2020/21 Statement of Director's 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 20120/21 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 2020 to May 2021
    - Papers relating to quality reported to the Board over the period April 2020 to May 2021
    - Feedback from the Commissioners dated10th June 2021 and 21st June 2021
    - Feedback from local Healthwatch organisations dated 17th June 2021, 18th June 2021 and 21st June 2021
    - Feedback from Overview and Scrutiny Committees dated 17th June 2021, 18th June 2021 and 21st June 2021
    - The Trust's complaints information reported to its Quality Assurance Committee of the Board of Directors, which will be published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - The latest national patient survey published 24th November 2020
    - The latest national staff survey published 11th March 2021
    - CQC inspection report dated 3rd March 2020 and 26th March 2021

- 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 Account 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:

25th June 2021……Chairman

25th June 2021……Chief Executive

Appendix 2: Glossary

Adult Mental Health (AMH) Services: Services provided for people aged between 18 and 64 – known in some other parts of the country as 'working-age services'. These services include 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 have Early Onset Dementia. Early Intervention in Psychosis (EIP) teams may treat patients less than 18 years of age as well as patients aged 18-64

Audit: An official inspection of records; this can be conducted either by an independent body or an internal audit department

Autism Services/Autistic Spectrum: This describes a range of conditions typically characterised by social deficits, communication difficulties, stereotyped or repetitive behaviours and interests, and in some cases cognitive delays

BAME: Black and Minority Ethnic; is defined as all ethnic groups except White ethnic groups. It does not relate to country of origin or affiliation

Board/Board of Directors: The Trust is run by a 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 in manages. It is overseen by a Council of Governors and monitored by NHS Improvement. It also:

- Ensure effective dialogue between the Trust and the communities it serves
- Monitors and ensures high quality services
- Is responsible for the Trust's financial viability
- Appoints and appraises the Trust's executive management team

Business Plan: A document produced once a year by the Trust to outline what we intend to do over the next three years in relation to the services that we provide

Child and Adolescent Mental Health Services (CAMHS): See Children and Young People's Services (CYPS)

Care Planning: See Care Programme Approach (CPA)

Care Programme Approach: describes the approach used in specialist mental health care to assess, plan, review and coordinate the range of treatment options and support needs for people in contact with secondary mental health services who have complex characteristics. It is called 'an approach' rather than a system because of the way these elements are carried out, which is as important as the tasks themselves. The approach is routinely audited

Care Quality Commission (CQC): The independent regulator of health and social care in England. They 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's Services (CYPS): Mental Health Services for children and young people under the age of 18 years old. This includes community mental health services, inpatient services and learning disability services

Cito: An information technology system which overlays the Trust's patient record system (PARIS) which makes it easier to record and view the patient's records

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 GP practices 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

Clinical Supervision: a supportive mechanism which involves clinicians meeting regularly to reflect on practice, with the intention of learning, developing practice and providing high quality, safe care to patients

Commissioners: The organisations that have responsibility for purchasing health services on behalf of the population in the area they work for

Commissioning for Quality and Innovation (CQUIN): A payment framework where a proportion of NHS providers' income is conditional on quality and innovation

Community Mental Health Survey: a survey conducted every year by the CQC. It represents the experiences of people who have received specialist care or treatment for a mental health condition in 55 NHS Trusts in England over a specific period during the year

Confidential Inquiry: A national scheme that interviews clinicians anonymously to find out ways of improving care by gathering information about factors which 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-creation: This is an approach where a policy or other initiative/action is designed jointly between TEWV staff and service users, carers and families

Council of Governors: Made up of elected public and staff members, and 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

Crisis Resolution & Home Treatment (CRHT) Team: Provide intensive support at home for individuals experiencing an acute mental health crisis. They aim to reduce both the number and length of hospital admissions and to ease the pressure on inpatient units

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 and Security Toolkit: 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

Data Quality Strategy: A TEWV strategy which sets out 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

Department of Health: The government department responsible for Health Policy

DIALOG: A clinical tool that allows for assessment, planning, intervention and evaluation in one procedure and allows more personalised Care Planning

Directorate: 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

Forensic Adult and 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 a prison or court, where their needs can be assessed and treated

Formulation: When 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 to Speak Up Guardian: Provides guidance and support to staff to enable them to speak up safely within their own workplace

Friends and Family Test (FFT): A survey put to service users, carers and staff that asks whether or not they would recommend a hospital/community service to a friend or family member if they need treatment

Gatekeeper/Gatekeeping: Assessing the service user before admission to hospital to consider whether there are alternatives to admission and the involvement in the decision-making processes that result in admission

General Medical Practice Code: The organisation code of the GP Practice that the patient is registered with. This is used to make sure a patient's GP code is recorded correctly

Guardian of Safe Working: Provides assurance that rotas and working conditions are safe for doctors and patients

Harm Minimisation: Our way of working to minimise the risks of sometimes multiple and conflicting harm to both service users and other people

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 (i.e. Local Authorities and the NHS) would work together to improve the health and wellbeing of their local population and to 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 Services Journal (HSJ): A peer-reviewed journal that contains articles on health care

HealthWatch: Local bodies made up of individuals and community groups, such as faith groups and resident's organisations 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

Home Treatment Accreditation Scheme (HTAS): Works with teams to assure and improve the quality of crisis resolution and home treatment services for people with acute mental illness and their carers

Hospital Episode Statistics (HES): 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

Improving Access to Psychological Therapies (IAPT): An NHS initiative to increase the provision of evidence-based treatments for common mental health conditions such as depression and anxiety by primary care organisations

Integrated Care Partnerships: An emerging NHS initiative to encourage integration and place-based planning

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

Intranet: This is the Trust's internal website used for staff to access relevant information about the organisation, such as Trustwide policies and procedures

Learning Disability Services: Services for people with a learning disability and/or mental health needs. TEWV has an Adult Learning Disability (ALD) service in each of its three localities and also has specific wards for Forensic LD patients. TEWV provides Child LD services in Durham, Darlington, Teesside and York but not in North Yorkshire

LeDeR: The learning from deaths of people with a Learning Disability (LeDeR) programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a Learning Disability and reduce health inequalities

Local Authority Overview and Scrutiny Committee: 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 focusses on Health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar and Cleveland councils have a joint Tees Valley Health OSC that performs this function

Locality: Services in TEWV are organised around three localities (Durham and Darlington, Teesside and North Yorkshire & York). Forensic Services are not organised on a geographical basis, but are often referred to as a fourth 'Locality' within TEWV

Locality Management and Governance Board (LMGB): A monthly meeting held in each locality (see above) that involves senior managers and clinical leaders who work in that Locality and take key decisions

Mental Health Act (1983): 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 in 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 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 with a mental health problem. They can be treated for 'functional' illness, such as depression, psychosis or anxiety, or for 'organic' mental illness (conditions usually associated with memory loss and cognitive impairment) such as dementia. The MHSOP Service sometimes treats people less than 65 years of age with organic conditions such as early-onset dementia

Ministry of Defence: The British government department responsible for implementing the defence policy set by Her Majesty's Government and is the headquarters of the British Armed Forces

Mortality Review Process: A Trust process to review deaths, ensuring a consistent and coordinated approach, and promoting the identification of improvements and the sharing of learning

Multi-Disciplinary: This means that more than one type of professional is involved, for example, psychiatrists, psychologists, occupational therapists, behavioural therapists, nurses, pharmacists all working together in a Multi-Disciplinary Team (MDT)

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 to 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 the patients and the public

National Reporting and Learning System (NRLS): 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

NHS Digital: Previously known as the Health and Social Care Information Centre (HSCIC) and 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 England: leads the National Health Service in England

NHS Improvement (NHSI): The independent economic regulator for NHS Foundation Trusts – previously known as Monitor

NHS Long-Term Plan (2019): A new plan for the NHS to improve the quality of patient care and health outcomes. It sets out how the £20.5 billion budget settlement for the NHS, announced by the Prime Minister in summer 2018, will be spent over the next five years

NHS Staff Survey: Annual survey of staff experience of working within NHS Trusts

Non-Executive Directors (NEDs): Members of the Trust Board who act as a 'critical friend' to hold the Board to account by challenging its decisions and outcomes to ensure they act in the best interests of patients and the public

North Cumbria and North East Integrated Care System: Consists of four Integrated Care Partnerships – North, South, East and West (see Integrated Care Partnerships)

PARIS: The Trust's electronic care record, designed with mental health professionals to ensure that the right information is available to those who need it at all times

Patient Advice and Liaison Service (PALS): A service within the Trust that offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers

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

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

Programme: A coordinated group of projects and/or change management activities designed to achieve outputs and/or changes that will benefit the organisation

Project: A one-off, time limited piece of work that produces a product (such as a new building, a change in service or a new strategy/policy) that will bring benefits to relevant stakeholders. Within 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): A unit (or ward) that is designed to look after people who cannot be managed on an open (unlocked) psychiatric ward due to the level of risk they pose to themselves or others

Quality Account: A report about the quality of services provided by an NHS Healthcare Provider, The report is 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 and Assurance

Quarter One/Quarter Two/Quarter Three/Quarter Four: Specific time points within the financial year (1st April to 31st March). Quarter One is from April to June, Quarter Two is from July to September, Quarter Three is October to December and Quarter Four is January to March

Reasonable Adjustments: A change or adjustment unique to a person's needs that will support them in their daily lives, e.g. at work, attending medical appointments, etc.

Recovery College: A learning centre where patients, carers and staff can enrol as students to attend courses based on recovery principles. Our recovery college, *ARCH*, opened in September 2014 in Durham; this resource is available to TEWV patients, carers and staff in the Durham area, and 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: An initiative that allows people to access Recovery College materials and peer support online (see above). This is available to service users and staff in all areas served by TEWV

Research Ethics Committee: An independent committee of the Health Research Authority, whose task it is to consider the ethics of proposed research projects which will involve human participants and which will take place, generally, within the NHS

Royal College of Psychiatrists: The professional body responsible for education and training, and setting and raising standards in psychiatry

Safeguarding: Protecting vulnerable adults or children from abuse or neglect, including ensuring such people are supported to get good access to healthcare and stay well

Secondary Uses Service: The single, comprehensive repository for healthcare data in England which enables a range of reporting and analysis to support the NHS in the delivery of healthcare services

Section 29a Notice: This is a warning notice served by the CQC where concerns are identified across either the whole or part of an NHS Trust and where it is decided that there is a need for significant improvements in the quality of healthcare

Senior Leadership Group (SLG): Individuals at the senior level of management within the organisation (e.g. Directors) who meet on a regular basis. They are responsible for the overall management of TEWV and the high-level decisions within the organisation

Serious Incident (SI): An incident that occurred in relation to NHS-funded services and care, to either 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 delivery of services, absconding from secure care

Single Oversight Framework: sets out how NHS Trusts and NHS Foundation Trusts are overseen

Specialties: The term that TEWV uses to describe the different types of clinical services that we provide (previously known as Directorates). The Specialties are Adult Mental Health Services, Mental Health Services for Older People, Children and Young People's Services and Adult Learning Disabilities

Staff Friends and Family Test: A feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It helps the Trust to identify what is working well, what can be improved and how

Statistical Process Control (SPC) charts: a graph used to show how a process changes over time and to see whether a situation is improving or deteriorating, whether the system is likely to be capable to meet the standard and whether the process is reliable or variable

Steering Group: Made up of experts who oversee key pieces of work to ensure that protocol is followed and provide advice/troubleshoot where necessary

Strategic Framework: primarily intended as a framework for thinking about the future and a guide to inform the investment and disinvestment decisions by those tasked with future planning

Substance Misuse Services: Clinical services who work with people who abuse alcohol, illegal drugs or over-the-counter or prescription medications in a way that they are not meant to be used

TEWV: Tees, Esk and Wear Valleys NHS Foundation Trust

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 Trust-wide

The Trust: see TEWV above

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 Adult Services

Trust Board: See Board/Board of Directors above

Trustwide: The whole geographical area served by the Trust's localities

Unexpected Death: A death that is not expected due to a terminal medical condition or physical illness

Urgent Care Services: Crisis, Acute Liaison and Street Triage services across the Trust

Whistleblowing: this is a term used when a worker highlights a concern about their organisation and/or services to the Freedom to Speak Up Guardian or NHS Regulators. This will normally be regarding something they have witnessed at work

Year (e.g. 2019/20): These are financial years, which start on the 1st April in the first year and end on the 31st March in the second year

Appendix 3: Key themes from action plans produced in response to 130 Local Clinical Audits in 2020/21

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
1. Infection Prevention and Control (IPC)	• All Infection Prevention and Control (IPC) audits are continuously monitored by the IPC Team and any required actions are rectified collaboratively by the IPC Team and ward staff. Assurance of implementation of actions is monitored by the Clinical Audit and Effectiveness Team via the clinical audit action monitoring database. • A total of **96** IPC clinical audits were conducted during 2020/21 in inpatient areas, prison teams, and community teams where there is a clinic. **73% (70/96)** of clinical areas achieved standards between 90-100% compliance. Local clinical audit action plans were implemented in collaboration with the IPC Team and the clinical team members to mitigate all areas of non-compliance.
2. Medicines Management	• The Trust Pharmacy Team continues developments to ensure that documentation is robust for leave/discharge controlled drugs medication. Pharmacy have re-introduced the controlled drugs newsletter within the Trust to encourage improvement in the management of controlled drugs and to share good practice. • The admissions checklist was updated to provide a prompt to staff to document evidence that patients are given information about their medication. • The Pharmacy Team issued a bulletin including key areas of note from the National Prescribing Observatory for Mental Health (POMH) clinical audit in relation to antipsychotic prescribing for people with a learning disability. Key areas highlighted included awareness of the Mental Capacity Act principles at the time of prescribing and associated documentation and use of the Trust's Psychotropic Medication Monitoring Guide. • The High Dose Antipsychotic Treatment (HDAT) monitoring chart was made available as a Word document to support recording of monitoring on the electronic patient record. • A presentation was given to the Trainee Doctor induction which included results from the Clinical Audit of Prescription and Administration Chart Standards. This highlighted the importance of completing all information on the new and re-written charts. The information was also adapted within the Nurse Medicines Management training to remind staff of the importance of not giving medication after the stop date and to ensure that there are two signatures obtained for depot medication.

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
3. Physical Healthcare	• A number of community mental health teams in MHSOP services have established health and wellbeing exercise programmes using existing facilities following clinical audit results. • The use of the Measure Yourself Medical Outcome Profile (MYMOP) was promoted to be conducted as part of the Physiotherapy Functional Clinical Link Pathway (CLiP). • All inpatient wards have the New Early Warnings Score (NEWS) as an agenda item within the MDT meeting or on their report out board • Clinical audit has evidenced key quality improvements for compliance with the Emergency Response Bag equipment and associated daily monitoring. • The requirement to conduct an e-cigarette risk assessment on admission of patients was highlighted to all teams. Teams were advised to undertake weekly reviews looking at suitability of product choice, strength, and quantity of nicotine for patients identified as smokers and admitted for more than one week. • Additional dedicated support was provided to specific wards by the Smoke Free Trust Lead following the clinical audit findings. • The assessment documentation has been adapted to include the requirements of history taking for medical or genetic problems/disorders for Autism Spectrum Disorder. An information pack on genetics and family risk of Autism is in development. • The Trust continues to use information from the monthly NHS Patient Safety Thermometer to compare and review this data against wider incident data to inform the Trust position in relation to measurable patient harms.
4. Service Provision	• Clinical audit results have been used to successfully establish a resource increase within the Autism Spectrum Disorder (ASD) Team.
5. Policy and Pathway Developments	• The Trust Did Not Attend (DNA) / Was Not Brought policy was amended following clinical audit findings to highlight the requirements relating to attempting same day contact with all patients irrespective of whether the patient has previously not attended or is unknown to services. The policy also includes a standard protocol for Crisis Teams and this was shared with all Crisis Team Managers. • A review of policies/procedures was undertaken and established that there was clear guidance in the Trust which includes a recording template to be for services to use. • The Autism Pathway will be amended to include a flowchart to ensure that there is a clear process for staff to follow all appropriate steps. • The Venous Thromboembolism (VTE) e-Learning training will be linked within the VTE Trust Policy. • The Trust Care Programme Approach (CPA) policy will be revised following clinical audit findings in line with system changes and national guidance, particularly in relation to the implementation of the Community Services Framework for Adults and Older Adults.
6. Supervision	• Specialist services monitor and routinely report the duration of clinical supervision received by staff. Local actions have been progressed within Locality Performance Improvement Groups in collaboration with Team Managers and Modern Matrons to make improvements in practice. • Clinical Audit has facilitated improvements in the documentation of supervision requirements within Health and Justice, Prison and Liaison & Diversion Teams. This is being further enhanced Trust wide through the recording of all supervision sessions on the electronic system (Foundry).
7. Transition from CAMHs to AMHs	• A review of the administration capacity available to support transition panels (for young people moving into adult services) in each locality is in progress. A standard process description has been implemented for meetings between professional to ensure consistent documentation of panel meetings. An agreed panel meeting format will also be standardised across the Trust led by the Service Development Manager.

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
8. Systems Development	• Findings from the Prescribing Observatory for Mental Health (POMH) audit cycle regarding Prescribing for Depression in Adult Mental Health Services have been used to support the development of the new electronic care records system (CITO). • Findings of the National Clinical Audit of Psychosis in EIP services have been used to support the development of the physical health monitoring for psychosis module within the new electronic care record. • Clinical audit findings identified areas which required improvement related to documenting functional problems/disorders. This is being actioned by adaptations to the differential diagnosis and screening document within the electronic care record. • The VTE risk assessment document will be built into the electronic care records system. This will facilitate generation of an automatic alert if the risk assessment has not been completed for the patient by the clinical staff.
9. Care Programme Approach	• A communication plan is in development to ensure staff are aware of changes in the CPA processes, primarily to support the introduction of DIALOG and other system developments. • A range of multi-media guidance is in development following learning from clinical audit findings to support the implementation of DIALOG.
10. Training	• Training in Autism Diagnostic Observation Schedule (ADOS-2) assessments was provided to clinical staff following clinical audit findings. • The Level 3 Safeguarding training was updated to include areas of good practice and areas for improvement identified by the safeguarding clinical audit.

Appendix 4: Feedback from our Stakeholders

Contact: Councillor Patricia Jopling
Direct Tel: 03000 269140
email: Patricia.jopling@durham.gov.uk
Your ref:
Our ref:

Mr. B Kilmurray,
Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust,
West Park Hospital
Edward Pease Way
Darlington
DL2 2TS

21 June 2021

Dear Mr Kilmurray,

Tees Esk and Wear Valleys Foundation Trust – Quality Accounts 2020/21

Please find attached Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee's response to your draft Quality Accounts for 2020/21.

The response provides commentary on the Trust's performance for 2020/21 as well as the identified priorities for 2021/22.

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,

On behalf of:
Councillor Patricia Jopling,
Chair of Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee

Resources
Durham County Council, County Hall, Durham DH1 5UF
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DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON TEES ESK AND WEAR VALLEYS NHS FOUNDATION TRUST QUALITY ACCOUNT FOR 20221

The Committee welcomes Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust's Quality Account 2020/21 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 usually undertakes in year monitoring of the trust's progress against their quality account priorities however, the pressure placed upon both the NHS and Social Care system by the COVID-19 pandemic alongside the reduced number of Overview and Scrutiny Committee meetings and more prioritised work programme has not made this possible during 2020/21.

The context for the Quality Account in terms of the pressure placed upon TEWV to maintain services and performance whilst at the same time ensuring that they are COVID-19 safe is noted. Members have engaged with the Trust in respect of the specific impact of the COVID-19 pandemic on the services provided by TEWV. Examination of the closure of inpatient beds at West Lane Hospital, Middlesbrough has previously taken place, and the committee have asked that the CQC inspection improvement plan be brought to members for consideration. A detailed examination of the implications of the West Lane Hospital closure and the plans for reprovision of the service has been undertaken by the county council's Children and Young Peoples' Overview and Scrutiny Committee.

The Committee considers that the Quality Account is clearly set out and that progress made against 2020/21 priorities is clearly identified. The committee notes the positive steps taken by the Trust during the past year including the support provided to Care Homes in County Durham by the Care Home Liaison staff; the launch of the Trust's new freephone service for those in mental or emotional distress; additional funding secured for Adult Learning Disabilities in Durham and Darlington working with Primary Care to complete annual health checks; and the commencement of the Care Home Liaison service across Durham and Darlington Mental Health Services for older people.

Members remain concerned about the impact of the current COVID-19 pandemic on mental health within the community, which is likely to result in a further increase in demand upon mental health services and therefore are keen to learn from TEWV as to how they are working with partners across the health and social care system to ensure that service users continue to be supported.

In respect of the proposed quality account priorities for 2021/22, the committee supports them and the associated actions. It also notes with some concern the cessation of the 2020/21 priority "Improve the clinical effectiveness and patient experience in times of transition from children and young peoples' mental health

services to Adult mental health services". This was an area of concern identified by the Committee particularly in view of the events leading to the closure of West Lane Hospital and the CQC inadequate judgement of the Trust. The Trust has indicated that the new trust-wide project "Improving Transitions and Service provision for people aged 16-25 in Tees Esk and Wear Valleys NHS Foundation Trust" has supersedes the work of the previous priority. It is therefore important that the work of this new project is implemented and monitored to ensure that it addresses those issues identified by the CQC.

Finally, in order to ensure that it continues to provide a robust health scrutiny function and to provide assurances in this respect to the residents of County Durham, the Committee would request a six monthly progress report on delivery of 2021/22 priorities and performance targets with a particular emphasis on the effects of COVID-19 on demand and the trust's response to this.

Tees, Esk and Wear Valleys NHS Foundation Trust – Draft Quality Account 2020/21

Members of the Health and Housing Scrutiny Committee welcomed the opportunity to consider the draft Quality Account 2020/21 for Tees, Esk and Wear Valleys NHS Foundation Trust and had the following comments to make:

Members noted the progress made against the four priorities, 'Making Care Plans more personal', 'Improve the clinical effectiveness and patient experience in times of transition from CYP to AMH Services', 'Reduce the number of Preventable Deaths' and 'Increasing the percentage of inpatients who feel safe on our wards' and welcome the actions outlined to further embed improvements for the priorities that will be continuing into 2021/22.

Members noted that Safety within the Trust has been identified and recognised as an area of weakness and a key area for overall improvement and so look forward to seeing improvements against the 2021/22 performance targets, with particular emphasis on the need to reduce the number of serious incidents where it was identified that the Trust contributed to these incidents; increase the percentage of patients who report feeling safe on the wards; and developing a safe working environment for all staff.

In relation to preventable deaths Members felt that this is very inpatient focused and overall, the majority of TEWV patients will be looked after in the community. Members requested further information be provided in respect of actions taken to address preventable deaths in community settings.
Members also requested further information be provided in respect of audits on aggression or restraint.

Priorities for 2021/22

In respect of the proposed quality account priorities for 2021/22, the committee supports the retention of the priority 'Making Care Plans more personal' and welcomed the amalgamation of the priorities 'Reducing Preventable Deaths' and 'Increasing the Percentage of Inpatients who feel Safe on our Wards' to form Priority 2 – Safer Care and the new priority 'Compassionate Care'.

In relation to the priority 'Improve the clinical effectiveness and patient experience in times of transition from CYP to AMH Services', Members noted that the majority of the actions to achieve this priority were suspended due to the Covid-19 pandemic and that the work of this priority has been superseded by the Trust-wide project 'Improving Transitions and Service Provision for People aged 16 to 25 years in Tees, Esk and Wear Valleys NHS Foundation Trust'. As such Members acknowledged that this priority would not be carried forward into the Quality Account priorities for 2021/22.

Overall, Health and Housing Scrutiny Committee welcomed the opportunity to comment on the Trust's Quality Accounts and were pleased with the Trusts progress against the chosen priorities, in a particularly 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 as and when circumstances allow these.

Councillor Ian Bell
Chair, Health and Housing Scrutiny Committee

From: christopher@healthwatchhartlepool.co.uk
[mailto:christopher@healthwatchhartlepool.co.uk]
Sent: 18 June 2021 12:29
To: PICKERING, Sharon (TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST)
Cc: KIRKBRIDE, Laura (TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST); Stephen Tomas; 'Zoe Sherry'; 'wrenn ARTHUR'
Subject: Healthwatch Hartlepool - Response to proposed TEWV NHS Foundation Trust Draft Quality Account 20/21

Dear Sharon,

First, may I thank you on behalf of Healthwatch Hartlepool for the opportunity you have gave us to comment on the Tees, Esk and Wear Valleys NHS Foundation Trust Draft Quality Account 2020/21. We appreciate what a difficult year everyone has endured, and the priority has very much been about keeping people (patients, staff, carers etc.) safe and protected during the pandemic. It is good that there remains ambition for future plans, up and above the difficulties encountered keeping status quo. Perhaps in the future we may be better informed of how planning and associated outcomes are embedded in our local communities. We feel the draft Quality Account has been crafted at quite a high level and therefore it has been difficult for us to share the document widely and initial feedback was that our members would have liked to see greater transparency of how services were being delivered locally across Hartlepool.

Initially we would like to raise the issue of care-planning (page 12) and note our concern that a consistent, patient-centred, co-produced approach to care planning has not been achieved across the Trust. This must be addressed in the coming year as it is central to the delivery of excellent care outcomes for patients and a key factor in achieving Priorities 2 and 3 (Safer Care and Compassionate Care) as outlined on Page 12. We would very much hope that the priority to improve the format, content, consultation, and explanation to every patient is indeed achieved. Every patient should have their personalised care plan that includes all services that they use.

Some Achievements really stand out and should be applauded. The CAMHS SPoC, which has had such a beneficial effect on access and signposting to appropriate services. We note the new free phone service, though welcome, it does not have the number attached. Likewise (Page 9) he DadPad app is new to us, and we would like to see this promoting.

We welcomed the ‘Big Conversation’ that involved so many people that allowed an insight into how the Organisation is perceived, and what could be remedied to make it make accessible and understood.

On the transition service CYP to AMH. We are happy to see the proposed changes. We noted the delayed metrics and we look forward to the update when these are published at Quarter 3. The ‘Freedom to speak up’, which came out of the Francis Review is a positive move. We sincerely hoped that all staff have access to this should they feel it necessary

May we also ask regarding Page 45 & the last paragraph about enhanced GP-Aligned Mental Health services? Is there any tangible evidence that has been

published to corroborate that this is working? We would welcome having sight of this if available.

It is extremely good to know the additional COVID19 monies for staffing has been put to good use.

Finally, we must say the performance indicator for Out 0f Area Placement (OAP's) (Page 61) is concerning. Though the explanation around the problems with the female wards and the COVID19 ward closures, which prevented new admissions and beds being sourced to other areas in the trust, there were still a large number of people placed away from families and friends, which would not be acceptable to some. It is hoped that this will soon be resolved as the pandemic hopefully passes.

Kind regards,

Mr Christopher Akers-Belcher
Chief Executive - Healthwatch Hartlepool

HealthWatch Hartlepool
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Wynyard Road
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Tel; 01429 288146
Visit: www.healthwatchhartlepool.co.uk

Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) Quality Accounts for 2020-21.

These comments are on behalf of Healthwatch Darlington Limited. (Jubilee House 1 Chancery Lane Darlington DL1 5QP). (June 2021)

Healthwatch Darlington (HWD) have welcomed the opportunity to be involved with Tees Esk and Wear Valley NHS Foundation Trust (TEWV) Quality Accounts over the last twelve months and understand the restrictions and delays which the Covid -19 pandemic has had on the Trust over this period.

Making Care Plans more personal

HWD appreciate the difficulties of implementing actions for this priority during the pandemic with the redeployment of staff which has highlighted why not much progress has been made other than some staff training. HWD are pleased to see that this will be rolled over to next year and hope to see improvements then.

Improve the clinical effectiveness and patient experience in times of transition from Child to Adult Services Priority

HWD were disappointed to read that the majority of this was suspended due to Covid-19 pandemic but are pleased to read that the Trust has a new initiative 'Improving Transitions and Service Provision for People aged 16 to 25 years, which is linked to the Trust's wider work around the NHS England CAMHS 'Whole Pathway Commissioning'. HWD look forward to learning more about the project and look forward to seeing more information.

Reduce the number of Preventable Deaths

HWD understand and recognise that people with a mental health problems, autism and/or a learning disability are likely to experience a much earlier death than the general population and are pleased to see that the Trust continue to set this as a priority. It is disappointing to see that there were 55 serious incidents being recorded which is well above the target of 30. However, you do report that each of these incidents have had a robust action plan in place for service improvement with the aim of reducing similar incidents during 2021/22. We are also pleased to see that families and carers are fully involved in reviews and investigations.

We also note the CQC rating of Requires Improvement and measures and action plan have been put in place to support the delivery of safe patient care.

PRIORITY 2021/22

Making Care Planning more Personal (this is a continuation of our previous Quality Improvement priority) HWD agree that this continues to be a priority as individuals have individual needs and this needs to be added to peoples care plaining.

Safer Care (this is an amalgamation of two of our previous Quality Improvement priorities - Reducing the number of Preventable Deaths and Increasing the percentage

of our inpatients who feel safe on the wards) HWD welcome this priority in light of the CQC recommendations.

Compassionate Care Reviewing HWD welcome this priority**.**

HWD agree and welcome these priorities, we understand the complex needs of some of the patients and appreciate the commentary within the report explaining these complexities and the reflection they have on targets.

Healthwatch Darlington agree with the priorities set out by the Trust for 2021-22 and thank you for involving Healthwatch Darlington. Healthwatch Darlington have enjoyed the opportunity to work with Tees Esk and Wear Valley NHS Foundation Trust. We look forward to working with the Trust in 2021-2022.

NHS
Vale of York
Clinical Commissioning Group

NHS Vale of York CCG
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York
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21st June 2021

Website: www.valeofyorkccg.nhs.uk

Dear Mr Kilmurray,

Re: Tees Esk and Wear Valleys NHS FT Quality Account 2020/21

Many thanks for the submission of the TEWV Quality Accounts. This details what the Trust has done to improve the quality of our services in 2020/21 and how you intend to make further improvements during 2021/22. NHS Vale of York CCG welcomes the opportunity to provide comments on this report.

Firstly, we would like to take this opportunity to thank all staff at Tees Esk and Wear Valleys NHS FT for their hard work and dedication during the COVID19 pandemic that has been ongoing for a significant period of time. The efforts taken in responding to this health crisis have been truly impressive across the health system. We would like to extend our gratitude and appreciation to you all, for your part in the local NHS and wider system response.

Following the Care Quality Commission (CQC) visit in January 2021 the CCGs are working with the Trust through the established NHSE/I led Quality Board to support the Trust in responding to actions arising from elements of the report. Whilst the overall rating of the Trust is currently 'Requires Improvement', system partners recognise the incredible amount of progress that has been made following inspection and how these actions will continue into the Quality priorities for 2021/22.

The Trust set out to achieve four priorities in 202/21. We appreciate that due to the impact of the pandemic varying levels of progress have been made against these priorities. Our comments are focussed mainly upon these key priorities

- **Making Care Plans more personal** - There has been limited progress made in this priority due in part to the pandemic and also note the patient reported views of personalisation have reduced during this year. We fully recognise the impact of the pandemic, however fully agree that this needs to continue as a priority for 2021/22.

- **Improve the Clinical Effectiveness and Patient Experience in times of Transition from CYP to AMH Services** – We recognise the change in scope for this work as the 'Improving Transitions and Service Provision for People aged 16 to 25 years in Tees, Esk and Wear Valleys NHS Foundation Trust' project commenced and the pandemic impact. We acknowledge the numbers of young people supported by the Trust are increasing with subsequent impact upon those requiring effective and personalised transition plans. Whilst the number of young people who have received a transition plan is positive, there is further work to do to ensure these are meaningful and enable a positive transition from the young person's perspective.

- **Reduce the number of Preventable Deaths** – We recognise the scale of work undertaken Trustwide following the CQC focussed inspection in January 2021. This is upon the background that there has been no reduction in the number of serious incidents where it was identified that the Trust contributed to the incident. Therefore work to ensure there are effective risk assessments and mitigations which are easily accessible and visible for all clinicians involved in an individual's care is paramount. Whilst this work has focussed upon process, we would be interested to hear more about how consideration for wider human factors, culture and compassion are integrated.

  Integrated working with physical health partners is welcomed in order to ensure physical health needs are appropriately assessed and plans in place to meet them. Continued integration is welcomed in order we ensure we strive to ensure our patients are cared for holistically.

- **Increasing the proportion of inpatients who feel safe on our wards** – We recognise there are varying factors that determine whether a patient feels safe, whether these be associated with their own illness or external factors on the ward. There has been slow progress over the year, which is anticipated due to the pandemic, however we expect to see actions being delivered that enable patient reported experience of 'feeling safe' to increase.

Quality Priorities for 2021/22

It is evident from the last year that aspects of the above priorities need to be continued and progress expedited. We therefore welcome and support the Trust's identified Quality Improvement Priorities for 2021/22 of :-

- Making Care Plans more personal
- Safer Care
- Compassionate Care

In addition to the actions identified for these priorities, we would welcome inclusion of mental health transformation where adults and older adults who have severe mental illnesses will be supported to access new and integrated models of primary and community mental health care. This in turn brings greater choice and control over their care, and to be supported to live well in their communities. Primary Care Network integration and closer working across social care and the voluntary care sector is fundamental to this.

The CCG would like to acknowledge the continued commitment from all staff to improve and deliver high quality services. We welcome the opportunity to review the Quality Account and look forward to continuing to work with the Trust to build on these successes.

We can confirm that NHS Vale of York CCG are satisfied with the accuracy of this Quality Account and consider it to be a fair reflection of the Trust's performance and acknowledges the progress made to improve patient safety and experience despite the challenges brought about by the ongoing pandemic. The key successes and challenges are reflected in the Quality Account.

The CCG look forward to continuing to work collaboratively with Tees Esk and Wear Valleys NHS FT in 2021/22 .

Yours sincerely.

Michelle Carrington

Executive Director Quality and Nursing

NHS Vale of York Clinical Commissioning Group

Thanks Laura,

It's a very informative QA, thank you.

My only two observations are:

- In terms of future priorities, I couldn't see a mention of the formation of provider collaboratives. This will be an exciting development for the Trust and will have some impacts on quality assurance in the future
- In relation to the quality metrics, I didn't see any mention of the Specialised Services Quality Dashboards (SSQDs). The mandatory reporting of these has been stood down (due to COVID), but where they have been completed they may have some usual data

Steven

Steven Duckworth
Head of Quality

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June 2021

Response from Healthwatch York to Tees, Esk and Wear Valleys NHS Foundation Trust Quality Account 2020/21

Thank you for giving Healthwatch York the opportunity to comment on your Quality Account 2020/21.

Healthwatch York acknowledge this year has been a uniquely challenging one for all partners. In previous years, we have welcomed the opportunity to work in partnership with TEWV on public engagement events. We have also been grateful in the past for the way the Trust have welcomed our volunteers and enabled their continuing involvement. We look forward to a time where we can once again work collaboratively on bringing people together to shape local services, especially the opportunities that the Community Mental Health Transformation work provides for doing this for York.

It is good to see that the focus on reducing preventable deaths will remain for 21/22, and that this work has a focus on improving the physical health of those experiencing mental ill-health. We were recently asked to get involved in surveying people about how well the physical health checks for people with severe mental illness are operating locally, and any barriers to this, and we look forward to working with TEWV to make sure this reaches the widest possible audience, and to make sure what we hear helps lead to improvements in our offer.

We also welcome the new priority around compassionate care. We hear so many stories where the fundamental problem boiled down to a failure to ever really listen, empathise, and then build care or support around this. We also hope this approach extends to supporting the resilience of frontline staff and managers, so that they feel able to be their best at work, rather than facing compassion fatigue and burnout.

Healthwatch York appreciates the commitment TEWV have shown to keeping partners informed, and particularly as the Coronavirus pandemic began to affect service delivery. This enabled us to provide accurate information at a time of very rapid change.

Dear Laura

Please see below the feedback from County Councillor John Ennis, the Chairman of the North Yorkshire County Council Scrutiny of Health Committee:

The North Yorkshire County Council Scrutiny of Health Committee has been in regular contact with the Tees Esk and Wear Valleys NHS Foundation Trust for a number of years and has appreciated the open and constructive dialogue that has been maintained as mental health services in the county have gone through a number of changes. We have seen a reduced emphasis upon in-patient treatment and consequently more investment in enhanced community services; the opening of a new, purpose built hospital in York; the development of community hubs and new facilities for community based work in Northallerton and Selby; widespread public engagement through 'Our Big Conversation'; and a strong focus upon improving the breadth and depth of services in the county. The last of these points will take time as the county has, historically, seen years of underinvestment in mental health services, when compared to similar local authority areas. It is recognised that the work to improve and expand services is demanding and is taking place within the context of ongoing workforce pressures and shortages.

The committee is interested to see how the Foundation Trust will work with the developing Integrated Care System and Partnerships, which will lead on the commissioning of health services in the county. In particular, how the profile of mental health services and the needs of service users will be maintained in amongst many competing demands and priorities.

The Foundation Trust has kept the committee fully informed of how it has adapted to working during the pandemic and what measures it has put in place to enable services to continue in a safe manor and in a way that is open and accessible to people with serious and enduring mental health problems. It is noted that the pandemic and periods of prolonged social isolation and stress associated with a series of lockdowns has increased the demand for services, often from people who have previously been unknown to them.

Whilst recognising the huge amount of work that the Foundation Trust has done over the past year to support service users and staff and implement new ways of working, there have been some concerns raised by the Care Quality Commission following inspections in March 2020 and March 2021. The committee has been kept informed of the reasons for the issues identified in the inspections and the plans that have been developed and implemented to respond to and rectify them, which has been appreciated. The committee will continue to monitor closely progress with the Trust's action plan for dealing with the CQC's criticisms.

Please do not hesitate to contact me if I can be of any further assistance.

All the best

Daniel

Daniel Harry

Democratic Services and Scrutiny Manager
North Yorkshire County Council
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Appendix 5: Our Quality Account – Plan on a Page

Priority One: Making Care Plans more personal

- Ensure finalised, working version of DIALOG is embedded within CITO
- Ensure all relevant stakeholders are aware of changes to CPA processes
- Develop guidance and training to support the implementation of DIALOG
- Identify how many patients/agreed others receive a care plan and understand key elements of safety, quality, timeliness and accessibility and address the issues identified
- Establish Steering Group with identified governance structures to oversee the development and implementation of high quality, collaborative care planning that is fit for purpose
- Agree how to align with but not duplicate the care plan and safety plan to ensure a simple, consistent and comprehensive plan
- Review and revise local CPA policy in line with system changes and national guidance
- Review and update care planning training
- Assess additional actions and priorities to remove barriers to care planning
- Work with teams and commissioners to ensure sufficient capacity is built into clinic scheduling to properly co-create and develop care plans

Priority Two: Safer Care

- Communicate and share the agreed patient safety priorities
- Determine the programmes of work for each of the four patient safety priorities, assess current baseline and identify process and outcome KPIs
- Promote the role of the Trusts Patient Safety Specialist
- Work in collaboration with the 'Better Tomorrow programme: learning from deaths, learning from lives' to improve our processes and develop support networks
- Review and update Learning from Deaths Policy
- Work proactively within the newly formed Regional Patient Experience Network
- Identify priority wards, talk to people currently on these wards, develop and implement an action plan
- Further review information from patient experience surveys and concerns raised from patients and carers
- Seek ideas as part of the 'mutual help' meetings that take place on the wards on what we can do to make patients feel safe
- Review current 'ward orientation' process for patients being admitted onto our wards and incorporate into personal safety plans
- Continue existing pilot of body cameras and develop a business case for further roll-out
- Deliver the four organisational learning work programmes
- Develop an integrated organisational learning report with an initial focus on patient safety
- Develop our systems for ensuring the impact of improvement actions from learning

Priority Three: Compassionate Care

- Hold engagement events with staff to develop our new ways of working together, with involvement of service users and carers and share outputs from these events
- Commission and deliver a range of educational approaches with a focus on Empathy and Compassion
- Design, develop and deliver a Trust leadership programme with service users and carers and all staff in formal leadership positions to complete
- Seek views of staff about organisational processes and systems which do not live the values, or which get in the way of them living the values
- Review People & Culture processes and policies in relation to Trust values
- Review our people management processes and policies in relation to Trust values
- Ensure people have access to meaningful breaks and thinking time
- Model the values in how we communicate, how we hold meetings
- Promote the values through our interactions with service users and carers
- Identify additional involvement opportunities e.g. HealthWatch, survivor groups, support groups
- Produce a prioritised plan for the future in conjunction with other partners
- Present findings and discuss possible changes with lead Directors around organisational processes and systems which do not live the values
- Implement a process to capture informal concerns and complaints that enables us to identify any key themes where patients have raised issues with us
- Director of Quality Governance and Patient Safety Team to work with patients and families to develop the Serious Incident review process

ITEM NO. 12

FOR DISCUSSION AND APPROVAL

TRUST BOARD

DATE:	**30 June 2021**
TITLE:	**Data Security and Protection Toolkit Position**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance** **Liz Romaniak, 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 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:

This paper has been prepared to brief the Board on the activities to date in regard to the Data Security and Protection Toolkit and to gain their approval to the reporting and publication of the Trust's compliance with the toolkit as at 30th June 2021.

The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly.

The Trust has collated evidence against all of the Data Guardians standards and will not be able to return a fully met position this year. It will therefore be necessary to provide an action plan to NHS Digital who will then turn our 'not met' position to one of 'standards not fully met (plan agreed)'. As the toolkit is a dynamic tool we can have our status changed to 'fully met' once the actions have been implemented. The four standards where an action plan will be put forward are for assertions 1.6.4 privacy by design, 4.2.3 policy for retention of audit logs, 7.3.6 back ups kept off site or in cloud, 10.2.1 verification of supplier certification annually. The June 2021 Audit & Risk Committee received the interim DSPT internal audit report and update and agreed to review the action plan and broader supporting actions at a subsequent meeting.

Full details are described below. The Board are required to have an understanding of the top three information risks identified and agreed with the Trust SIRO. The Information department currently has five risks identified in this paper together with the top three data protection risks.

Recommendations:

- That the Trust Board accept the contents of the paper and approve the final publication of the Data Security and Protection Toolkit as at 30th June with all evidence items in place and an action plan for four standards not yet met.

MEETING OF:	**TRUST BOARD**
DATE:	**30 June 2021**
TITLE:	**Data Security and Protection Toolkit Position**

1. INTRODUCTION & PURPOSE:

1.1 The Data Security and Protection Toolkit (formerly IG Toolkit) is an online self-assessment tool published by NHS Digital that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly.

1.2 The purpose of this paper is to:-

- Give the current completion status;
- Identify any evidence items not yet completed that will be reported with an action plan;
- Identify the Trusts top information risks for discussion and agreement
- Provide confirmation, by exception, of the results of the SIRO report

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The toolkit is divided into ten standards, and each standard is broken down into a number of assertions. Evidence items are required against each assertion, some of which are mandatory, and some being non-mandatory.

2.2 There are 110 mandatory evidence items, and for an organisation to be rated 'satisfactory', they must have completed all mandatory evidence items in their toolkit by 30th June 2021.

3. CURRENT STATUS

3.1 Trust position as at 16 June 2021

As at the 16 June 2021 all assertions have been completed. Four assertions have been identified as needing an action plan. The final external audit will take place on 21 June. It is anticipated that the final result will be to post the action plan for four assertions..

An interim DSPT audit was completed by Audit One to support the June 2021 submission and this was reported to and discussed at the June Audit and Risk Committee. The audit also compared the Trust's self assessment and auditor assessment to provide a 'confidence' rating.

The Audit One lead was able to provide context to the Director of Information, with whom she reviewed the interim Audit Report, and indicated that the findings benchmarked favourably compared with around 20 other organisations for whom a DSPT interim audit had been completed by Audit

One. The Trust's action plan will target a status of 'met' for all four assertions during 2021/22 (quarter 3).

The Committee has agreed that they will receive the action plan and a more detailed progress update following submission.

3.2 Outstanding evidence items that require an action plan

Assertion description	Action Required	Completion date
1.6.4 Provide the overall findings of the last privacy by design audit	Spot checks on IG processes such as wearing of ID badges have not been completed due to Covid restrictions. Develop plan of IG/security spot checks for the year ahead	30th September 2021
4.2.3 Logs are retained for a sufficient period reviewed regularly and can be searched to identify malicious activity	A policy is required to document the control activity. Policy will be developed and implemented. This is a new mandatory requirement for this year.	31st July 2021
7.3.6 Are your back ups kept separate from your network offline or in a cloud service designed for this purpose	The Data Centre manager is currently reviewing options to procure a solution to achieve this pending approval and funding. Subject to that business case being completed and funding being confirmed, completion is projected as 30/11/2021.	30th November 2021
10.2.1 Your organisation ensures that any supplier that could impact on the delivery of care, or process personal identifiable data, has the approved certification	The Information and Technical Security teams will develop a rolling plan of audit to ensure supplier certifications are re-verified annually (i.e. including mid contract term) and certifications for legacy systems obtained. Any issues identified in implementing the plan, particularly with regards to legacy systems, will be raised with the Senior Information Risk Owner via Digital Transformation and Safety Board for consideration of risk. The plan will prioritise those suppliers where the processing of personal data is involved. This plan is projected to be in place by 31 July 2021.	31st July 2021

3.3 Top five risks for the Information Department

Description	2020/21			Risk Description
	Risk Assessment		Risk Rating 20/21	
	Impact (i)	L'Hood (l)		
Event logging policy	7	3	21 ⇔	Cause: Ineffective Monitoring and Incident Response As a result of limited event Logging (no Policy defined) (technical) Event: Cyber security Incident occurs Impact: This may result in exposed, corrupted and deleted medical records, and loss of accountability. Cost of investigation and remediation." "A limited audit trail in the event of a cyber breach
Phishing or social engineering of staff who have not had specific training	7	3	21 ⇩ (from 35)	Cause: Lack of staff understanding and awareness of how to accurately spot a phishing email Event: Phishing Attack Impact: Malware or ransomware installed on trust systems
Information flows	7	3	21 ⇩	Cause: The Trust has a legal duty to ensure its information flows are complete, accurate and up to date.

			(from 28)	These are currently maintained on an excel spreadsheet which is not reviewed regularly. Event: The Trust may not be fully aware of all relevant processing activities. Impact: We use the information flows data to inform patients and staff of what data we collect regarding their care, and with whom we share this (via privacy notices). The patient or staff member may not be fully informed of how, why or with whom their data is shared with if the information flows are incomplete, which is a breach of the Data Protection Act 2018 (GDPR)
On call arrangements	7	3	21 (new risk)	Cause: Local systems are not covered by on call arrangements. Event: The failure of a networking component out of hours Impact: Important local systems other than Paris e.g. Attend Anywhere and Health Roster become unavailable to staff out of hours with no support available resulting in clinical risk
Cyber security awareness at Board level	7	3	21 ⇩ (from 28)	Cause: Lack awareness of trust cyber security issues at board level Event: An identified risk occurs Impact: Limited opportunity to mitigate risk

3.4 Top four issues for the Information Governance Team

Description	2020/21			Risk Description
	Risk Assessment		Risk Rating 20/21	
	Impact (i)	L'Hood (l)		
Staffing in DPO Team	7	4	28	The small team in the Data Protection Office makes it vulnerable to sickness or absence especially at short notice. The deadlines for response to the Subject Access request are tight and requests equal approximately 200 per month. Current sickness and absence levels mean the team is struggling to cope. The impact of this is complaints from requestors which may ultimately lead to a fine from the ICO.
Email disclosure	7	5	35	Emails requested by staff cannot effectively be disclosed without asking staff to self-declare. The DPA team could get copies of each email account but staff request emails of many staff at once and the DPA team do not have the resource to interrogate all of the email accounts needed. Staff are often requesting emails because of a disciplinary, bullying or freedom to speak issue and so when staff are asked to self-declare the requestor can feel or indeed be vulnerable further problems. Staff side feel (and I agree) that this is unfair. Staff feel that the Trust is providing a barrier to their request and subjecting them to further harm.
Inability to comply with DPA principles	7	4	28	There is a risk of the Trust breaching the requirements of the Data Protection Act 2018 (GDPR) if we cannot apply and act upon retention and destruction dates to our information flows and records held on information systems.
CCTV	7	4	28	Staff do not understand processes and as a result when staff or patients request CCTV footage they are sometimes denied access because footage has been deleted. This is a serious breach of a person's access rights.

4. IMPLICATIONS:

4.1 Compliance with the Care Quality Commission (CQC) Fundamental Standards:

CQC do receive the DSPT ratings for all Trusts.

4.2 Financial/Value for Money:

There are no direct financial implications from this report other than those that could result from the Trust not meeting its mandatory requirements as part of the Data Protection Act 2018.

4.3 Legal and Constitutional (including the NHS Constitution):

If an organisation does not meet its mandatory requirements, this would be reported to the CQC, DHSC and NHS England/Improvement.

4.4 Equality and Diversity:

There have been no equality and diversity issues raised as part of the reporting of the Data Security and Protection Toolkit.

4.5 Other implications:

None identified

5. RISKS:

5.1 There are significant financial and operational/safety risks if information security breaches occur or information systems fail, impacting on the regulation and business of the Trust. The risk is also reputational and could affect the Trust's licence to practice depending upon the scale of a breach.

The risks and issues identified above could have an impact on the Trust.

6. CONCLUSIONS:

6.1 The action plans above are accepted and the Trust reports an 'unmet' status as at 30 June 2021 with a view to moving to not fully met (plan agreed) once agreed with NHS Digital. A plan will be prepared to move to fully met by the end of quarter three 2021/22.

7. RECOMMENDATIONS:

7.1 That the Trust Board accept the contents of the paper and approve the final publication of the Data Security and Protection Toolkit as at the 30th June 2021 with all evidence items in place and an action plan for standards 1.6.4, 4.2.3, 7.3.6 and 10.2.1 as above .

Author: Andrea Shotton and Louise Eastham
Title: Information Risk, Policy and Records Standards Manager, Head of Information Governance and Data Protection Officer

Background Papers:

SIRO Report
Digital Safety Board Minutes and Actions

Appendix One – Summary of Incidents notified to the ICO

DATE	REF	PROBLEM	ACTION	OUTCOME
25-Mar-21	23489	Group email sent to 63 recipients without using BCC function so recipient email addresses were disclosed to all in the group. One recipient submitted a complaint and requested financial reparations stating that they had received an explicit email and their computer had become infected with a virus following the incident although they stated that they could not confirm either were as a direct result of the incident.	Advised PALS and Team responsible that it was unlikely that we were the root cause of the infection and sought advice regarding making an ex gratia payment from the Trust's Claims Manager who agreed that it may set a precedent and be taken as an implicit acceptance of responsibility. Team has now implemented a new checking system for sending out group emails.	Awaiting reply from ICO.
18-Mar-21	23401	Student nurse accessed electronic records of family member without clinical need.	Referred to Trust's placement team for investigation.	Not required to report.
10-Mar-21	23320	Staff Member reported that they had accessed the electronic records of a family member without clinical need stating that they had broken glass in order to do so as they were concerned about the patient's safety.	Privacy Officer confirmed that Staff Member had not been clinically involved with the patient. Access to the electronic patient record system has been suspended and the incident will be investigated by HR as a disciplinary matter.	Awaiting reply from ICO.
26-Feb-21	23167	Service user stated that she wanted to opt out of various systems holding her data. The IG manager redacted her details from the email and forwarded to a member of staff in another organisation to ask for procedure. The service user informed the IG Manager that the name was still visible through the redaction.	The person to whom the email was sent has been asked to destroy and confirm that they did not read and have not transferred to anyone else.	Not required to report.
26-Feb-21	23166	Service user attended a service improvement group (SIG) meeting. Details of SIG members were circulated to Co-Production SIG members which included names of service users involved in those groups. One member highlighted that consent had not been sought to circulate their name. Service user reported the incident and her distress that it happened. She feels that the Trust regularly fail to keep her details anonymous when she is working on business	Recall of the email was attempted. Members will be asked to delete the email and remove any email address that they have saved. They will be asked to confirm that they have undertaken this action.	ICO stated no further action.

		improvement initiatives.		
28-Jan-21	22838	Member of staff accessed a patient record without a business need. No clinical information was accessed only demographic information.	Staff Member's line manager is aware, report submitted to HR to consider under the Disciplinary Policy/Procedure.	Not required to report.
30-Sep-20	21463	A privacy breach of an electronic patient record was detected after a clinician requested close monitoring. A relative of the patient had accessed the record on two separate occasions. This was not picked up in the break glass audit due to a typo in the staff member's name.	Member of staff works for an organisation under contract to the Trust. Member of staff, their manager, and the IG Manager informed and disciplinary process is in progress.	Not required to report.
26-Aug-20	21063	Staff member accessed an electronic patient record without a need to know; no information was viewed as they did so in error. After speaking to the Privacy Officer, Staff Member discussed this in vague terms to colleagues not identifying anyone. The patient whose record was breached was also a staff member of the team from where the Staff Member worked and as a result of this conversation one colleague was able to identify the patient; they have correctly assumed from knowledge they already had that the former colleague is a patient but this has not been confirmed to them.	The way that the Privacy Officer contacts staff is being reviewed as the Staff Member who caused the privacy breach appeared to panic and their resulting actions caused a confidentiality breach.	No further update received.
14-Aug-20	20901	Staff Member emailed a copy of their outcome letter to Patient who replied to state it had been copied to a GP and queried why as this is not their GP. The error had been caused by an issue the team were not aware of with the referral form where the wrong GP surgery was pulling through when a particular GP was selected on the form. This did not appear to have been reported as an incident at the time and came to light when a claim was received however it had been reported but the incident coding did not generate a notification to Compliance & Standards.	Patient received an emailed apology and offer to discuss the incident further from Staff Member. Patient then contacted Team Manager to express her concerns regarding the incident and her contact with the Staff Member. Team Manager replied to explain how the error occurred and stated that they had rectified the issue and were ensuring all staff double check that the GP details are correct. Team Manager also reassured Patient that the letter had been destroyed by the GP upon receipt, explained why information is shared with GPs and that she should have been informed of this at the time of the assessment, provided an apology on behalf of Staff Member, and offered ongoing support.	Claim received by Trust citing distress. ICO stated no further action. Report also went to DHSC.

24-Jul-20	20653	Patient A disclosed to staff that she had been abused as a child by her step-father. The care team for Patient B were then also informed by Patient A's care team as they are half siblings and it was recorded in Patient B's records to assist in managing his care. It was noted that Patient B and his mother were likely unaware of this disclosure and the entry was marked "CONFIDENTIAL INFORMATION NOT TO BE SHARED OR EDITED". However the entry was then copied in full and disclosed to Patient B who informed his mother and Patient A. Patient A then contacted her care coordinator in distress.	Patient A's care team offered additional support to manage her distress and created a crisis plan. Patient B's care team put a plan in place to manage his care and contacted his GP to retrieve their copy of the information. Patient B's care coordinator confirmed that the usual process for sending copies of care plan reviews was not followed; this was due to changes in working as a result of the pandemic and staff overlooking part of the approved process, which has been amended to prevent a recurrence. Patient A requested further explanation regarding the incident and investigation, which was provided by Senior Information Investigations Officer working with her care team.	Patient A suffered severe detriment as a result of this incident and was given additional support by her care team. ICO requested further information on two occasions and concluded that regulatory action was not required.
05-Jun-20	19980	A message was sent out via digital mailroom to inform patients about a new Crisis Service. There was a mis-match between patient names and addresses. Originally it was thought that 1,131 patients were affected but only 78 patients (7%) have been affected. Self-validation checks did not pick up the error.	We wrote to the patients affected and gave them the correct information. New validation checks have been put in place so the error does not occur again.	No update received
02-Jun-20	19943	Disclosure of health information was made to a patient, including a form that a doctor had completed. The doctor mistakenly wrote their home address instead of their work address. This information was overlooked for redaction when it was checked for third party information as part of the process for managing 'right of access'.	The Trust arranged retrieval of the form from the patient and provided a redacted version of the information. Contacted staff member to inform them.	Not required to report.
24-Apr-20	19552	Staff Member took a photo of some cakes from the unit that were sitting on top of a patient's care plan and posted the photo to her social media. The patient's name was clearly visible in the photo.	Photo removed within 10-15 minutes of posting and did not appear to have been shared. Staff member suspended from bank pending response from ICO. Patient informed; his father stated he may complain.	ICO stated no further action and staff member was allowed to return to the bank.
04-Apr-20	19406	Service user asked a member of ward staff to look at some	Thorough investigation into how the initial request was	ICO stated the Trust had

		ward CCTV footage of her; member of staff did so and reported to the patient that she saw “nothing untoward”. Patient says she then verbally requested this footage. Member of staff told the patient she would have to make a formal request. The footage was not preserved and was only retained for 28 days so could not be disclosed.	made and whether the footage had been retained. Staff member was not aware that the verbal request was valid and that footage should have been preserved. Unable to find documentary evidence of patient's requests for access.	failed to comply with its requirements but no further action was taken. Report also went to DHSC.