Board of Directors 23 May 2018 (PUBLIC)

23 May 2018, 13:30 to 15:30
The Board Room, St Nicholas Hospital, NE3 3XT

Agenda

1. Service User/Carer Experience

2. Apologies

Chair

3. Declarations of interest

Chair

4. Minutes of previous meeting held on 25 April 2018

Decision

Chair

Item 4 - Public Board of Directors minutes.pdf (6 pages)

4.1. Action list and matters arising not included on the agenda

Discussion

Chair

Item 5 - Action List.pdf (2 pages)

5. Chair's Remarks

Information

Chair

6. Chief Executive's Report

Information

Chief Executive

Item 7 - CE Report May 2018.pdf (5 pages)

Quality, Clinical and Patient issues:

7. Safer Staffing Levels (Quarter 4)

Discussion

Executive Director of Nursing and Chief Operating Officer

Item 8i - Safer Staffing Q4 report.pdf (11 pages)

8. Annual Security Management Report

Discussion

Executive Director of Nursing and Chief Operating Officer

Item 8ii - Security Management Annual Report - Board of Directors -23 May 2018.pdf (18 pages)

9. Integrated Commissioning and Quality Assurance Report (April Month 1)

Discussion

Executive Director of Commissioning and Quality Assurance

Item 8iii - BoD Monthly Commissioning Quality Assurance Report 18-19 month 1.pdf (35 pages)

Workforce

10. Workforce Directorate Quarterly update

Discussion

Executive Director of Workforce and Organisational Development

Item 9i - Workforce Quarterly report - May 2018.pdf (9 pages)

11. Whistleblowing/Raising Concerns update

Discussion

Executive Director of Workforce and Organisational Development

Item 9ii - Whistleblowing and Raising Concerns Update - May 2018.pdf (6 pages)

Strategy and Partnerships

12. CEDAR update

Discussion

Executive Director of Nursing and Chief Operating Officer

Item 10i - CEDAR Stage 1 Proposals Board Paper Final Draft.pdf (9 pages)

Regulatory

13. Annual Quality Account

Decision

Executive Director of Commissioning and Quality Assurance

Item 11i - BoD Quality Account 2017-18 (23 May 2018).pdf (101 pages)

14. Annual Governance Statement

Decision

Executive Director of Commissioning and Quality Assurance

Item 11ii- Annual Governance Statement.pdf (14 pages)

15. Self-Certification G6 and CoS7

Decision

Executive Director of Commissioning and Quality Assurance

Item 11iii - BoD Compliance with Licence Declaration May 2018.pdf (17 pages)

16. Operational Plan 2018/19

Decision

Executive Director of Nursing and Chief Operating Officer

17. Annual Accounts and Management Representation Letter

Decision

Executive Director of Nursing and Chief Operating Officer

Minutes / Papers for information

18. Committee updates

Information

Non-Executive Directors

19. Council of Governors Issues

Information

Chair

Minutes

Board of Directors' meeting held in public		
Wednesday, 25th April 2018	**1.30pm – 3.30pm**	**Conference Room, Ferndene**

Present:

Ken Jarrold	Chair
Alexis Cleveland	Non-Executive Director
Dr Leslie Boobis	Non-Executive Director
Miriam Harte	Non-Executive Director
John Lawlor	Chief Executive
Dr Rajesh Nadkarni	Executive Medical Director
Gary O'Hare	Chief Operating Officer and Executive Director of Nursing
Lisa Quinn	Executive Director of Commissioning and Quality Assurance
Peter Studd	Non-Executive Director
James Duncan	Executive Director of Finance
Lisa Crichton Jones	Executive Director of Workforce and Organisational Development

In attendance:

Caroline Wild	Deputy Director, Corporate Relations & Communications
Damian Robinson	Deputy Medical Director, Safer Care

Agenda Item		Action
43/18	**Welcome and apologies** Ken Jarrold welcomed everyone to the meeting including Cheryl who was attending to share her journey through services and also Jenny Wilkes and Sharon Baines from the CQC. Apologies were received from Martin Cocker and Ruth Thompson.	
44/18	**Declarations of interest** Alexis Cleveland informed the Board that she was now Chair of the Food Standards Agency Review of Cutting Plants and Cold Stores. This will be added to the public register. There were no further interests declared.	
45/18	**Minutes of previous meeting held on 28 March 2018** With an amendment to correct Gary O'Hare's job title, the minutes of the meeting held on 28 March 2018 were agreed as a true and correct record.	

46/18	**Action list and matters arising not included on the agenda** The action list was noted. There were no further matters arising.	
47/18	**Chair's Remarks** Ken has recently met with four of the local Healthwatch Chairs. He reported that it was a positive meeting and commented that he is looking forward to undertaking some joint work with them to support the communities we serve. He also reported that the NHS Improvement Chair, Dido Harding and NHS England Chair, Malcolm Grant met recently with local Trust and CCG Chairs in Newcastle. This was a helpful meeting and encouraging discussion. The Chair had recently visited Hopewood Park to find out about the single point of access, Initial Response Service and Street Triage. He was very impressed by the passion and responsiveness of staff working in the service and the excellent partnership working with the police. Finally, he highlighted the Trust Nursing Conference which he described as a truly inspirational and emotional day. He recalled the very moving stories told, especially as part of the Schwartz Round. He commented that this clearly reflects the high quality nursing leadership in the Trust at all levels.	
48/18	**Chief Executive's Report** John Lawlor presented the report. He invited Gary O'Hare to comment on the nursing conference and Gary commented that the day was a phenomenal experience which focused on the significant benefits to staff wellbeing and overall service user experience which have been developed across the trust following work to embed the nursing strategy. In relation to the Deciding Together, Delivering Together process, James confirmed that a number of public and private meetings have taken place to share our current thinking in relation to the next steps. These have been broadly supported, with an acknowledgement that some elements require further planning.	
49/18	**Service User Experience** Cheryl spoke about her personal experience of using NTW services. The Board thanked Cheryl for her thoughtful description of her journey through services, and welcomed her offer to be involved in future service development in the Trust.	
50/18	**Quality, Clinical and Patient Issues** **i) Safer Care Report Quarter 4** Damian Robinson presented the report which included an update on learning from deaths.	

	Damian highlighted the work on 'human factors' which has previously been raised with the Board. Training for senior managers has been arranged and Board members are invited to attend a day long training session on 28th June 2018.	**ALL**
	Peter commented that the improving 'Positive and Safe' figures are pleasing to see.	
	Peter also asked about the recent poor weather and how this affected the reduction in the number of incidents? Damian confirmed that this was not currently clear.	
	Peter also asked about the ending of Mazars input into learning from deaths. Damian confirmed that this had been a one year contract which came to an end. However the trusts involved have agreed to reinstate this work for a further year.	
	Alexis commented on the promising progress. She asked if there was any review of whether learning is being embedded after actions were picked up. Damian responded positively and explained that the Learning and Improvement Group will consider this further and look at ways to make sure that learning is embedded in practice rather than relying on action plans as evidence of change.	**GOH**
	Les asked if there could be a summary of the changes that have been made to practice. Damian confirmed that this will be considered for all serious incident templates so that this information is gathered more consistently.	**GOH**
	Lisa Crichton Jones commented that the safer care bulletin has been particularly useful. It was agreed that this will be circulated to the NEDS in the Friday envelope.	**CW**
	John commented on the outstanding issues with violence and aggression and would appreciate more detailed consideration to understand what more we can do to reduce violence and aggression and to support staff and service users further. Gary O'Hare commented on the influence that one or two patients can have on these figures, and reflected that this could be presented differently in the report, however this is a clear focus of ongoing work.	**GOH**
	The Chair summarised the impressive learning that shines through the report.	
	The Board received the report.	
	ii) Service User and Carer Experience Summary Report – Quarter 4	
	Lisa Quinn presented the report, highlighting that the figures showed an 89% recommendation rate. She noted that the Trust has also sustained an improvement in responses from carers.	
	Lisa confirmed that work is ongoing to think about how to share this information (at team level) across the organisation.	

The Board received the report.

iii) Integrated Commissioning and Quality Assurance Report (March, Month 12)

Lisa Quinn presented the report confirming that the overall assessment from NHSI remained at segment 1 and the Trust is 100% compliant with CCG requirements.

Lisa highlighted the link to the CCG dashboards for the Five Year Forward View for mental health.

Alexis asked about the Out of Area placements – Lisa confirmed that the report shows inappropriate out of area placements only.

James Duncan commented on the financial report and confirmed that since the report was written final figures have been received. Following final agreement of contracts with Northumberland CCG, he confirmed that the incentive funding had been at a level of £1.8m and our year end surplus is £9m.

James confirmed that NTW has received confirmation from NHS England in respect of an outstanding debt in relation to an individual patient. He also confirmed that agency spend has ended £0.9m under our target. All financial targets have been achieved.

A report setting out the overall contract position across all CCGs will be presented to the May Board.

John commented on system changes in South Tyneside which may make the issues of waiting times more difficult to understand. Lisa confirmed that work was ongoing across providers to improve the situation. Lisa confirmed that a more detailed report on this would come through the quality priorities process.

Alexis asked about the £1.2m reduction in Northumberland and implications of that. James confirmed that this is included in the 18/19 operational plan.

Ken reflected that this was a positive report, despite some worrying elements and thanked the team for their hard work.

iv) Staff Friends and Family quarter 4 Report

Lisa Crichton Jones presented the report.

She highlighted the deteriorating trend amongst support staff and confirmed that the next round of speak easies will be an opportunity to understand this further. Some work is also being undertaken with national colleagues in relation to retention.

Lisa noted the improvements in response over the 3 year trend from staff overall.

v) Guardian of Safe Working Hours Quarter 4 Report

	Rajesh Nadkarni presented the report. He confirmed that the trust has a new guardian, Dr Clare McCleod. Rajesh also updated on a recent letter from the Medical Director of NHS England following a recent legal case. Rajesh confirmed that NTW was compliant with all requirements. The Board noted the report. **vi) Visit Feedback Themes** Gary O'Hare presented the report which was noted by the Board. Miriam asked about the progress with digital dictation. Gary confirmed that the trust is continuing to work with M Modal to develop an appropriate digital voice solution.	
51/18	**Regulatory** **i) Operational Plan 2018-19 and Financial Budgets** James presented the report. He confirmed that NHS Improvement have now allocated the Trust a lower control total for 2018/19. The required Trust surplus before provider sustainability funding has reduced by £2.8m but there is also a reduction in our sustainability funding of £0.7m. The required surplus is now £3.5m (including £2m provider sustainability funding). This has increased the required Trust generated surplus by £0.7m from the draft operational plan submission. This increases the savings target by £0.7m but it is expected that this will be met from non-operational measures. A further implication of delivering a lower surplus is that our use of resources financial risk rating will reduce from a 1 to 3. However NHS I have confirmed that this will not affect our overall assessment and we will still be considered a Segment 1 trust. James also noted the financial implications of the pay award and the potential for a funding gap. Les asked about the pay award and whether this would be taken into account in relation to the control total. James confirmed that treasury should fund this, but the mechanism for this is unclear so this creates some risk and complication. Ken commented on the huge demand on services to meet the £12m reduction which will create pressure on services. Gary spoke to the Board about the rigorous quality impact assessment process that has been undertaken across services to ensure that any financial changes do not impact negatively on clinical quality. Rajesh confirmed that there have been a number of processes that the proposals have been considered through. James also highlighted that the Northumberland CCG contract for 2018/19 requires a further £2.3m of savings from a reduction in services in Northumberland to support their Recovery Programme. About £0.9m has been identified so far.	

	ii) NHS Improvement Single Oversight Framework Quarter 4 Report Lisa Quinn presented this report to the Board for information, which sets out the end of year positions. Received. **iii) Data and Cyber Security Standards** Lisa Quinn presented the report which set out the NTW response to the 10 cyber security standards. Alexis asked about GDPR compliance assurance for the Trust. Lisa referred to the GDPR preparation session held for the Board previously and confirmed that a detailed assurance process has been undertaken. Rajesh also confirmed the detailed work that had been undertaken. Lisa confirmed this would be reviewed and is subject to internal audit. The Board received the report.	
52/18	**Minutes / Papers for information** **i) Council of Governors' issues** Ken updated on the work of the Nomination Committee, including developing a co-chairing arrangement for this group. He also updated that the steering group had met to think about future governor agendas. He is also continuing to meet with governors for 1:1 meetings. Alexis asked about the local authority governors. Ken confirmed that he would encourage local authority governors to attend more regularly. **ii) Committee updates** There were no further updated from committees.	
53/18	**Questions from the public** There were no questions from the public.	
55/18	**Date, time and place of next meeting** Wednesday, 23rd May 2018, St Nicholas Hospital, Gosforth. 1.30pm – 3.30pm	

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Action Sheet

Item No.	Subject	Action	By Whom	By When	Update/Comments
Month April 2018					
21/18	Safer staffing	Possible development session re care hours per patient day	Gary O'Hare	To be added to Board cycle	
21/18	Safer staffing	Quarterly report to be presented to CDT Workforce group	Gary O'Hare/Lisa Crichton Jones	asap	CDT – Workforce agenda 4 June 2018
50/18	Human Factors Training	Board members Human Factor training session	All	28th June 2018	
50/18	Safer Care Embedding learning from Actions	Learning and Improvement Group will consider this further and look at ways to make sure that learning is embedded in practice rather than relying on action plans as evidence of change.	DG/GOH		
50/18	Safer Care Summary of changes to practice	Changes to practice to be added to all serious incident templates	DG/GOH		
50/18	Safer Care Violence and Aggression	Detailed information to be provided to understand how we can reduce violence and aggression and support staff and service users	GOH		

Complete					
50/18	Safer Care Bulletin	To circulate to NED in Friday enveloped	Caroline Wild	4 May 2018	Complete – The April bulletin was circulated on Friday 5 May 2018 and will be added monthly going forward

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date:	23 May 2018

Title and Author of Paper:	Chief Executive's Report John Lawlor, Chief Executive

Paper for Debate, Decision or Information: Information

Key Points to Note:

Trust updates

1. Workforce and Organisational Development Director
2. Collective Leadership Programme: Joint Operational and Corporate Services Sharing and Learning Event, May 10th

Regional updates

3. Gateshead System Partnership Workshop
4. North East Staff Survey Results
5. Newcastle CVS - GaN Canny : The views of the voluntary, community and social enterprise sector in Gateshead and Newcastle
6. Workforce Race Equality Standard

National updates

7. Report into deaths amongst people with learning disability
8. Recent Reports on Mental Health
9. NHS Providers On The Day Briefing 9 May 2018

Outcome required: For information

Chief Executive's Report

28 March 2018

Trust updates

1. **Workforce and Organisational Development Director**
   As of Friday 1 June, there will be some changes to the senior workforce leadership team. Lisa Crichton-Jones has been appointed as Director of Workforce Transformation for the North East and North Cumbria Integrated Care system. Lisa will be on secondment, working with colleagues across health and care within the region, focusing on workforce development and transformation. She will return to the Trust in January 2020.

   During this time, Lynne Shaw will be Acting Director of Workforce and Michelle Gill will be assuming the role of Deputy Director. Both Lynne and Michelle have many years' experience of working within NTW, and across wider NHS services. They are looking forward to working with colleagues and staff across the Trust in these new roles. We wish them all well in continuing their work to support NTW to be 'a great place to work.'

2. **Collective Leadership Programme: Joint Operational and Corporate Services Sharing and Learning Event, May 10th**
   A key focus of this programme has been to support our continuous leadership development, to build the confidence and skills to lead collectively; to embed a culture of quality improvement; to secure a truly engaged and empowered workforce; and to enable more devolved decision making as close to our service users as is practical.

   The joint sharing and learning event gave both participants of the operational and corporate programmes the opportunity to take stock on where we are at and how far the programme has helped the participants to continue to build on the many strengths NTW enjoys. The event was attended by 120 leaders. We spent some time exploring our collective understanding around responsibilities: "your job, my job, our job" and learnt a great deal about where our leaders feel we are at the moment, developing a good collective understanding about the Trust's priorities.

   This event helped us to show that we are all pointing in the same direction and hopefully will enhance the way we work together, collaboratively. This is key to the future success of the Trust in empowering our workforce "to be the best they can be".

Regional updates

3. **Gateshead System Partnership Workshop**
   Partners across the Gateshead system are planning a week long intensive planning event to develop thinking on an integrated care system over the week 4th-8th June. The workshop will explore how to take forward planning for an integrated care system under the flowing headings:

   - Commissioning for better outcomes
   - System Architecture-governance
   - System Architecture-finance
   - Provider delivery
   - Planning ahead

   Key principles that have already been agreed are developing integrated strategic commissioning for improving population health outcomes, and developing integrated provider delivery. Crucially there is no intention to create new organisations or

organisational vehicles, but to develop ways in which existing partners can deliver integrated care for better outcomes within an aligned system. There will be a further update on outcomes of the workshop in July.

4. **North East Staff Survey Results**
The North East Social Partnership Forum (SPF) recently received a presentation from NHS Employers to share the headlines from the Staff Survey, from a whole North East perspective. The presentation focused on the core results in relation to the areas of staff engagement, line management, health and wellbeing, diversity and inclusion and raising concerns. In addition an NHS Employers colleague with lead responsibilities for work programmes on staff engagement and staff surveys, recently attended the HRD forum to discuss some of the staff survey themes.

Some of the headlines included:

- The NE is the top performing region across a number of staff survey metrics.
- Staff engagement; NE are above national score for recommendation of the organisation and contributing to improvements.
- Immediate manager support: NE are above national score and **NTW scored the best score in the region on this metric, which reflects our good people management practices.**
- Health and wellbeing: NE improved in all the key findings in this area and better than national score. NE results in this area were described as being very strong overall.
- Diversity and Inclusion: NE Region higher than national score.
- Culture, Bullying, harassment and abuse: Some wide variety in NE scores. NTW scored the best score in the region on two key metrics; the lowest % of staff experiencing harassment, bullying or abuse from staff in the last 12 months and the highest % of staff reporting most recent experience of harassment, bullying or abuse.
- Culture – nationally and regionally scores have decreased but the NE results remain higher than national average.
- Overall staff engagement score: Average has improved since 2016 for the region. NE Higher than the national score.

Whilst neither the region, nor any individual organisation are complacent about these results, they show good workforce practice across the region. Whilst individual organisations will progress with their own internal actions for further local improvement, the SPF has agreed to include two priority areas within their work plan for this year. These are engagement / wellbeing and the raising and reporting of concerns and unsafe clinical practice.

Link to the: Staff Survey 2017 NE Presentation

5. **Newcastle CVS - GaN Canny: The views of the voluntary, community and social enterprise sector in Gateshead and Newcastle**
Newcastle CVS has produced 'GaN Canny: The views of the voluntary, community and social enterprise sector in Gateshead and Newcastle'. This involved a survey of local organisations, and information from visits and meetings. Questions were asked about the organisations – their status, achievements and challenges, and what pressures they had identified for the future. More importantly, what issues were impacting on the people they supported and within their local communities.

168 voluntary and community organisations completed the survey and they represent a reasonable reflection of local voluntary and community organisations and social enterprises. Link to a copy of the report:

https://www.cvsnewcastle.org.uk/images/Publications/GaN_Canny_2018.pdf

6. Workforce Race Equality Standard

A group representing leaders from across the NHS in the North East met recently to discuss how best to enable colleagues from black or minority ethnic groups (BME) to achieve their full potential within the NHS.

The group, chaired by Jim Mackey, chief executive of Northumbria Healthcare NHS Foundation Trust, heard from Joan Saddler, associate director of patients and communities at the NHS Confederation. She advised that, despite one in four members of staff working within the NHS being from BME groups, only four out of the 235 chief executives are black or minority ethnic. This is a similar picture across most NHS leadership roles.

In addition, a report into whistleblowing in the NHS showed how BME staff are:

- More likely to be victimised by management than white staff (21%: 12.5%)
- Less likely to be praised by management after raising concerns than white staff (3%: 7.2%)
- More likely to not raise a concern for fear of victimisation (24%: 13%)

To tackle these challenges, NHS England introduced a few years ago, The Workforce Race Equality Standard (WRES), a set of metrics that will, for the first time, require all NHS organisations to demonstrate progress against a number of indicators on race equality, including a specific indicator to address low levels of BME representation at trust board level.

In the North East, NHS organisations have agreed to work together to learn from one another, to tackle this issue head on. They have united to create solutions that ensure our BME workforce is developed and supported to progress in their careers and apply for roles at higher levels.

As the NHS celebrates its 70th birthday, we must all recognise its diverse workforce is one of the things that make it so special. As NHS trusts plan for the future, we must all strive to disrupt the status quo and achieve equality of opportunity across senior leadership roles.

NHS organisations across the North East want to be in the forefront of this work and, as plans develop, will ask staff to share their views giving everyone the opportunity to input ideas, comment and get involved.

Anyone with an interest in this work who would like to get involved at an early stage can contact Chris Rowlands (Equality and Diversity Lead) or Daisy Mbwanda, Chair of our BAME staff network.

National updates

7. **Report into deaths amongst people with learning disability**
   The Learning Disabilities Mortality Review Programme published its first annual review recently, which includes several recommendations for different parts of the health system in relation to premature mortality with people with learning disabilities. NTW is one of 9 Mental Health Trusts as part of a Northern Consortium, working together to establish consistent approaches to recovery and investigating deaths.

   Link: LeDeR-annual-report-2016-2017-Final

8. **Recent Reports on Mental Health**
   I have provided links to recent publications of two significant reports with a focus on mental health:

   - The Government's Green Paper on mental health: failing a generation – a joint report by the Health and Social Care Select Committee and the Education Select Committee.

     Link: https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/642/642.pdf

   - The interim report of the Independent Review of the Mental Health Act – the review being chaired by Professor Sir Simon Wessely (former President of the Royal College of Psychiatrists) and commissioned by the Department of Health and Social Care.

     Link:
     https://www.gov.uk/government/publications/independent-review-of-the-mental-health-act-interim-report

9. **On the day Briefing – NHS Providers 9 May 2018**
   The link below providers a helpful summary of some other reports

   Link: NHS Providers on the day briefing - May 2018.pdf

NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST

Board Report

Meeting Date: Wednesday 23rd May 2018

Title and Author of Paper:
Safer Staffing Quarter 4 Report
Jackie King, Clinical Nurse Manager
Anne Moore, Group Nurse Director, Safer Care

Executive Lead: Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

Paper for Debate, Decision or Information: Information

Key Points to Note:

The report includes exception data and analysis of all ward staffing against Safer Staffing levels for Quarter 4.

Some wards are outside of the agreed staffing levels this quarter, the report focuses on exception reporting for some of those ward groups

Wards which experienced staffing pressures were able to maintain safe patient care through use of roster management and the staffing escalation procedure. There were no instances of harm attributed to safer staffing levels.

It is proposed that 2018-2019 reports to Board will include a brief narrative/exception report mapping vacancies, incidents and percentage of sickness against wards in line with the new guidance and date for each ward on Care Hours Per Patient Day

Risks Highlighted to Committee: None

Does this affect any Board Assurance Framework/Corporate Risks?: No
Please state Yes or No
If Yes please outline

Equal Opportunities, Legal and Other Implications: N/A

Outcome Required: The Board of Directors are to note the content of the report.

Link to Policies and Strategies:
Safer Staffing
Carter 90 day Rapid Improvement Review

Background

In line with the National Quality Board Guidance issued in November 2013, and in order to assist provider organisations to fulfil their commitments as outlined in Hard Truths (now known as Safer Staffing) the Government made a number of commitments to make this information more publically available. The Trust continues to comply with the requirements of safer staffing.

The commitments were;

- To publish staffing data from April 2014
- A Board report describing the staffing capacity and capability, following an establishment review, using evidence based tools where possible. To be presented to the Board every six months
- Information about the nurses, midwives and care staff deployed for each shift compared to what has been planned and this is to be displayed at ward level
- A Board report is made available containing details of planned and actual staffing on a shift by shift basis at ward level for the previous months. To be presented to the Board every three months
- The quarterly report must also be published on the Trust's website, and Trusts will be expected to link or upload the report to the relevant hospital(s) web page on NHS Choices.

NTW has adopted a robust application of the guidance including;

- An agreed methodology is in place incorporating both the electronic and paper rostering systems to gather the staffing information in a systematic manner
- RAG system is in place to alert Group Nurse Directors of any wards that have deviated from the agreed staffing levels
- Ward Managers report on a weekly basis highlighting any variance and reasons why on the planned staffing for their ward
- An escalation process is in place for both in hours and out of hours including on call mechanisms
- The information is collated to support analysis of ward staffing
- A Clinical Nurse Manager who oversees the process and escalates as required to service and director leads
- Safer staffing is discussed and monitored at ward/service group and key Trustwide meetings.

The Care Quality Commission (CQC) will seek compliance with all the actions as part of their inspection regime and NHS Improvement will act where the CQC identifies any deficiencies in staffing levels in Foundation Trusts.

Quarter 4 update

A number of the wards are outside of the agreed staffing levels this quarter the focus is on those wards whose combined qualified and unqualified data do not achieve a minimum of 95% for either day or night duty. The exceptions and rationale have

been listed below however going forward, in line with the new guidance, future reports will include a more in-depth analysis of this combined data.

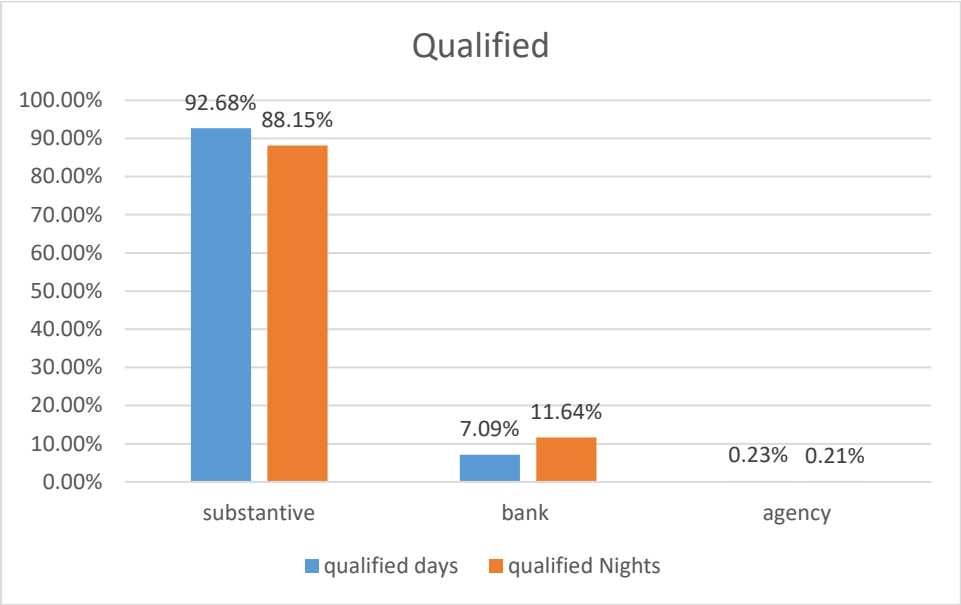
Aidan, Bede, Cuthbert and Oswin

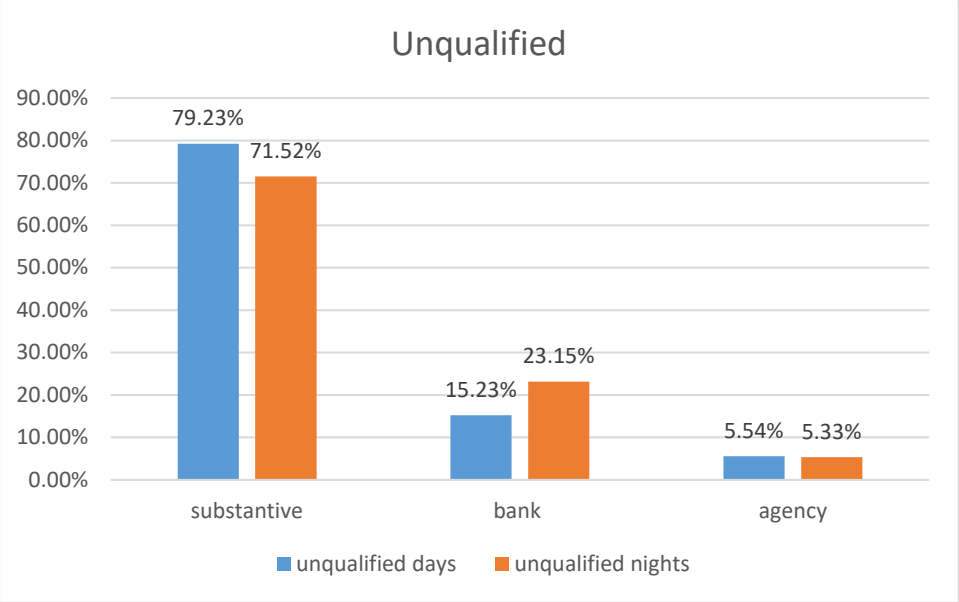
All of the ward managers for the above wards meet on a weekly basis to manage the staff across the service. Cuthbert has had a number of patients who are on leave and the staff have been utilised in the other wards across the service. Oswin have had a newly qualified nurse who has been on nights with another qualified nurse as part of their development and induction (preceptorship). They have also had reduced occupancy which has released staff to work across the service on other wards who have vacancies or absences.

St Georges Park

All of the ward managers in St Georges Park come together on a weekly basis to discuss staffing across the site regardless of Group. The substantive staff are then deployed across the site before booking bank staff. All aspects are considered in this meeting including the acuity of the patients on the wards at that. This has had an impact on both the temporary staff used and the cover across the site as whole.

Bank and Agency and Fill Rates
There has been a small increase in the use of bank and agency this quarter mostly due to the end of year rush on annual leave.





Staffing Solutions

Staffing Solutions now manages all temporary and flexible staffing through one Central Team in the organisation, therefore enabling more creative and flexible approaches to any staffing shortfalls and ensuring compliance with stringent allocation and monitoring mechanisms. The RPIW action plan has resulted in a number of streamlined processes ensuring maximum fill rates to shifts and working closely with ward and team managers to understand staffing demands.

NHSI 90 Day Carter Review

The Trust were approached in early 2017 to participate in a cohort of 23 mental health and community trusts to look at e-rostering and other related issues. This followed on from similar work that was carried out the previous year in the Acute Sector, as part of Lord Carter's wider review.

The Trust Board agreed to participate and to date four national workshops have been attended. NHSI visited the Trust in October 2017 and a further visit, to include Lord Carter, was scheduled for 6th February 2018 which unfortunately had to be cancelled due to Lord Carter's commitments.

As part of the 90 Day Rapid Improvement Programme various data has been submitted to NHSI which has provided them an opportunity to work with Trusts to understand the productivity of different skill mix composition in inpatient wards.

It is recognised that the needs of patients using inpatient services are often quite different, therefore a new measure namely Care Hour per Patient Day (CHPPD) has been introduced. CHPPD provides a representation of the number of care hours available to patients and is a measure that enables wards of a similar size, speciality and patient group to be benchmarked both locally and across the cohort.

There are three main areas of focus which are:

- To examine the operational arrangements that exist at service delivery level which determine rostering forward based clinical staff, and to compare the planned hours of care with paid hours.

- To measure and compare workforce productivity and efficiency across NHS mental health and community providers (permanent and temporary staff).

- To identify those factors which appear to enable effective rostering management and so reduce the need for the use of agency staffing, which might then be replicated across the NHS in England.

Work is underway to roll out the carter work into all of the inpatient areas in the trust and the safer team has engaged with the groups to do this.

Planned developments for Safer Staffing and Care Hours per Patient Day (CHPPD) going forward

The Group Nurse Director for Safer Care is proposing a reporting process with the Clinical Care Groups which will furnish future report with detail of inpatient wards where staffing levels fall outside of tolerance in 3 or more areas. The metrics for the tolerance areas being tested will include Skill mix; newly registered nurse mix; Bank / agency hours; vacancy factor and incidents.

To ensure that all of the inpatient wards remain engaged in safer staffing it is proposed that all Inpatient Managers and Matrons will have access to a dashboard to provide additional assurance to the board that all inpatient areas have significant oversight of their performance against the key safe staffing metrics and not just those included in the exception report.

National Quality Board and Safer Staffing

NHSI on behalf of the NQB published new guidance in January 2018

Safe, sustainable and productive staffing outlines the expectations and framework within which decisions on safe and sustainable staffing should be made to improve health outcomes. It ensures delivery of safe, effective, caring, responsive and well-led care on a sustainable basis, and that organisations employ the right staff with the right skills in the right place and at the right time.

This improvement resource makes specific reference to adopting these expectations in mental health services, recognising the nuances that exist in this provision. The content has been developed by a reference group of sector leaders and was informed by a review of literature, in consultation with service users and carers. It aims to provide quality and consistency through the recommendations for board accountability and expectations of clinical leaders at service and team levels.

Example dashboard templates to monitor safe, sustainable and productive staffing, and escalation processes have been included, as well as an outline of a strategic staffing review. This resource also lists documents relevant to safe, sustainable and productive staffing in mental health services.

While this improvement resource focuses on the expectations of provider organisations, it also supports commissioners in developing their own assurance framework. Furthermore, the standards and tools given in this resource inform the staffing aspects of effective commissioning of future mental health services and pathways.

Boards are accountable for ensuring safe, sustainable and productive staffing and a comprehensive staffing review must be provided annually to them. A summary of the key issues to consider in the delivery of safe, sustainable and productive staffing will be provided to the next Board meeting

Conclusion

The Board of Directors are asked to recognise the work which is underway and the impact that this has made. Much cross Trust collaboration is now being undertaken to use the learning from this work to inform developments and action planning in relation to the challenges associated with ongoing staffing and Recruitment.

Safer Staffing Requirements

In March 2014 NHS England and the Care Quality Commission jointly published guidance on the delivery of the Hard Truths commitments associated with publishing staffing data regarding nursing, midwifery and care staff. The commitments are to publish staffing data from April 2014.

As agreed at the June 2014 Board of Directors, monthly exception reports would be received explaining the reasons for staffing being 10% under planned and 20% over planned.
The RAG rating on the exception report attached shows

- red for any ward under 90%,
- white for within range
- green for wards over 120%

Data is only reported for inpatient wards; day services or community services are not reported to NHS England. All reports have been submitted as required.

Changes

New guidance has been issues by NHSI as from April 2018 there will be a change in the data that is submitted for safer staffing. This will be in the format of Care Hours per Patient Day (CHPPD) .This will be reflected in reports from May using April 2018 data.
The Clinical Care groups are engaged in the review and development of the Safer Staffing report. All exceptions are reviewed via the groups. Work is underway to ensure that all requests for staffing data is coordinated through the strategic staffing group.

Safer Staffing Exceptions

The exceptions listed below relate to a selection of wards where planned and actual staffing levels show significant variances. These may be due to a number of factors i.e. short term vacancies, sickness and/or increased levels of clinical activity

Examples of variance for March 2018 including rationale:

- **Adult Forensic SNH Oswin**

  All of the ward managers for the forensic wards meet on a weekly basis to manage the staff across the service and utilise resource effectively.

  Cuthbert
  Cuthbert has had a number of patients who are on leave and the staff have been utilised in the other wards across the service.

  Oswin
  Oswin have had a newly qualified nurse who has been on nights with another qualified nurse as part of their development and induction (preceptorship). They have also had reduced occupancy which has released staff to work across the service on other wards who have vacancies or absences.

- **Marsden**

  The ward has shown higher levels of planned experienced unqualified staffing to support current unfilled qualified vacancies. This has been in response to an increase in acuity of the patient group, requiring increased eyesight observations

- **Embleton**

  The increased variation in staffing is as a result of the clinical needs of patients with escort of patients admitted to general hospital, eyesight observations and seclusion requiring an increase in the unqualified staff numbers.

- **Stephenson**

  Increased levels of staffing were required over the time period due to escorting a patient to receive treatment in a general hospital requiring both unqualified and qualified escort

In conclusion

Safer Staffing levels are within acceptable ranges reflecting activity and use of resources. Recruitment campaigns 22/23 have recently concluded and processing and clearances are underway for successful qualified nursing candidates. There are a number of wards that have qualified vacancies these wards are utilising experienced support staff to supplement this shortfall although no ward has been without a qualified nurse on duty.
There were no incidents of harm attributed to staffing levels.

The Carter Review pilot at St Georges Park is having a positive impact on the safer staffing information for that area actions include review of flexible working, level loading annual leave and review of acuity tools. Action plans are in place across each locality to roll the improvements in staff utilisation across the trust. This will be reported in the June Report

Jackie King Clinical Nurse Manager Flexible Staffing
Anne Moore Group Nurse Director Safer Care
May 2018

ward name	Specialty1	specialty2	Planned Q	Actual Qua	Planned U	Actual Unq	Planned Q	Actual Qua	Planned U	Actual Unqualified Night
ALNMOUTH	710 - ADULT MENTAL ILLNESS		1335	1281.42	697.5	831.48	333.25	433.77	666.5	592.5
ASHBY	711 - CHILD and ADOLESCENT PSYCH		1335	1190.75	1860	3611.38	333.25	348.25	1333	2661.22
BLUEBELL COURT	710 - ADULT MENTAL ILLNESS		1335	1058.07	930	1070.78	333.25	348.92	333.25	331.67
EMBLETON	710 - ADULT MENTAL ILLNESS		1335	1188.08	697.5	1561.05	333.25	347.5	666.5	1423.2
HAUXLEY	715 - OLD AGE PSYCHIARTY		1102.5	909.93	1395	1628.18	333.25	333.25	666.5	685.42
KINNERSLEY	710 - ADULT MENTAL ILLNESS		1335	1281.03	1162.5	1265.8	333.25	345.45	666.5	694.02
LENNOX	711 - CHILD and ADOLESCENT PSYCH		1242	1023.53	1782.5	3825.98	333.25	368.35	666.5	1155.13
NEWTON	710 - ADULT MENTAL ILLNESS		1335	1153.15	930	1946.08	333.25	350.12	1333	973.97
REDBURN YPU	711- CHILD and ADOLESCENT PSYCH		2467.5	2714.33	2092.5	2487.18	999.75	850.81	1333	2308.95
STEPHENSON HOUSE	711 - CHILD and ADOLESCENT PSYCH		1102.5	1593.67	2325	3306.38	333.25	376.31	999.75	1557.75
THE RIDING	711 - CHILD and ADOLESCENT PSYCH		1102.5	1107.62	2208.75	1937.05	333.25	398.63	666.5	1113.9
WARKWORTH	710 - ADULT MENTAL ILLNESS		1335	1017.23	697.5	952.2	333.25	347.97	666.5	799.15
WOODHORN	715 - OLD AGE PSYCHIARTY		1567.5	1004.98	2325	2351.33	333.25	346.98	1333	1377.43
MITFORD	700 - LEARNING DISABILITY		1955	2673.97	11051.5	12170.05	999.75	1173.77	9331	11858.3
FRASER HOUSE	711 - CHILD and ADOLESCENT PSYCH		1335	1255.07	2092.5	2478.48	333.25	361.38	666.5	1095.32

ward name	Specialty1	Day Reg %	Day Unreg	Night Reg %	Night Unre	Overall Da	Overall Nig	Day Reg %age	Day Unreg	Night Reg %age	Night Unreg %age
ALNMOUTH	710 - ADULT MENTAL ILLNESS	95.99%	119.21%	130.16%	88.90%	100.00%	100.00%	101.31%	131.90%	100.00%	112.85%
ASHBY	711 - CHILD and ADOLESCENT PSYCHIATRY	89.19%	194.16%	104.50%	199.64%	100.00%	100.00%	81.36%	178.83%	120.22%	198.29%
BLUEBELL COURT	710 - ADULT MENTAL ILLNESS	79.26%	115.14%	104.70%	99.53%	97.20%	100.00%	81.35%	110.83%	126.09%	103.17%
EMBLETON	710 - ADULT MENTAL ILLNESS	88.99%	223.81%	104.28%	213.53%	100.00%	100.00%	84.26%	162.01%	107.72%	119.39%
HAUXLEY	715 - OLD AGE PSYCHIARTY	82.53%	116.72%	100.00%	102.84%	99.62%	100.00%	85.24%	113.81%	103.70%	112.60%
KINNERSLEY	710 - ADULT MENTAL ILLNESS	95.96%	108.89%	103.66%	104.13%	100.00%	100.00%	88.72%	113.05%	107.71%	104.72%
LENNOX	711 - CHILD and ADOLESCENT PSYCHIATRY	82.41%	214.64%	110.53%	173.37%	100.00%	100.00%	64.74%	167.61%	100.00%	157.14%
NEWTON	710 - ADULT MENTAL ILLNESS	86.38%	209.26%	105.06%	73.07%	100.00%	89.06%	90.58%	201.41%	119.88%	56.84%
REDBURN YPU	711- CHILD and ADOLESCENT PSYCHIATRY	110.00%	118.86%	85.10%	173.21%	100.00%	100.00%	107.02%	127.48%	90.71%	183.42%
STEPHENSON HOUSE	711 - CHILD and ADOLESCENT PSYCHIATRY	144.55%	142.21%	112.92%	155.81%	100.00%	100.00%	160.98%	118.68%	109.75%	119.35%
THE RIDING	711 - CHILD and ADOLESCENT PSYCHIATRY	100.46%	87.70%	109.62%	167.13%	94.08%	100.00%	123.00%	88.33%	129.21%	122.48%
WARKWORTH	710 - ADULT MENTAL ILLNESS	76.20%	136.52%	104.42%	119.90%	100.00%	100.00%	92.75%	161.87%	100.00%	111.82%
WOODHORN	715 - OLD AGE PSYCHIARTY	64.11%	101.13%	104.12%	103.33%	82.62%	100.00%	64.07%	109.04%	100.00%	101.69%
MITFORD	700 - LEARNING DISABILITY	136.78%	110.12%	117.41%	127.08%	100.00%	100.00%	133.34%	112.59%	99.61%	122.56%
FRASER HOUSE	711 - CHILD and ADOLESCENT PSYCHIATRY	94.01%	118.45%	108.44%	164.34%	100.00%	100.00%	97.75%	116.35%	116.98%	166.83%

ward name	Specialty1	specialty2	Planned Q	Actual Qua	Planned U	Actual Unq	Planned Q	Actual Qua	Planned U	Actual Unqualified Night
ALDERVALE - MEADOW VIEW	710 - ADULT MENTAL I		1335	1283.15	930	1809.47	333.25	333.27	666.5	1024.9
BEADNELL	710 - ADULT MENTAL I		870	819.67	930	601.58	333.25	357.8	333.25	566.63
BECKFIELD - DENE	710 - ADULT MENTAL I		1567.5	1433.98	1860	2477.2	333.25	499.5	1666.25	1918.67
BRIDGEWELL - MILL COTTAGE	710 - ADULT MENTAL I		1102.5	1140.08	1162.5	1696	333.25	419.33	666.5	884.67
BROOKE HOUSE	710 - ADULT MENTAL I		1102.5	942.75	930	1102.97	333.25	353.28	666.5	343.58
CLEADON - ROSEWOOD	715 - OLD AGE PSYCHI		1800	1624.58	2092.5	1323.33	333.25	368.88	1333	1204.2
CLEARBROOK - LOWER WILLOWS	710 - ADULT MENTAL I		1335	1484.58	930	2128.33	333.25	343.52	666.5	1153.2
LONGVIEW - EAST WILLOWS	710 - ADULT MENTAL I		1507.5	1171.93	697.5	1164.55	333.25	367.1	666.5	823.97
MARSDEN	715 - OLD AGE PSYCHI		1102.5	1260.65	1860	2374.8	333.25	472.38	1333	1461.98
MOWBRAY	715 - OLD AGE PSYCHI		1275	1473.78	1395	1210.37	333.25	345.7	666.5	734.07
ROKER	715 - OLD AGE PSYCHI		1102.5	1243.32	1395	1573.88	333.25	335.85	666.5	906.12
ROSE LODGE	700 - LEARNING DISAB		2032.5	1980	1860	4570.03	666.5	669.88	999.75	2330.48
SHOREDRIFT - BEDE 1	710 - ADULT MENTAL I		1680	1203.52	697.5	1134.52	333.25	340.7	666.5	751.1
SPRINGRISE - WEST WILLOWS	710 - ADULT MENTAL I		1507.5	1326.75	697.5	1275	333.25	351.33	666.5	815.33
WALKERGATE WARD 1	314 - REHABILITATION		1567.5	1496.5	3255	2705.72	666.5	493.35	1666.25	2564.54
WALKERGATE WARD 2	710 - ADULT MENTAL I		1567.5	1168.08	2325	2209.18	333.25	350.8	999.75	1689.07
WALKERGATE WARD 3	314 - REHABILITATION		1567.5	1239.57	2790	1666.95	666.5	725.9	666.5	815.02
WALKERGATE WARD 4	314 - REHABILITATION		1800	987.28	2790	2204.05	666.5	567.72	666.5	1149.18
WARD 31A	710 - ADULT MENTAL I		1102.5	1278.07	1162.5	716.18	333.25	355.53	333.25	332.1

ward name	Specialty1	specialty2	Day Reg %a	Day Unreg	Night Reg S	Night Unreg %age	Overall Da	Overall Night Coverag	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age
ALDERVALE - MEADOW VIEW	710 - ADULT MENTAL ILLNESS		96.12%	194.57%	100.01%	153.77%	100.00%	100.00%	105.71%	203.24%	100.00%	161.15%
BEADNELL	710 - ADULT MENTAL ILLNESS		94.21%	64.69%	107.37%	170.03%	79.45%	100.00%	94.84%	65.73%	107.10%	160.40%
BECKFIELD - DENE	710 - ADULT MENTAL ILLNESS		91.48%	133.18%	149.89%	115.15%	100.00%	100.00%	98.57%	147.37%	106.08%	120.54%
BRIDGEWELL - MILL COTTAGE	710 - ADULT MENTAL ILLNESS		103.41%	145.89%	125.83%	132.73%	100.00%	100.00%	106.17%	175.98%	126.41%	139.70%
BROOKE HOUSE	710 - ADULT MENTAL ILLNESS		85.51%	118.60%	106.01%	51.55%	100.00%	78.78%	85.80%	108.76%	107.05%	51.05%
CLEADON - ROSEWOOD	715 - OLD AGE PSYCHIARTY		90.25%	63.24%	110.69%	90.34%	93.75%	100.00%	92.79%	70.69%	107.62%	81.00%
CLEARBROOK - LOWER WILLOWS	710 - ADULT MENTAL ILLNESS		111.20%	228.85%	103.08%	173.02%	100.00%	100.00%	105.47%	245.26%	100.00%	196.91%
KINNERSLEY												
LONGVIEW - EAST WILLOWS	710 - ADULT MENTAL ILLNESS		77.74%	166.96%	110.16%	123.63%	100.00%	100.00%	79.11%	180.04%	131.87%	140.26%
MARSDEN	715 - OLD AGE PSYCHIARTY		114.34%	127.68%	141.75%	109.68%	100.00%	100.00%	101.42%	104.26%	106.64%	102.02%
MOWBRAY	715 - OLD AGE PSYCHIARTY		115.59%	86.76%	103.74%	110.14%	100.00%	100.00%	119.69%	77.89%	100.00%	106.85%
ROKER	715 - OLD AGE PSYCHIARTY		112.77%	112.82%	100.78%	135.95%	100.00%	100.00%	111.56%	128.50%	104.01%	139.17%
ROSE LODGE	700 - LEARNING DISABILITY		97.42%	245.70%	100.51%	233.11%	100.00%	100.00%	113.07%	209.88%	84.77%	228.33%
SHOREDRIFT - BEDE 1	710 - ADULT MENTAL ILLNESS		71.64%	162.66%	102.24%	112.69%	100.00%	100.00%	67.21%	146.50%	120.49%	100.17%
SPRINGRISE - WEST WILLOWS	710 - ADULT MENTAL ILLNESS		88.01%	182.80%	105.43%	122.33%	100.00%	100.00%	84.41%	182.53%	137.49%	103.83%
WALKERGATE WARD 1	314 - REHABILITATION		95.47%	83.13%	71.02%	153.91%	89.30%	100.00%	97.57%	85.16%	72.52%	145.59%
WALKERGATE WARD 2	710 - ADULT MENTAL ILLNESS		74.52%	95.02%	105.27%	168.95%	84.77%	100.00%	82.03%	97.53%	106.12%	193.70%
WALKERGATE WARD 3	314 - REHABILITATION		79.08%	59.75%	108.91%	122.28%	69.41%	100.00%	83.48%	63.37%	106.93%	104.80%
WALKERGATE WARD 4	314 - REHABILITATION		54.85%	79.07%	85.18%	172.42%	66.92%	100.00%	52.92%	85.35%	94.17%	169.74%
WARD 31A	710 - ADULT MENTAL ILLNESS		115.92%	82.61%	106.69%	99.65%	88.77%	100.00%	130.37%	74.48%	100.00%	106.84%

ward name	Specialty1	specialty2	Planned Q	Actual Qua	Planned U	Actual Und	Planned Q	Actual Qua	Planned U	Actual Und	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age	Overall Day Coverage	Overall Night Coverage	Day Reg %age	Day Unreg %age	Night Reg %age	Night Unreg %age
AIDAN	712 - FORENSIC PSYCH		1567.5	1199.65	1395	1211.48	333.25	334.55	999.75	645.27	76.53%	86.84%	100.39%	64.54%	81.69%	82.47%	72.09%	109.19%	110.78%	84.06%
AKENSIDE	715 - OLD AGE PSYCHI		1102.5	1220.8	1395	1160.6	333.25	336.45	666.5	783.1	110.73%	83.20%	100.96%	117.49%	96.96%	100.00%	109.46%	102.18%	100.00%	106.61%
BEDE	712 - FORENSIC PSYCH		1567.5	1038.1	930	843.4	333.25	333.25	666.5	756.74	66.23%	90.69%	100.00%	113.54%	78.46%	100.00%	74.01%	108.16%	100.39%	100.70%
COLLINGWOOD COURT	710 - ADULT MENTAL		1335	1228.27	697.5	1098.38	333.25	357.18	666.5	968.73	92.01%	157.47%	107.18%	145.35%	100.00%	100.00%	97.77%	93.94%	102.75%	116.78%
CUTHBERT	712 - FORENSIC PSYCH		1567.5	1059.42	930	796.87	333.25	355.27	666.5	692.12	67.59%	85.68%	106.61%	103.84%	76.64%	100.00%	63.94%	90.94%	102.38%	102.38%
ELM HOUSE	710 - ADULT MENTAL		1102.5	1040.43	1395	951.78	333.25	341.17	333.25	340.65	94.37%	68.23%	102.38%	102.22%	81.30%	100.00%	88.63%	77.29%	100.00%	98.40%
FELLSIDE	710 - ADULT MENTAL		1335	682.5	697.5	2598.82	333.25	367.85	666.5	2221.72	51.12%	372.59%	110.38%	333.34%	100.00%	100.00%	69.89%	322.48%	107.02%	301.54%
FRASER HOUSE	711 - CHILD and ADOL		1335	1255.07	2092.5	2478.48	333.25	361.38	666.5	1095.32	94.01%	118.45%	108.44%	164.34%	100.00%	100.00%	97.75%	116.35%	116.98%	166.83%
LOWRY	710 - ADULT MENTAL		1335	1054.55	697.5	1002.83	333.25	372.77	666.5	824.97	78.99%	143.77%	111.86%	123.78%	100.00%	100.00%	76.56%	160.89%	122.42%	130.53%
OSWIN	712 - FORENSIC PSYCH		1800	1478.45	930	1044.8	333.25	427.72	666.5	605.98	82.14%	112.34%	128.35%	90.92%	97.24%	100.00%	92.68%	92.04%	116.89%	88.96%
RADS AT GIBSIDE	710 - ADULT MENTAL		1335	1050.3	465	788.42	333.25	333.25	333.25	580.1	78.67%	169.55%	100.00%	174.07%	100.00%	100.00%	75.69%	123.72%	104.13%	126.17%
WILLOW VIEW	710 - ADULT MENTAL		1102.5	1216.67	930	955.88	333.25	363.83	666.5	345.12	110.36%	102.78%	109.18%	51.78%	100.00%	80.48%	94.71%	113.38%	101.73%	53.26%
LAMESLEY	710 - ADULT MENTAL		1335	1627.03	697.5	864.98	333.25	364	666.5	910.47	121.87%	124.01%	109.23%	136.60%	100.00%	100.00%	123.51%	118.84%	122.81%	129.51%
KDU CHEVIOT	700 - LEARNING DISAB		1242	1272.2	1069.5	1324.97	333.25	400.73	666.5	739.54	102.43%	123.89%	120.25%	110.96%	100.00%	100.00%	92.18%	133.80%	128.46%	108.92%
KDU LINDISFARNE	700 - LEARNING DISAB		1242	1149.98	1426	2122.32	333.25	372.32	666.5	1071.22	92.59%	148.83%	111.72%	160.72%	100.00%	100.00%	76.93%	143.80%	108.41%	161.47%
KDU WANSBECK	700 - LEARNING DISAB		1242	1074.28	713	1177.83	333.25	384.05	666.5	1108.12	86.50%	165.19%	115.24%	166.26%	100.00%	100.00%	85.08%	179.37%	107.57%	162.27%
TWEED UNIT	700 - LEARNING DISAB		1242	892.9	1604.25	1991.97	333.25	381.12	999.75	1425.6	71.89%	124.17%	114.36%	142.60%	98.03%	100.00%	75.99%	125.99%	126.09%	140.64%
TYNE UNIT	700 - LEARNING DISAB		1242	1035.13	2495.5	2496.1	333.25	385.25	1333	1459.19	83.34%	100.02%	115.60%	109.47%	91.68%	100.00%	88.04%	107.27%	107.66%	107.58%

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: Wednesday 23rd May 2018

Title and Author of Paper:
Security Management – Annual Report 2017 / 2018
Tony Gray - Head of Safety, Security and Resilience
Craig Newby – Deputy Head of Safety, Security and Resilience
Claire Andre – Clinical Police Liaison Lead

Executive Lead: Gary O'Hare – Executive Director of Nursing and Chief Operating Officer

Paper for Debate, Decision or Information: Information

Key Points to Note:

- 10th annual report on Security Management arrangements in place within the Trust.
- This report integrates Lone Working, Physical Assaults on Staff and Security Management, into one report, having previously been presented in separate reports.
- Update provided on integration of Emergency Preparedness, Resilience and Response arrangements since January 2018.
- Update provided on future considerations of security management technology.

Risks Highlighted to Board: None to report.

Does this affect any Board Assurance Framework/Corporate Risks?
Please state Yes or No - No

Equal Opportunities, Legal and Other Implications:

Outcome Required: The Board of Directors are asked to note the content of this report.

Link to Policies and Strategies: Security Management Strategy / Security Management Policy – NTW (O)21 and supporting Practice Guidance Notes.

Northumberland, Tyne and Wear NHS Foundation Trust

Security Management Annual Report

April 2017 – March 2018

Caring | Discovering | Growing | **Together**

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Introduction

Northumberland, Tyne & Wear NHS Foundation Trust is committed to the delivery of an environment for those who use or work in the Trust that is properly secure so that the highest possible standard of clinical care can be made available to patients. Security affects everyone who works within the NHS. The security of staff, patients, carers and assets is a priority of the Board within the development and delivery of health services.

All of those working within the Trust also have a responsibility to be aware of these issues and to assist in preventing security related incidents or losses. Reductions in losses and incidents relating to violence, theft or damage will lead to more resources being freed up for the delivery of patient care and contribute to creating and maintaining an environment where all staff, patients and visitors feel safe and secure.

The purpose of this report is to provide information and assurance of the controls currently in place to create a pro-security culture across the Trust, as well as informing of the work currently being carried out across the organisation to improve security arrangements.

This is the tenth Security Management Annual Report for Northumberland Tyne & Wear NHS Foundation Trust.

Background

This is the first annual report produced without any national security standards in place, following the end of NHS Protect in March 2017, as stated at that point, it was agreed that local arrangements for boards to decide on appropriate security measures in place for each NHS organisation.

This change acknowledged that such external organisations such as the Health & Safety Executive will still have a legal responsibility to oversee and enforce any staff safety issues that are passed to them about the Trust, and the Care Quality Commission would have a view of our safe staffing information as a regulated activity.

Security Management Director (SMD) and Local Security Management Specialist (LSMS) nominations

The roles of the SMD and LSMS were previously defined in law to carry out the following functions:-

The Executive Director of Nursing and Chief Operating Officer in their capacity as the Trust's Security Management Director shall assume responsibility on behalf of the Board of Directors for all aspects of Security Management within the Trust. They will ensure that all management arrangements are in place to ensure compliance with the Trust's policy arrangements and supporting Practice Guidance Notes which covers the following areas:-

- Closed Circuit Television
- Lone Working
- Counter Terrorism Response (including bomb threats)
- Working in Partnership with the Police
- Trust Search Dog
- Hospital Lockdown
- Nuisance and Malicious Calls

In order to maintain and improve the safety and security systems within the Trust, the Security Management Director has deemed it appropriate to maintain the Trust's Local Security Management Specialists, as part of the central Safer Care Team.

The two individuals are the authors of this report, and have a greater portfolio than security management which covers the following areas:-

- Security Management
- Health & Safety Compliance
- Incident System Management
- Policy Administration and Management
- Central Alert System

With effect from 12th January 2018 the Trust's Local Security Management Specialists also took on responsibility for the Emergency Preparedness, Resilience and Response processes to further integrate these into the Safety systems of the Trust.

Current Position and Review of the Year

It is important that the organisation is still sighted on the activity relating to Safety & Security now more than ever before.

The following is a review of the work carried out over the last year.

The LSMS function regularly undertake security based risk assessments on behalf of the organisation. These assessments cover a range of subjects including:

- Targeted risks to Trust staff and support for lone working situations
- Security of premises
- Protecting property and assets
- Security preparedness and resilience
- Use of weapons/Use of illicit substances

The results of security risk assessments and associated recommendations are shared with key stakeholders. Security risk assessments are carried out both reactively and pro-actively and Clinical Environmental Risk Assessments include aspects of security management when they are carried out on in-patient wards.

The Clinical Environmental Risk Assessment process complies with the requirements of the Care Quality Commission Ligature Brief Assessment for in-patient wards, acknowledging this is where 3 out of every 4 incidents occur. There were over 50 assessments carried out in the last 12 months.

The assessment process also considers safety and security of the following areas:-

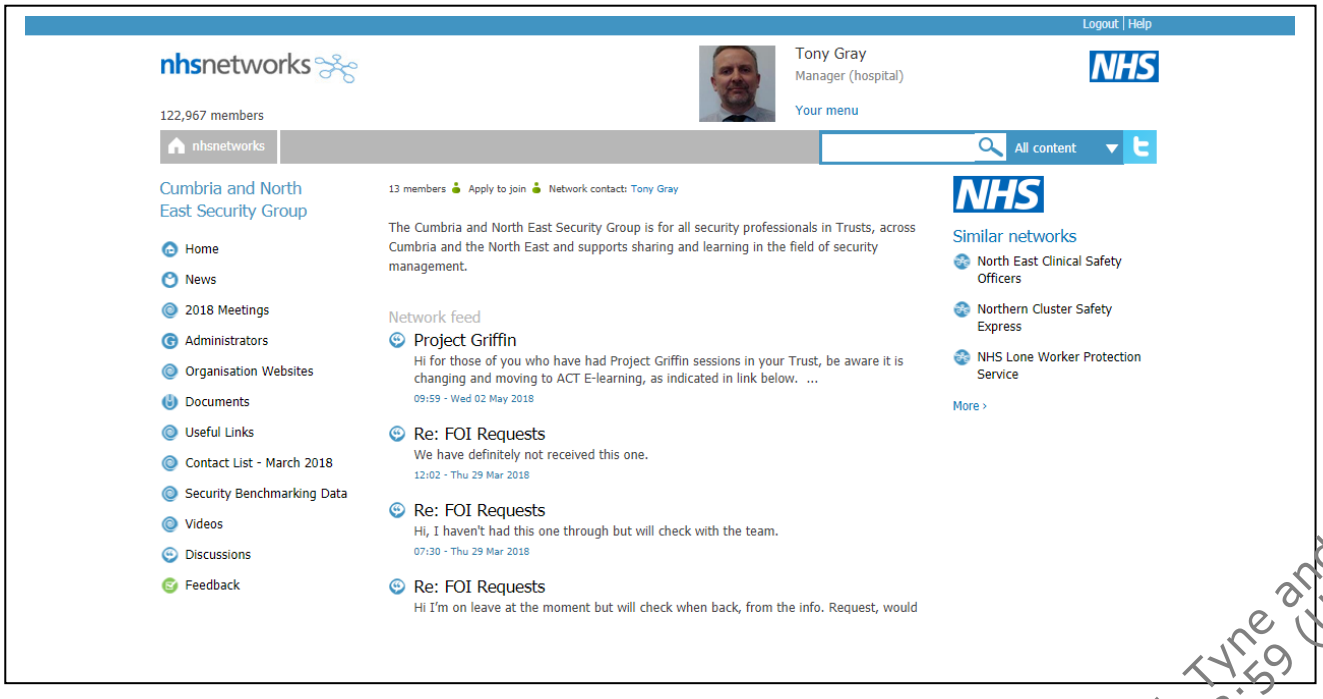
- CCTV
- Staff Attack Systems
- Door Access
- Asset Security
- Building Security
- Abscond Risk
- Substance Misuse / concealment / supply etc.

Working with Others

The Trust security management arrangements have operated under the umbrella of a memorandum of understanding with the National Police Chiefs Council (Previously ACPO), NHS Protect and the Crown Prosecution Service. This helps the Trust to work proactively with partner agencies to ensure, where possible, we protect staff, patients, premises, property and assets.

The Trust has a number of key stakeholders and is determined to ensure important information is shared, where possible, and deter those who may be minded to breach security – using publicity to raise awareness of the likely consequences, both personally and to the NHS.

As the regional Security arrangements ceased in 2017, it was agreed that the Regional Security Management Meeting would be retained, as this was a useful forum for sharing knowledge and learning across all the Security Managers in healthcare organisations across Cumbria and the North East. These meetings have taken place over the last year and been well attended, with the Trust hosting and chairing them on a rotational basis. The Head of Safety, Security and Resilience has also taken on administrative responsibilities for a new network (part of NHS Networks) for sharing and learning, and this has attracted wider local and national interest. The screen shot below shows the set-up of this resource, and it is used as an on-line forum and information sharing platform.



Clinical Police Liaison Lead

The Clinical Police Liaison Lead, continues to work closely with a network of officers from Northumbria Police and forces nationally, and continues to be part of Her Majesty Inspectorate of Constabulary, Fire & Rescue services (HMICFRS) expert reference group looking at how mental health can form part of the Police inspections and what should be seen as good practice. There has been continued interest in the Clinical Police Liaison Lead function from other areas nationally, as the role is now seen as a key element of excelling

with partnership working. Due to uniqueness of the role and knowledge base it has also led to the role becoming involved in assisting Northumbria Police Professional Standards Department (PSD), and the Independent Office of Police Complaint's (IPOC) to work on their processes. Helping them to develop further around their dealing of those that are vulnerable and mentally unwell, as their current systems are not always supportive of this group.

Alongside Steve Baker an Inspector (Northumbria Police Force Mental Health Lead), have both presented at a number of national forums around the partnership work in the North East and the role in NTW. This has more recently included the National Police Mental Health forum which 41 police forces attended, and was chaired by Chief Constable of Dyfed – Powys Police, Mark Collins who is the National Police Chief Council lead. Mr Collins has also visited NTW services and has spoken highly of what he has seen from our modern facilities to Crisis services. He has said nationally about NTW being the best mental health trust he has seen in this country, due to the services and partnership work with Northumbria Police.

There continues to be much work within the Trust around working with our police colleagues, including building and sustaining relationships with new officers and supervisors working with teams and sites. Dealing with concerns and issues that arise, and building knowledge of staff within Police Awareness and inputs at professional events, like the nursing conference. Also embedding the essential culture to ensure we continue to learn together, by inviting Police to be a part of our Incident After Action Reviews where they have been involved in the incident. Work is being done about gathering better information and data of our work. The Safeguard Incident System cause group has changed to 'Police & Emergency Services activity' from 'Police Issue'. With more developed primary cause categories to help us build better data around Police activity within our services and this will form part of Police & Partner Meetings.

Training has continued throughout the year to Police Officers, including Control Room supervisors, and Custody Sergeants. With a plan to train officers from all areas of Northumbria Police as mental health navigators moving forward. There has been training delivered in force also for Blue light Champion's. Raising awareness and talking mental health with officers of all ranks and Police staff. Thus ensuring they know where to go for support and how to access services and support when they need it. This has led to the role being contacted by those needing that guidance and support to access services themselves, as this has built the trust within Northumbria for people to speak freely.

Respond Multi Agency training has continued with great success, and a further scenario of an incident on an In-patient ward has been developed. Funding was secured with thanks to North Tyneside Clinical Commissioning Group (CCG) some further funding from NHS England, and the local agencies involved. This has meant there are now more booked sessions throughout the year running all three scenarios across the Trust geographical area each month. The National interest has continued, with leads from Metropolitan Police and the Home Office observing Respond, and expressed a wish for this to be rolled out in their area. North Wales are also progressing to roll out of Respond Training. There has been further interest from other areas also, all at various stages of progression. We are now proactively contacting all local areas to tell them about this training and opportunities for them. A cost package has been developed, to help sustain Respond without making a profit. We have taken Respond Training to a number of national platforms, presenting to various audiences led by the Project Co-ordinator.

Security Incidents

The Trust acknowledges that the national security reporting system was closed down on the 31st March 2017, however we continue to report security incident within the Trust, and this forms part of the monthly and quarterly Safer Care reporting activity, that is received throughout the organisation and externally to Commissioners as part of our contracts.

The Clinical Business Units report the highest number of security incidents, and the majority of these are aggression and violence on in-patient wards. The following gives a breakdown of the activity. All this activity is considered and actioned when it occurs and reported to clinical groups on a weekly or monthly basis to consider corrective action.

Again it is acknowledged that currently the Trust can now only compare its activity with its own reporting culture given the demise of national systems reporting on this.

The tables in Appendix 1 gives a breakdown of the types of security incidents the Trust experiences. From these tables there can be seen over the last 3 years the Trust recorded 1,734, 1,999 and 2,267 incidents respectively of a security nature, which shows an increasing picture as we have developed our transparent security culture over the years.

Some of this increase is naturally related to the increase of detection of substances on in-patient wards by the Trust's Search handler and dog.

In 2017 we also started to receive intelligence in the form of incidents from our out of hours security personnel, who identified security breaches as they went about their patrols, these had previously been unreported.

Preventing significant security incidents or breaches from occurring, or minimising the risk of them occurring by learning from operational experience about previous incidents, using technology and sharing best practice is a key element of the LSMS role, and they are notified of every security incident that occurs anywhere in the Trust as soon as it is reported.

Where appropriate, security risks are included on the Department and Trust Risk Registers to enable security risks to be managed in accordance with the Trust's Risk Management Strategy.

Our contract with external Security Contractor is under constant review, and their support for a security provision on all main hospital sites as well as comprehensive CCTV monitoring brings a significant level of safety to staff and patients out of hours.

Our CCTV systems benefit from routine 6 monthly maintenance inspections, which forms part of a comprehensive maintenance contract. All of the Trusts CCTV systems comply with the Information Commissioners CCTV Code of Practice. As part of this, the CCTV contractor provide 24 hour, 365 day cover to access and burn off images to support Police investigations, allegations of staff abuse or other security related activity. The costs associated from this activity come from a central budget which is overseen by the Head of Safety and Security to give an update to the Security Management Director on the costs associated with this contract.

Counter Terrorism – Awareness and Training

The Trust held a number of sessions of Project Griffin in 2017/18, so that Executive Directors, Operational Directors, Heads of Functions and Clinical and non-clinical staff, could be made aware of the terror threat.

Project Griffin is the national counter terrorism awareness initiative for business produced by NaCTSO to protect our cities and communities from the threat of terrorism.

The threat from terrorism is serious, but it is important to keep it in perspective. This threat comes principally from DAESH (also known as ISIL), Al Qaida, and groups and individuals who can be directed, encouraged or inspired by them. The level of threat is complex and ranges from crudely planned attacks to sophisticated networks pursuing ambitious and coordinated plots.

The aim of Project Griffin is to:

- Help understand the threat from terrorism to the UK
- Guide individuals on what to do if they find themselves involved in a terrorist incident or events that lead up to a planned attack
- Enable people to recognise and report suspicious activity

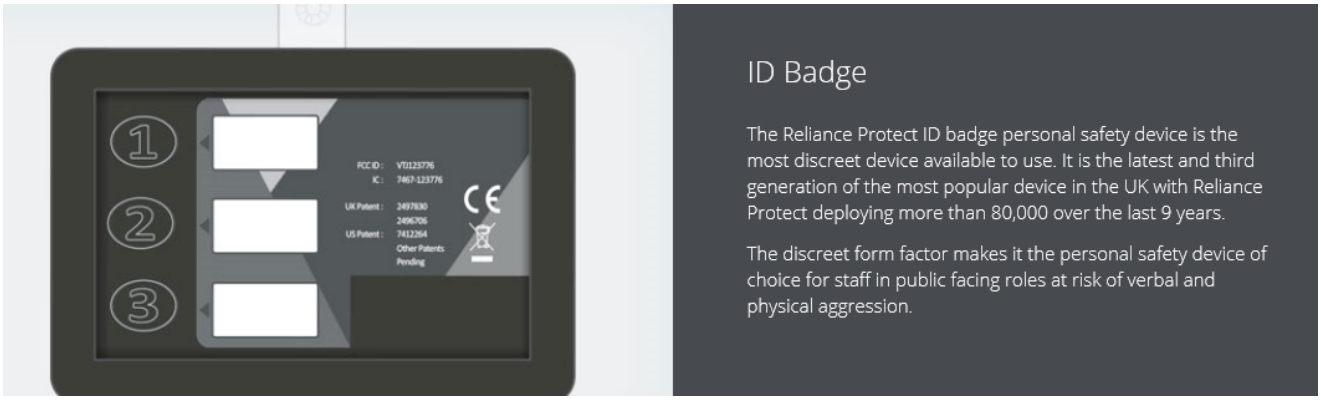
Project Griffin is a briefing event to increase public and staff awareness of how best to reduce and respond to the most likely types of terrorist activities. The events was presented by a trained police counter terrorism advisor.

Lone Working

Health care workers have long been identified as a high risk group when considering lone working. Issues identified in high profile incidents emphasise the scale of the risk faced by mental health care staff on a daily basis.

Lone Workers also face particular problems when it comes to assaults, such as verbal abuse or harassment. Very often, these assaults take place in one to one situations with no other evidence available to support taking action against alleged offenders. This can result in the reluctance by Lone Workers to report incidents that occur, leading to a feeling that nothing can be done to protect them or deal with the problems they face. Lone workers, by the nature of their work, can feel isolated or unsupported, simply by the very fact that they do not work in an environment surrounded by their colleagues or others.

The Trust has had in place a robust contract and system of work to protect its lone workers using the identicom lone working solution.



The system comes in the form of an ID badge holder and all staff receive full training, the system was originally commissioned as part of a centrally funded Department of Health initiative in 2008, and the Trust has continued to use and develop the system since its inception. In 2008, the Trust rolled out over 400 devices to its community staff, and as community services have developed in 2017/2018 our 2,000th device went live. We have built a strong relationship with Reliance Protect.

It is acknowledged that as one of the biggest users of this system nationally, there will always be opportunities for improvement of usage, and the Safety Team in partnership with clinical groups have worked through the year with the national supplier, to improve effectiveness. This included several meetings and a visit to the national alarm receiving centre in Pontefract, to understand when the alerts occur how they are responded to and why it is important that the right information is available.

Over the last year there have been a number of genuine red alerts, which have been dealt with in an effective and safe manner. In some of these cases the police were required and as a result a response was provided allowing the incident to be managed by the police rather than the member of staff.

The Safety Team continue to provide managers across the Trust with up to date usage information, which allows them, in turn, to ensure devices are used effectively by the lone workers they manage.

Throughout 2017/18 the Trust has been upgrading the system so that all devices will be GPS enabled to give better location detection for staff and ensure prompt assistance when they escalate for support

In the last annual report there were 13,800 amber alerts being left every month to tell the national alarm receiving centre where staff were and who they were going to visit, the following table gives a breakdown of the activity over the last 12 months, and shows the increase in use.

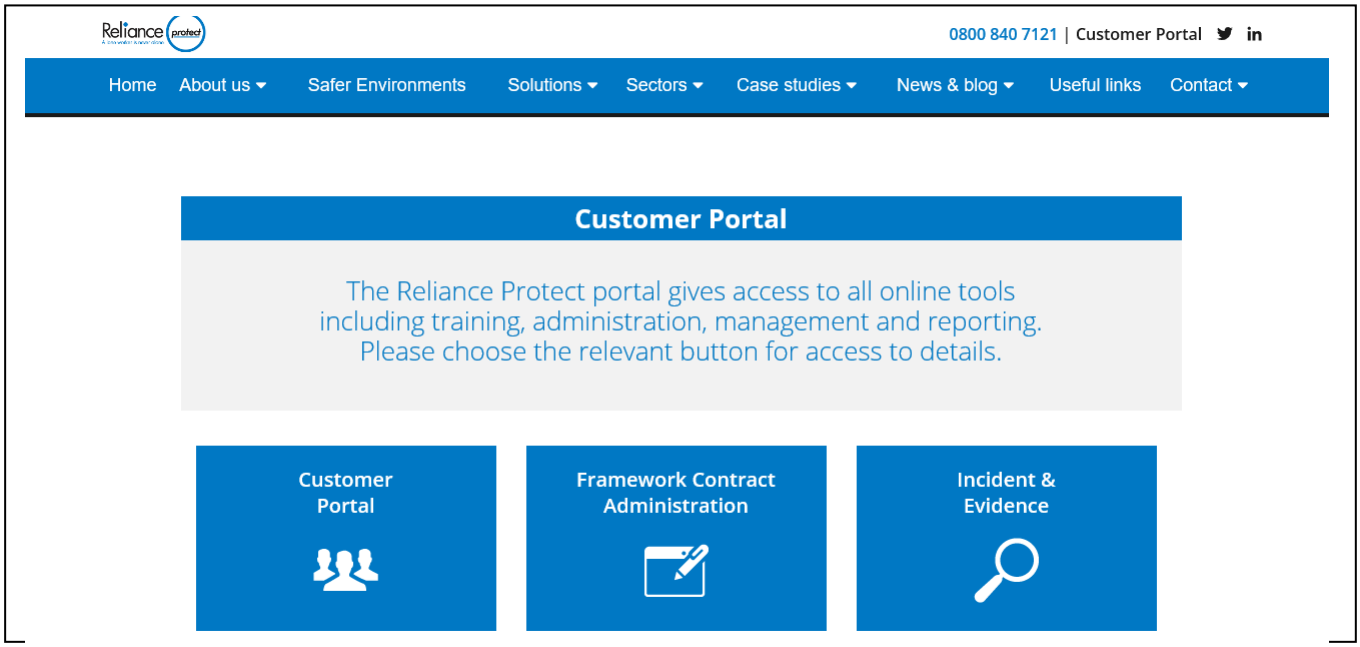
Month/Year	Amber Alerts	Live Devices
March 2018	14719	1952
February 2018	13986	1953
January 2018	16526	1948
December 2017	12957	2009
November 2017	16390	1992
October 2017	17093	1959
September 2017	17215	1904

Whilst the amber alerts appear to have diminished over time this is in direct relation to implementation of Data Protection requirements, where previous activity is deleted on a device when it is re-used, re-issued. As part of the transition from series 7 devices to new series 8 – GPS enabled devices, amber alerts continues to rise again from February 2018 onwards, and at the time of writing there are over 2,000 devices in use, with 16, 418 alerts.

August 2017	18384	1922
July 2017	18356	1979
June 2017	19140	1968
May 2017	17641	1781
April 2017	15474	1760

Future developments of Lone Working

As we continue our development of the system in partnership with the company, we are continuing the development of the on-line portal, and all staff carry out their training through this portal, within the next 6 months, performance and management information will also come on line, to support more efficient use of the system.



Tackling Illicit Drug Use

The use of illicit drugs and new psychoactive substances (NPS formerly known as legal highs) continues to be a problem in some inpatient setting. A number of serious incidents have occurred relating directly to consumption of illicit substances both on the ward and following an episode of leave, media reports and national research have continued to highlight the problem the North East is facing. The Trust is not an outlier in this, and the Trust is currently working in partnership with Tees, Esk and Wear Valley NHS Foundation Trust the Trust to share learning, but also we are now jointly sharing our Search Dog and Handler across both organisations and working closely with respective Police Forces that cover the geographical locations, to identify trends and report activity, sharing intelligence of vehicles that come onto Hospital sites and known sellers of illicit substances.

Reducing the impact of Violence and Aggression

The prevalence of violence and aggression in mental health / learning disability is far higher than any other healthcare provision.

The organisation is fully sighted on the pre-cursors to aggression and violence within the Trust, and the detailed report relating to our Positive and Safe Strategy detailing our implementation of our Talk 1st initiative will be available in June 2018. We continue to report on the related activity every quarter through the Safer Care Report.

In respect to aggression and violence to staff the local incident activity still complies with the national definitions of physical and non-physical assault as below.

The definitions of physical assault have not changed.

The Trust will always continue to report all physical and non-physical assaults. The definitions are:-

Physical Assault *– The intentional application of force to the person of another, without lawful justification resulting in physical injury or personal discomfort.*
Non-Physical Assault *– The use of inappropriate words or behaviour causing distress and / or constituting harassment.*

From a historical context the previous NHS Protect figures for physical assaults have been archived and as such there is no longer a requirement to report into a national system and as such the true national figure is no longer known. However due to an influx of Freedom of Information Requests throughout 2017/18, there is now a voluntary collection of data under way for 2017/18 by the Head of Operational Security in NHS England, this is due to be submitted in June 2018.

NHS Protect – Published Figures
The table below gives a comparison of the last five years of published figures.

	2011/ 12	2012/13	2013/14	2014/15	2015/16
Type of Trust	Number of Physical Assaults	Number of Physical Assaults	Number of Physical Assaults	Number of Physical Assaults	Number of Physical Assaults
Ambulance	1,630	1,397	1,868	1,861	2,300
Acute	15,536	16,475	17,900	19,167	20,018
Primary Care	1,540	0	1,731	1,616	2,130
MH & LD	**41,038**	**43,699**	**47,184**	**45,220**	**46,107**
Total	59,744	61,571	68,683	67,864	70,555

Reported Physical Assaults Within the organisation

The nationally published figures were always adjusted based on an audit carried out every year by NHS Protect, irrespective of whether the organisation was audited or not, which frequently resulted in a downgrade of the number of assaults publicly reported. The below table gives the actual number of physical assaults recorded in the Trust's Risk Management System for each of the financial years. More information on Aggression and Violence is included in the table at Appendix 2.

	2011/12	2012/ 13	2013/ 14	2014/15	2015/16	2016/17	2017/18
Trust	Total Assaults	Total Assaults	Total Assaults	Total Assaults	Total Assaults	Total Assaults	Total Assaults
Northumberland, Tyne & Wear NHS Foundation Trust	2,321	3,278	3,277	3,595	3,715	3,825	3,780

In the year 2017/18 the Trust witnessed its first decline in physical assaults on staff, since it started to report on the information in 2006. Whilst it is only a reduction of 45 assaults this is against a back drop of an increase in general incident reporting of 2,164 over the same period. Whilst the reduction of incident activity is welcomed the Local Security Management Specialists, continue to work in partnership with the Positive and Safe Team to understand the individuals who account for a significant number of the assaults, and support clinical teams with the appropriate information and access to timely reports to update and improve care planning to reduce and mitigate the activity where it can be.

Future Activity

The nature of incident activity that is safety and security related continues to change due to continuous learning, but also due to operational changes.

With the implementation of the site wide smoke free policy. Every Mental Health Trust has seen an increase in illicit substance and smoking activity in areas that are no longer allowed, and this has become a risk to the environment from a Fire Safety perspective as well to staff and patients as part of the management of the activity.

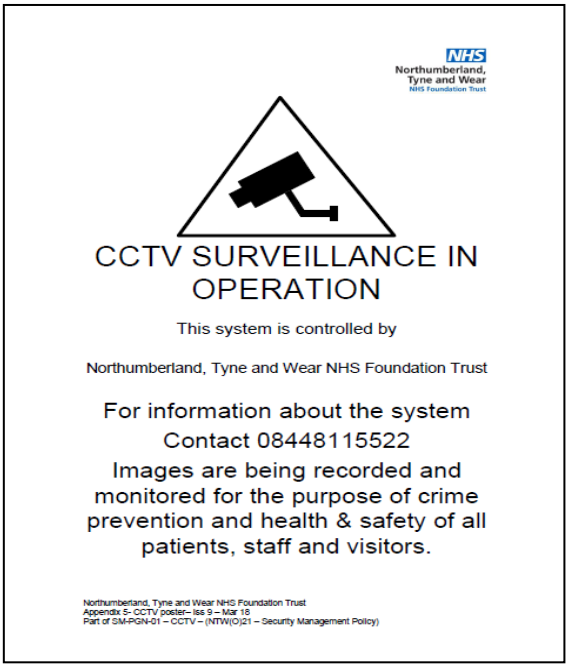
To this end the Trust is looking at a number of initiatives to assist in detecting this and other activity before it escalates into more serious incidents and creates more harm predominantly in Acute Admission and the Psychiatric Intensive Care Unit.

Metal Detection

Business Cases have already been submitted for the potential role out of the Metrasens metal detection system, which will identify any ferrous material such as lighters, weapons etc. This will be progressed throughout 2018.

Closed Circuit Television

The Trust already has robust systems in some more modern in-patient services such as Hopewood Park, which benefits from over 250 cameras, recording digitally 24 hours a day. These recordings have been instrumental to deter and detect crimes on the hospital site. A full assessment of need has been carried out and a report is being prepared for consideration by Directors.



Body Worn Cameras

Body worn cameras are increasingly being worn in society from front line policing to Local Authority / NHS staff / Security staff and doormen etc, and have recently been deployed in Mental Health organisations. The Trust is currently arranging a pilot of 2 nationally available systems to learn how these could be used in the Trust, acknowledging the difference CCTV has made over the years, but also to accept the national research around behaviour change, that results in their adoption.

Lone Working – Community Solutions

Whilst the nature of lone working hasn't changed in community settings over the years, staff feedback has indicated that a potential range of solutions for different on-site / off-site scenarios may be appropriate in future, and the Trust is working in partnership with its lone working contractor to review the available solutions to keep its staff safe, acknowledging technology is ever evolving. A range of options are currently under consideration within the organisation.

Report Conclusion

The Trust continues to work to mitigate the security risks faced both internal / external to the organisation. As the organisation continues its journey of development, and the NHS as a whole goes through major transformational change, it is acknowledged that safety and security remains paramount and on the highest level of all agendas throughout the Trust.

In short, security needs to be considered by all levels of staff from the Board to the ward and the understanding at each level of the organisation for the parts to play to continue to improve the quality and safety of care that is delivered within the resources we have available.

Security Incidents April 2015 – March 2018

Cause 1	2015-16	2016-17	2017-18
S01 Theft Of Staff Property At Work	4	4	4
S02 Theft Of Patient Property	9	15	9
S03 Theft Of Hospital Property	5	17	22
S04 Theft Of Hospital Property - Data/Hardware	3	3	6
S05 Theft Of Non Hospital Property	4	6	3
S06 Damage Of Personal Property At Work	17	14	23
S07 Damage To Hospital Property - Patient	316	421	335
S08 Damage To Hospital Property - Accidental	20	13	18
S09 Damage To Hospital Property - Other	22	36	44
S10 Trespass On Hospital Property	4	4	4
S11 Audit Differences - General Goods/stock	0	1	0
S13 Audit Differences - Money	0	0	1
S14 Security - Building Not Secured	37	52	129
S15 Security - Intruder Alarms Triggered	4	31	90
S16 Barricade Situation	2	5	5
S17 Alleged Theft	10	7	6
S18 Attempted Theft	4	2	5
S19 Security - Other	157	198	288
S20 Loss - Other	76	117	143
S21 Attempted Break-In	2	1	5
S22 Actual Break-In	1	2	7
S23 Weapon Discovered/Found	47	51	41
S24 Illicit Drugs Discovered/Found	92	118	90
S25 Failure Of Staff Attack Alarm - Operational	37	44	28
S26 Suspicious Behaviour	16	20	39
S27 Nuisance / Mallicious Phone Calls	7	14	26
S28 Loss Of Dept / Ward Keys	31	32	28
S29 Presumed NPS / Illegal Highs	24	3	2
S30 Illicit Drug Use	64	118	105
S31 Attempted Vandalism	66	223	67
S32 Locked Doors Due To Clinical Activity	45	32	193
S33 Room Searched For Contraband	70	87	132
S34 Contraband Seized	88	69	112
S35 Damage To Property Of Others	5	9	11
S36 Secure Unit Security Breach	34	24	28
S37 Failure Of Lone Worker Device	1	5	8
S38 Damage To Patients Property	8	14	18
S39 Alarm Sounded No Response	1	7	7
S40 Positive Drug Screening	23	41	26
S41 Suspicion Of Illicit Drug Dealing	19	22	43
S42 Patient Handcuffed	119	9	0
S43 Loss Or Theft Of Lone Working Device	0	1	5

S44 Keys Left Insecure	4	4	3
S45 Anti-Social Behaviour	2	14	6
S46 ERB Used	130	3	0
S47 Failure Of Staff Attack Alarm - Testing	24	13	2
S48 Theft Of Patient Money	3	2	5
S49 Theft Of Staff Money	5	1	1
S50 Theft Of Trust Money	3	0	1
S51 Theft Of Visitor Money	0	1	0
S52 Failure Of Lone Worker Procedure	0	1	0
S53 Transport Of Patient	21	35	48
S54 136 Suite Issue	6	1	1
S55 Lone Worker Issue	9	11	12
S56 Nuisance / Malicious Communication	3	8	23
S57 ERB Unavailable	1	3	0
S58 Lack Of Response	13	6	7
S59 Secure Transport Issues	3	1	0
S60 Reliance Reporting Inaccuracies	13	0	0
S61 Bomb Threat	0	3	1
S62 CCTV Failure/Issues	0	0	1
Total Incidents	**1734**	**1999**	**2267**

Aggression and Violence Incidents April 2015 – March 2018

Cause 1	2015-16	2016-17	2017-18
V01 Physical Assault Of Staff By Patient	3709	3822	3777
V02 Physical Assault Of Visitor/Gen.Pub. By Patient	135	131	110
V03 Physical Assault Of Patient By Patient	716	785	691
V04 Threatening Behaviour By Patient To Staff	1047	1193	841
V05 Threatening Behaviour By Patient To Pat	452	381	387
V06 Threatening Behaviour By Patient To General Public	60	78	90
V07 Physical Assault Of Staff By General Public	4	3	3
V08 Physical Assault Of Patient By Public	19	18	22
V09 Physical Assault Of General Public By General Public	2	3	1
V10 Threatening Behaviour By Gen. Pub. To Staff	28	48	49
V11 Threatening Behaviour Of Public To Patient	7	17	8
V12 Threatening Behaviour Of Gen. Pub. To Gen. Pub.	3	3	6
V16 Threatening Behaviour By Staff To Staff	0	0	1
V17 Threatening Behaviour By Staff To Patient	1	0	0
V19 Racial Abuse By Patient To Patient	19	30	20
V20 Racial Abuse By Patient To Staff	72	132	106
V21 Allegation Of Racial Abuse By Staff To Patient	2	0	0
V22 Sexual Assault By Patient To Patient	1	0	0
V23 Sexual Assault By Patient To Staff	2	12	42
V25 Allegation-Sexual Assault Of Patient By Staff	1	0	0
V26 Allegation-Sexual Assault Of Patient By Other	0	2	0
V30 Verbal Abuse Of Staff By Patient	411	727	630
V31 Verbal Abuse Of Staff By Gen. Pub	40	42	43
V32 Sexual Assault By Patient To Other	1	0	2
V33 Allegation Of Sexual Assault By Patient On Oth	0	1	2
V34 Alleged Physical Assault By Patient To Other	8	25	10
V35 Patient Planned Intervention	709	672	658
V36 Aggressive Behaviour To Staff	1728	2137	4037
V37 Threat To Kill Staff	82	118	114
V38 Threatening Behaviour With Weapon To Staff	27	59	46
V39 Aggressive Behaviour To Others	3055	1582	1504
V40 Threat To Kill To Others	57	64	61
V41 Threatening Behaviour With Weapon To Others	32	46	27
V42 Verbal Abuse Of Staff - Non Targeted	108	147	94
V43 Verbal Abuse Patient To Patient	22	61	50
Total Incidents	**12560**	**12339**	**13432**

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors

Meeting Date: 23rd May 2018

Title and Author of Paper: Integrated Commissioning & Quality Assurance Report (Month 1 April 2018) – Anna Foster, Deputy Director of Commissioning & Quality Assurance

Executive Lead: Lisa Quinn, Executive Director of Commissioning & Quality Assurance

Paper for Debate, Decision or Information: Information & Discussion

Key Points to Note:

- This report provides an update of Commissioning & Quality Assurance issues arising in the month, including progress against quality standards.
- Achievements include Northumberland Children and Young Peoples service reduction in over 18 week waiters.
- Challenges remain waiting times across many adult and children's services, in particular South of Tyne Services for Children and Young People
- There has been little change in the month in relation to other workforce, training and quality standards.
- Training improvements in the month are Rapid Tranquilisation and MHA Combined Training
- The executive summary on page 1 provides further points to note.

Risks Highlighted: waiting times and sickness.

Does this affect any Board Assurance Framework/Corporate Risks: Yes

Equal Opportunities, Legal and Other Implications: none

Outcome Required / Recommendations: for information and discussion

Link to Policies and Strategies: NHS Improvement – Single Oversight Framework, 2017/18 NHS Standard Contract, 2017-19 Planning Guidance and standard contract, 2017-18 Accountability Framework

Northumberland, Tyne and Wear NHS Foundation Trust

NTW Integrated Commissioning & Quality Assurance Report

2017-18 Month 1 (April 2018)

Contents:

1. Executive Summary:

- The Trust remains assigned to segment 1 by NHS Improvement as assessed against the Single Oversight Framework (SOF). (page 4).
- At Month 1, the Trust has a year to date deficit of £0.5m which is £0.3m behind plan. The Trust is forecasting to meet its control total of £3.5m by delivering a surplus before Provider Sustainability Funding of £1.5m and receiving its Sustainability funding of £2.0m. The Trust's finance and use of resources score is currently a 3 (this is a sub theme of the Single Oversight Framework) and the forecast year-end risk rating is also a 3. The main financial pressures during month 1 were staffing pressures in the Autism Unit and smaller pressures around staffing reductions. See page 20.
- South Tyneside, Sunderland and NHS England fully achieved the contract requirements during month 1 however, there are a number of contract requirements largely relating to CPA metrics which were not achieved across other local CCGs during the month. (page 11)
- There are continuing pressures on waiting times across the organisation, particularly within community services for children and young people. Each locality group has developed action plans which are being monitored via the Business Delivery Group and the Executive Management Team. (page 18)
- All CQUIN scheme requirements are forecast to be achieved during Quarter 1 (page 12)
- All of the four of the quality priorities are internally forecast as amber at month 1. (page 22)
- The Accountability Framework for each group is currently forecast as 4 due to the continuing underperformance in each group against a number of quality metrics. (p 23)
- Reported appraisal rates have increased in the month to 83.6% (was 82.8% last month). (p21)
- The in month sickness absence rate has increased to 5.14% in the month. The 12 month rolling average sickness rate has increased to 5.63%.(p 21)
- Training rates have continued to see most courses above the required standard. The courses more than 5% below the required standard are Rapid Tranquilisation Training at (78.1% was 73.8% last month), MHA Combined Training (76.2% was 74.3% last month) (p 21)
- The service user and carer FFT recommended score has decreased to 88% in April which is below the national average. (page 26)

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

SOF:	1	The Trust's assigned shadow segment under the Single Oversight Framework remains assigned as segment "1" (maximum autonomy).

Waiting Times

- The number of people waiting across adult services has decreased in the month (excluding gender dysphoria, adult autism diagnosis etc), the number waiting over 18 weeks has increased marginally in the month.
- The number of people waiting for specialised adult services has increased slightly in the month along with the proportion of those waiting more than 18 weeks which has continued to increase.
- Waiting times to treatment for children and young people have decreased in the month across all areas, those waiting more than 18 weeks have seen a significant reduction in the month.

Quality Priorities:

Quarter 1 forecast:	Quarter 1 forecast part achieved:	Quarter 1 forecast not achieved	
3	0	1	In total there are four quality priorities identified for 2017-18 and at month 1 three are forecast as achieved whilst the waiting times is forecast as not achieved.

CQUIN:

Quarter 1 forecast:	Quarter 1 forecast part achieved:	Quarter 1 forecast not achieved	
10	0	0	There are a total of ten CQUIN schemes in 2017-18 across local CCGs and NHS England commissioned services. Most have been internally forecast as achieved at month 1.

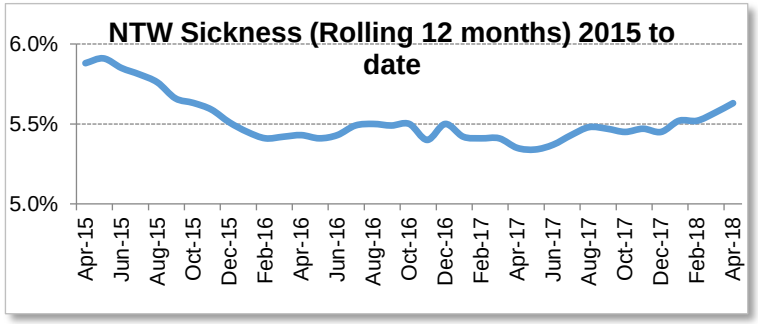
Workforce:

Statutory & Essential Training:

Standard Achieved Trustwide:	Performance <5% below standard Trustwide:	Standard not achieved (>5% below standard):	
13	4	2	Clinical Supervision training (84.4%), PMVA Basic training (80.1%), PMVA Breakaway (83.2%) and Information Governance (91.9%) are within 5% of the required standard, MHA combined training (76.2%) and Rapid Tranquilisation training (78.1%) are more than 5% below the standard.

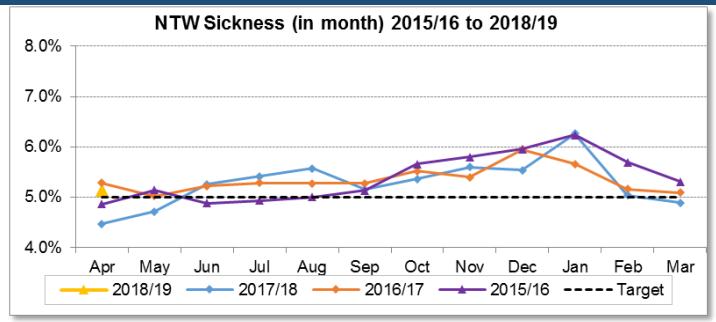
Appraisals: Appraisal rates have increased to 83.6% in April 18 (was 82.8% last month).

Sickness Absence:



The "in month" sickness absence rate is above the 5% target at 5.14% in April 2018

The rolling 12 month sickness average has increased to 5.63% in the month



Finance:

At Month 1, the Trust has a year to date deficit of £0.5m which is £0.3m behind plan. Pay spend at Month 1 was £21.3m which is £0.3m above plan and includes £0.7m agency spend which is in line with the planned trajectory to hit our agency ceiling of £8.0m but £0.2m above planned spend.

The Trust is forecasting to meet its control total of £3.5m by delivering a surplus before Provider Sustainability Funding of £1.5m and receiving its Sustainability funding of £2.0m. The Trust's finance and use of resources score is currently a 3 (this is a sub theme of the Single Oversight Framework) and the forecast year-end risk rating is also a 3.

The main financial pressures at Month 1 relate to pay costs. There is a significant staffing pressure in the Autism Unit and there are smaller pressures across the Trust related to the staffing reductions required to deliver planned savings that haven't been achieved yet. The Trust needs to reduce pay spend to bring the financial position back in line with plan and to achieve this year's control total.

To achieve this, spending on temporary staffing (agency, bank and overtime) needs to reduce. Work is ongoing to deliver the required staffing reductions and to improve efficiency and productivity across the Trust.

Contract Summaries:

NHS England	Northumberland & North Tyneside CCGs	Newcastle / Gateshead CCG	South Tyneside CCG	Sunderland CCG	Durham, Darlington & Tees CCGs	Cumbria CCG
100% of metrics achieved in month 1	90% of metrics achieved in month 1	90% of metrics achieved in month 1	100% of metrics achieved in month 1	100% of metrics achieved in month 1	87% of metrics achieved in month 1	62% of metrics achieved in month 1
The areas of under performance continue to relate mainly to CPA metrics and 7 day follow up						

2. Compliance

a) NHS Improvement Single Oversight Framework

Self assessment as at Quarter 1 2018 to date against the "operational performance" metrics included within the Single Oversight Framework:

Metrics: (nb concerns will be triggered by failure to achieve standard in more than 2 consecutive months)	Frequency	Source	Standard	Quarter 1 to date self assessment	NTW % as per most recently published MHSDS/RTT/EIP/IAPT data	National % from most recently published MHSDS data	Comments. NB those classed as "NEW" were not included in the previous framework	Data Quality Kite Mark Assessment
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	Monthly	UNIFY2 and MHSDS	92%	100%	100%	87.50%	National data includes all NHS providers and is at February 2018	
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	Quarterly	UNIFY2 and MHSDS	50%	77.4%	92%	76.70%	Published data is as at February 2018	
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:								
a) inpatient wards	Quarterly	Provider return / CQUIN audit	90%	98%	no data	no data	Q1 YTD Metric 1426	
b) early intervention in psychosis services	Quarterly	Provider return / CQUIN audit	90%	92%	no data	no data	Q1 YTD Metric 1427	
c) community mental health services (people on Care Programme Approach)	Quarterly	Provider return / CQUIN audit	65%	95%	no data	no data	Q1 YTD Metric 1425	
Data Quality Maturity Index Score (DQMI)			95%	92%			Published data is at Quarter 2 2017	
Number of Out of Area Placements (Active at period end)				3	0	685	Published data relates to January 2018. NTW self assessment data relates to March 2018	
Improving Access to Psychological Therapies (IAPT)/talking therapies							NTW data relates to March	
· proportion of people completing treatment who move to recovery	Quarterly	IAPT minimum dataset	50%	49.8%	50.0%	50.7%	NEW metric 1079 published data January 2018	
· waiting time to begin treatment :								
- within 6 weeks	Quarterly	IAPT minimum dataset	75%	99.2%	100.0%	89.4%	published data January 2018	
- within 18 weeks	Quarterly	IAPT minimum dataset	95%	99.8%	100.0%	98.7%	published data January 2018	

NHS Improvement Single Oversight Framework & Model Hospital Portal

As at the end of February 2018, the Trust remains segment 1 within the Single Oversight Framework as assessed by NHS Improvement. There are currently 16 mental health providers nationally achieving this rating. There is currently one MH providers in the lowest segment (segment 4), 26 providers within segment 2 and five providers remain in segment 3.

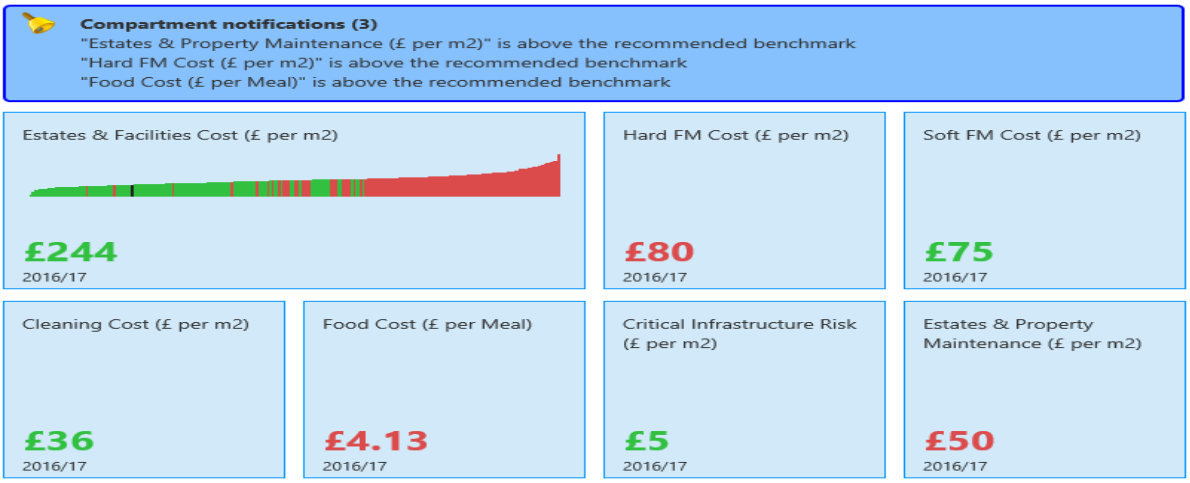
Sickness

The information in relation to overall staff sickness has not been updated since the last report and therefore the trust is still showing a notification for this metric with an overall sickness rate of 5.69% (this figure is from November 2017).

Estates and Facilities

There remain as reported in last month's update the following three notifications against metrics for Estates and Facilities:-

- Hard FM Cost
- Estates and Property Maintenance
- Food Costs,

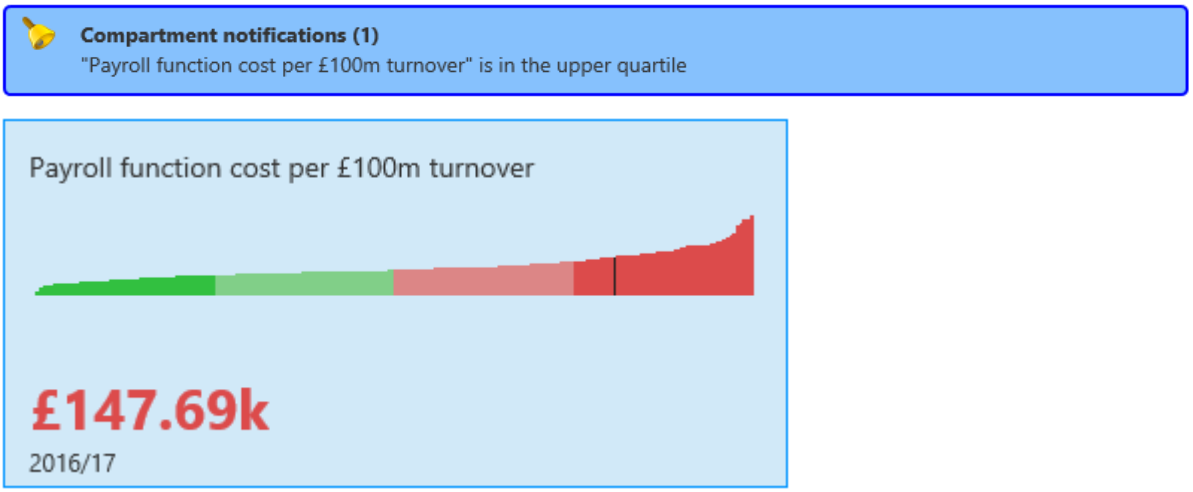


Finance Function

There is a new notification showing in the Finance Function compartment, this is in relation to "Cost of Accounts Receivable per invoice raised".

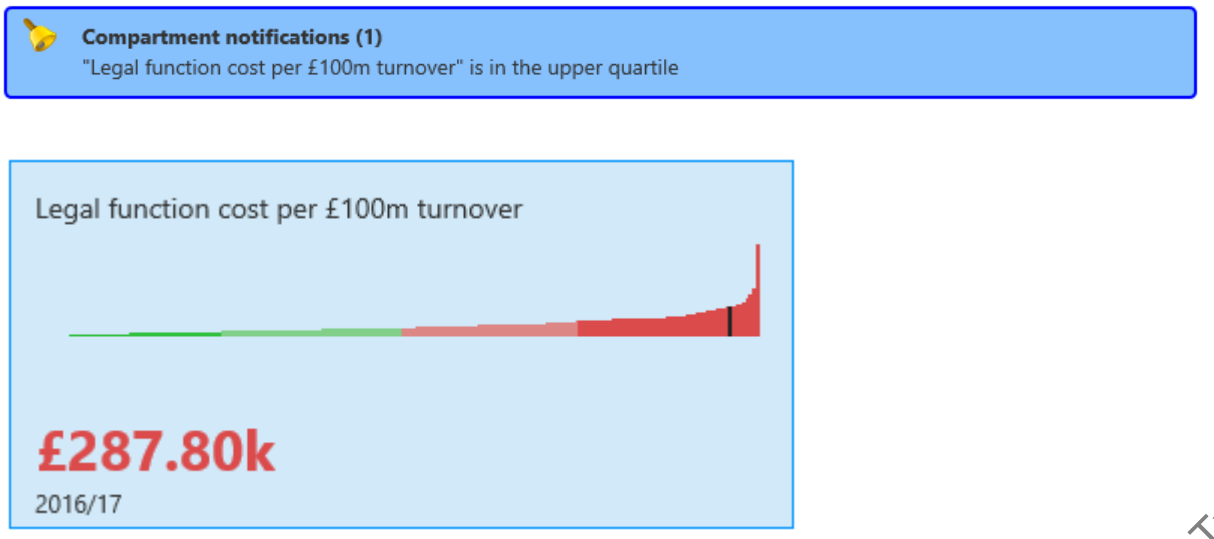
Payroll Function

The Trust has a new notification in the Payroll Function Compartment. This shows that the Trust is in the upper quartile for payroll function cost per £100m turnover.



Legal Function

The model hospital has a new notification showing for the Trust in relation to Legal costs. This show the trust in the upper quartile for legal function cost per £100m turnover.



It should be noted that the information shown within this report is an exception based, there is further data on a wide range of other metrics available within the model hospital portal.

2. Compliance
b) CQC Update April 2018

CQC Well Led with Core Service Inspection

- Inspections to the following core services have taken place - CAMHS inpatient wards, specialist community CAMHS, acute wards for adults of working age and psychiatric intensive care units and wards for older people with mental health problems. These inspections took place between 16 April 2018 and 27 April 2018.

- A number of interviews and focus groups took place between 30 April 2018 and 2 May 2018. The inspection process continues during May with the well-led review taking place between 15-17 May 2018.

Never Event Thematic Review

A team of inspectors went to Hopewood Park on the 23 April 2018 as part of a national thematic review of never events and visited the following services – Beckfield, Aldervale, Bridgewell, Longview and the IRS team. The review continues in the form of interviews with members of the senior management team and these have been arranged for the 14 May 2018.

Focussed Inspections

Publication of the reports following a focussed inspection visit to two core services (acute wards for adults of working age/psychiatric intensive care units and long stay rehabilitation mental health wards for working age adults) in May 2017 are awaited. The delay in publication relates to an ongoing investigation.

Registration notifications made in the month:

Notification to change our Statement of Purpose has been submitted to the CQC to inform them of changes to our vision, values, ambitions and hospital telephone numbers.

Mental Health Act Reviewer visits in the month:

<u>Lennox, St Nicholas Hospital – visited on 9 April 2018</u>

This was an unannounced planned visit by a Mental Health Act Reviewer. During the visit, the CQC toured the ward facilities to check they were suitable for the patient group. Three patients were interviewed in private and one patient was interviewed with staff at his request. The CQC spoke to the Ward Manager and interviewed the Clinical Lead. The CQC reviewed three patients' records and the prescription and authorisation certificates for all of the patients.

During the previous visit on 31 January 2016, three actions were identified, one of which remains partially resolved, this related to issues with the ward environment, which included areas of the ward being cold. During this visit the Mental Health Reviewer noted that the temperature of the seclusion room was recorded as 15 degrees, this appeared a low temperature.

Fellside, Queen Elizabeth Hospital - visited 11 April 2018

This was an unannounced scheduled visit by a Mental Health Act Reviewer. During the visit, the CQC toured the ward facilities. Three detained patients and two informal patients were interviewed in private. The nurse in charge was interviewed. The CQC reviewed three patient records and all medication authorisation certificates and prescription charts.

During the previous visit on 21 December 2016, five actions were identified, one of which remains partially resolved and this related to patients involvement in care planning.

Bede – visited 19 April 2018

Awaiting formal feedback from CQC.

Lindisfarne – visited 27 April 2018

Awaiting formal feedback from CQC.

Recently published CQC inspection reports to note:

Trust	Date of Inspection	Date of Report	Overall rating	Comments	Link to Report
Hertfordshire Partnership University NHS Foundation Trust	Feb 2018 4 core services visited	April 2018	Good	Under the new CQC process of inspection the trust's overall rating remains unchanged.	here
Leeds and York Partnership NHS Foundation Trust	Jan 2018 6 core services visited	April 2018	Requires improvement	Under the new CQC process of inspection the trust's overall rating remains unchanged. Their rating for the well-led key question has improved from requires improvement to good.	here
Dorset Healthcare University NHS Foundation Trust	Dec 2017 11 core services visited	April 2018	Good	Under the new CQC process of inspection the trust's overall rating	here

Trust	Date of Inspection	Date of Report	Overall rating	Comments	Link to Report
				has improved to good. Their ratings for all of the key questions have seen an improvement with the exception of safe.	

CQC Recent News Stories:

Sexual Safety on Mental Health Wards

The CQC has written to all specialist mental health NHS trusts in England to inform them of an upcoming workshop to explore what can be done to improve sexual safety on mental health wards.

The letter sent last month outlines the issues around sexual safety on mental health wards that were highlighted in their State of Care in Mental Health Services 2014-17 report. Published in August 2017, the report noted that "a substantial number of services admitted both men and women to the same wards" and that this can lead to "a heightened responsibility to ensure that patients are safe from sexual harassment and sexual violence".

Following from this, CQC worked with NHS Improvement to examine how specialist mental health NHS trusts in England are reporting patient safety incidents of a sexual nature. This included exploratory analysis of nearly 60,000 reports submitted to National Reporting and Learning System (NRLS) by trusts over a three month period, more than 900 of which were related to sexual incidents on mental health wards.

The CQC intends to publish a national briefing on this subject later in the year.

WannaCry cyber attack

The Public Accounts Committee has published a report following its inquiry into the cyber attack on the NHS, which caused widespread disruption to health services in May 2017. Although the Department of Health and Social Care and NHS bodies have learned lessons from WannaCry, the report says they have a lot of work to do to improve cyber-security for when, and not if, there is another attack. The report sets a June deadline for the Department to update on costed plans for vital security investment, and make a series of recommendations.

2. Compliance

c) Five Year Forward View for Mental Health

Children and Young People Eating Disorders	Quarter 4 UNIFY Submission	April – September 2017 England
Number of Urgent cases seen within one week	93.7%	72.1%
Number of Routine cases seen within four weeks	82.1%	80.6%

Children and Young People		
Under 18 admitted to Adult wards	NTW April 2018	Quarter 1 2017/18 England
Number of patients	0	57
Number of Bed Days	0	428

IAPT - Sunderland	NTW April 2018	April – September 2017 England
% seen within 6 weeks	99.2%	88.9%
% moving to recovery	49.8%	50.7%

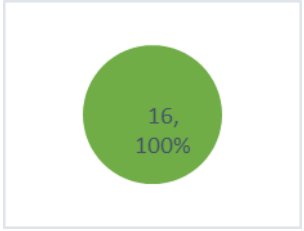
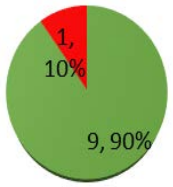
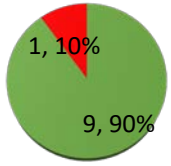
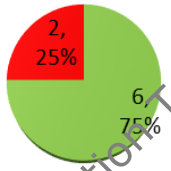
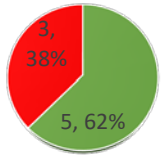
EIP	NTW April 2018	April – September 2017 England
% starting treatment within 2 weeks of referral	77.4%	75.9%

	NTW April 2018	April – September 2017 England
7 day follow up	97.9%	96.7%

Latest NHS England Five Year Forward View CCG dashboards are available here

3. Contract Update April 2018

a) Quality Assurance – achievement of quality standards April 2018

NHS England	Northumberland & North Tyneside CCGs	Newcastle / Gateshead CCG	South Tyneside CCG	Sunderland CCG	Durham, Darlington & Tees CCGs	Cumbria CCG
						
All achieved in month 1	The contract underperformed in month 1 on Crisis & Contingency (57 patients, 93.2%)	The contract underperformed in month 1 on 7 day follow up (3 patients, 92.7%)	All achieved in month 1	All achieved in month 1	The contract under performed in month 1 on Crisis & Contingency (2 patients, 94.3%) and CPA review in 12 months (2 patients, 93.3%)	The contract under performed in month 1 on Completion of Risk assessment (5 patients, 78.3%), Crisis & Contingency (2 patient, 84.6%) and CPA review in 12 months (1 patients, 90.0%)
						

3. Contract update April 2018

b) CQUIN update April 2018

CQUIN Scheme:	Annual Financial Value	Requirements	Quarterly Forecast:				
			Q1	Q2	Q3	Q4	Comments
1.Improving Staff Health and Wellbeing	£625k	To improve the support available to NHS Staff to help promote their health and wellbeing in order for them to remain healthy and well.					
		Improving the Uptake of Flu Vaccinations for Front Line Clinical Staff					
		Healthy food for NHS staff, visitors and patients					
2. Improving physical healthcare to reduce premature mortality in people with serious mental illness(PSMI)	£625k	Assessment and early interventions offered on lifestyle factors for people admitted with serious mental illness (SMI).					
3. Improving services for people with mental health needs who present to A&E	£625k	Ensuring that people presenting at A&E with mental health needs have these met more effectively through an improved, integrated service, reducing their future attendances at A&E.					
4. Transitions out of Children and Young People's Mental Health Services	£625k	To improve the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services.					
5. Preventing ill health by risky behaviours – alcohol and tobacco	£625k	To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco.					
6. Health and Justice patient Experience	£5k	NHS England has a national priority and focus on patient experience in order to improve the quality of services.					
7. Recovery Colleges for Medium and Low Secure Patients	£1.2m	The establishment of co-developed and co-delivered programmes of education and training to complement other treatment approaches in adult secure services.					
8. Discharge and Resettlement		To find initiatives to remove hold-ups in discharge when patients are clinically ready to be resettled into the community. To include implementation of CUR for MH at pilot sites					
9. CAMHS Inpatient Transitions		To improve transition or discharge for young people reaching adulthood to achieve continuity of care through systematic client-centred robust and timely multi-agency planning and co-ordination.					
10. Reducing Restrictive Practices within Adult Low & Medium Secure Services		The development, implementation and evaluation of a framework for the reduction of restrictive practices within adult secure services, to improve patient experience whilst maintaining safe services.					
Grand Total	**£3.7m**						

3. Contract update April 2018

c) Service Development and Improvement Plan – NHS England

	Milestones	Progress
Review Mental Health Secure Outreach Team against service specification called Forensic Outreach and Liaison Service	Ensure service meets the national specification Develop action plan to meet service specification with clear timescales Reach a clear understanding of the types of contacts and activity levels by professionals within the team	We are waiting for the publication of the new service specification. The services have contributed to the consultation. There has been a delay in the information being published which was originally expected late January 2018 Web-ex re the FOLS provision of the service in 3 pilot areas is arranged and NTW were involved, business case was submitted however application was not approved We will be engaged with the Wave 1 and work towards successful application for Wave 2 Service specification and achievable outcomes from FOLS specification will be reviewed against current pathway once all information is available
Gender Dysphoria Service	NTW to work with NHS England to develop a clear description of the types of contacts within the service and how they are recorded NHS England to review the service against the new specification which is out to consultation NTW will work with NHSE to complete the national reporting template when implemented	Data set complete and submission has been made in line with the requirements starting from 6th October 2017 and backdated to April 2017. Awaiting National Specification Changes to the NTW systems are now in place to support reporting. COMPLETE
Mental Health and Deaf Team	NTW to work with NHS England to develop a clear description of the types of contacts within the service and how they are recorded	We are waiting for confirmation from NHSE in relation to the continuation of the national MH and deafness dataset. Combined data in relation to NTW/TEWV to be submitted on a quarterly basis from Q1 2018/19
Peri-natal outreach	If funding is agreed nationally, implement development of peri -natal outreach service in line with agreed business case	We are waiting for confirmation from NHSE of funding

	Milestones	Progress
Peri natal service	To ensure that the service meet the new specification when published	We are waiting for the publication of the new service specification. Service leads are involved in its development.
CAMHS Tier 4 National Service Review	NTW and NHS England to work together to implement recommendations from the national service review	We are continuing to work with commissioners on the trajectories and bed configuration element as part of the new care models arrangements
Adult Secure National Service Review	NTW and NHS England to work together to implement recommendations from the national service review	We are still waiting the specific outcomes of the review with recommendations however we are already working with commissioners on the trajectories and bed configuration element as part of the new care models arrangements There has been a delay in the information being published which was expected late January 2018 NCM's joint application was successful and this was implemented on the 1st October 2018 and is in its infancy with development teams being established to create collaborative service delivery across NE & Cumbria Work has commenced to repatriate people close to home, this is part of the NCM's
Secure Outreach and Transitions Team	**If approved and agreed by NHS England** Develop Secure Outreach and Transitions Team as per agreed business case	Continued collaborative working with bed based services, TEWV and partner organisations, shared pathways are developed including partnership working with Cumbria to establish discharge pathway to repatriate patients. The case load is expanding as the team becomes established and referral process is embedded. Currently working with all bed based patients in low & medium secure service, the team has continued to discharge patients and prevent readmissions due to close working relationships with providers. The team are working with bed based services attending review meetings, establishing IDD, the reduction in bed based service & achieving 2017/18 trajectories have been supported by SOTT involvement As the discharge date is established SOTT increase their presence to actively establish discharge pathway, working with care provider, delivering training, developing care risk management plans and supporting transition post discharge.

	Milestones	Progress
		Performance criteria has been identified with a draft report being sent to commissioners in Q4 for discussion. This will be provided quarterly in 18/19 and contain both numerical and qualitative information. KLOE's have been updated and shared with LIG
Adult Medium and Low Secure services	To ensure that the services meet the new specifications when published	We are still waiting for the publication of the new service specification. The services have contributed to the consultation. There has been a delay in the information being published it was expected late January 2018 Web-ex re the FOLS provision of the service in 3 pilot areas was arranged and NTW were involved and business case was submitted but not accepted.
CAMHs Tier 4 services	To ensure that the services meet the new specifications when published	The service has worked with NHSE case managers to map the current services against the new specifications and to identify any pressure areas or gaps in provision. A separate piece of work has been undertaken to map the performance requirements contained in the new specifications against what is currently collected and what would be required to move to the new framework. This will be reviewed initially internally with support of the commissioning and quality assurance team.
Neuropsychiatry	The current service specification is in draft. NTW will work with NHSE to ensure that the service meets the specification when finalised.	The service has worked with the commissioners to agree a service specification and are currently working to it as a draft spec. This will be reviewed once the national specification is in place. The quality of care is of a high standard and meets the needs of the population.
CNDS	NTW to work with NHS England to develop a clear description of the types of contacts within the service and how they are recorded	The team has continued to work on ensuring contacts are appropriately captured in RIO for sharing with commissioners. A narrative report detailing the other elements of work delivered by the service is now being provided.

3. Contract update April 2018

d) Mental Health Currency Development Update

Mental Health Currency Development Update																	
			Q4 2017-18			Q1 2018-19			Q2 2018-19			Q3 2018-19			Q4 2018-19		
Key Metrics	Contract Standard	Internal Standard	Jan	Feb	March	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Current Service Users, in scope for CPP, who are in settled accommodation			60.1%	60.3%	60.2%	60.6%											
Current Service Users on CPA			9.4%	9.4%	9.4%	9.4%											
Current in scope patients assigned to a cluster			88.1%	88.2%	88.2%	88.7%											
Number of initial MHCT assessments that met the mandatory rules			85.6%	86.1%	84.3%	81.9%											
Number of Current Service Users within their cluster review threshold		85%	79.5%	79.3%	79.7%	81.1%											
Current Service Users with valid Ethnicity completed MHMDS only	90%	90%	93.6%	93.8%	93.8%	94.0%											
Current Service Users on CPA, in scope for CPP who have a crisis plan in place	95%	95%	91.3%	91.8%	91.6%	91.9%											
Number of CPA Reviews where review cluster performed +3/-3 days either side of CPA review within CPP spell		85%	75.0%	77.5%	74.0%	74.8%											
Number of Lead HCP Reviews where review cluster performed +3/-3 days either side of review within CPP spell		85%	57.3%	58.0%	58.6%	57.4%											
Current Service Users on CPA reviewed in the last 12 months	95%	95%	97.0%	96.5%	96.4%	97.1%											

1. Contracts
e. Commissioner Quality Assurance Visits April 2018

- NHS England visited the Neuropsychiatry Community Team based at Walkergate Park on the 5th April 2018. Overall the visit was extremely positive and it was felt valuable to be able to speak with a number of staff. Service users were offered the chance to meet the visiting team via invitations from the service but the offer was not taken up. The following actions, based upon points raised, were highlighted, which may be beneficial to the service:

  1) Work with internal Communications Team to facilitate understanding of role of service within the hospital;
  2) Explore suitable methods to raise profile outside of hospital – this may help to further prevent hospital admissions through early interventions.

4. Waiting Times

As at 30th April 2018, there were almost 6,400 people waiting for a first contact to NTW adult community services and 1,750 waiting for treatment within community CYPS. There were also 3,000 people waiting for a healthcare professional allocation.

Key points to note from April 2018:

- The number of people waiting has decreased in the month across adult services (excluding gender dysphoria, adult autism diagnosis etc), those waiting over 18 weeks in these areas has also increased during the month.
- The number of people waiting to access specialised adult services has slightly increased in the month and the proportion of these waiting more than 18 weeks for specialised adult services continues to increase.
- Waiting lists for treatment for children and young people have decreased slightly in the month across all areas, but in South Tyneside there have been increases in the number of young people waiting more than 30 weeks for treatment.

Waiting Times Summary April 2018	As at 30th April 2018:		As at 31st March 2018:	
1. Number of service users waiting to access **Adult Services ***	4850		4973	
Proportion waiting more than 18 weeks at that date:	**328**	**6.8%**	**307**	**6.2%**
Proportion waiting more than 30 weeks at that date:	**90**	**1.9%**	**72**	**1.4%**
excluding ** gender dysphoria, adult autism diagnosis, adult ADHD etc*				
2. Number of service users waiting to access **Specialised Adult services** *:	1552		1497	
Proportion waiting more than 18 weeks at that date:	**1034**	**66.6%**	**984**	**65.7%**
Proportion waiting more than 30 weeks at that date:	**705**	**45.4%**	**673**	**45.0%**
** gender dysphoria, adult autism diagnosis, adult ADHD etc*				
3. Total number of children and young people waiting for **treatment** by **community CYPS** services:				
Northumberland	216		326	
Proportion waiting more than 18 weeks at that date:	0	0.0%	43	13.2%
Proportion waiting more than 30 weeks at that date:	0	0.0%	0	0.0%
Newcastle	331		347	
Proportion waiting more than 18 weeks at that date:	40	12.1%	45	13.0%
Proportion waiting more than 30 weeks at that date:	2	0.6%	2	0.6%
Gateshead	266		291	
Proportion waiting more than 18 weeks at that date:	40	15.0%	39	13.4%
Proportion waiting more than 30 weeks at that date:	0	0.0%	0	0.0%
South Tyneside	189		194	
Proportion waiting more than 18 weeks at that date:	107	56.6%	108	55.7%
Proportion waiting more than 30 weeks at that date:	56	29.6%	52	26.8%
Sunderland	741		744	
Proportion waiting more than 18 weeks at that date:	334	45.1%	311	41.8%
Proportion waiting more than 30 weeks at that date:	101	13.6%	109	14.7%
4. Services in scope for RTT (**referral to treatment**) measurement:				
Incomplete waiters less than 18 weeks	*100% achieved*		*100% achieved*	
Incomplete waiters more than 52 weeks	*100% achieved*		*100% achieved*	
5. Number of service users with **no recorded HCP/care co-ordinator** or **record of CPA status**	3057		3172	

Gender RTT Waiting Times

The service is working towards achievement of an RTT 18 week standard and has recently commenced submission of waiting times data to NHS England, which is shown below for information. Note that the national procurement exercise is still pending.

There has been a slight decrease during April and currently there are 574 people waiting for treatment to commence, of whom 378 have not yet had a first contact.

	As at 31.10.17	**As at 30.11.17**	**As at 31.12.17**	**As at 31.01.18**	**As at 28.02.18**	**As at 31.03.18**	**As at 30.04.18**
Number of Patients waiting for first contact	360	374	374	372	356	366	378
Proportion waiting less than 18 weeks for first contact	30%	36%	28%	28%	24%	24%	25%
Proportion waiting more than 18 weeks for first contact	70%	64%	72%	72%	76%	76%	75%
Number of Patients waiting for treatment	576	590	580	577	559	576	574
Proportion waiting less than 18 weeks for treatment	15%	21%	16%	15%	12%	14%	15%
Proportion waiting more than 18 weeks for treatment	85%	79%	84%	85%	88%	86%	85%

5. Finance Update April 2018

Financial Performance Dashboard

NTW Income & Expenditure

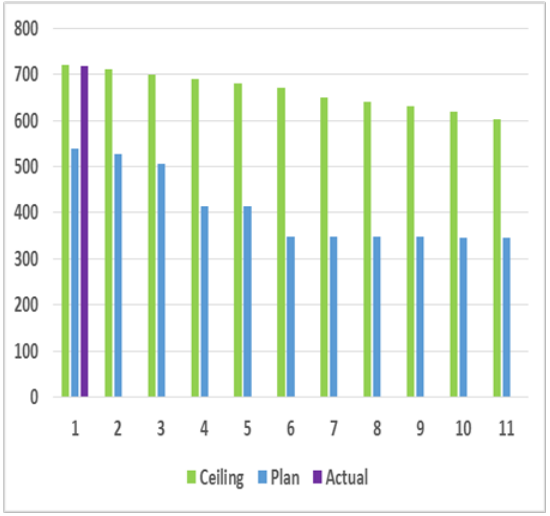
	YTD Plan £m	YTD Actual £m	YTD Variance £m
Income	25.9	25.9	0.0
Pay	(21.0)	(21.3)	0.3
Non Pay	(5.1)	(5.1)	0.0
Surplus/(Deficit)	**(0.2)**	**(0.5)**	**0.3**

Control Totals

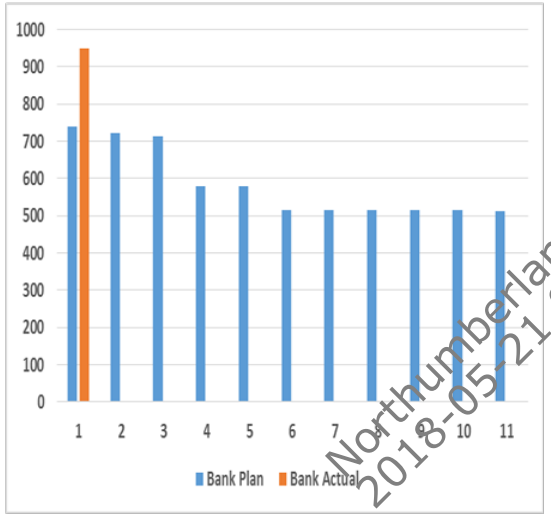
	YTD Plan £m	YTD Actual £m	YTD Variance £m
North	2.2	1.8	0.4
Central	1.9	1.8	0.1
South	2.4	2.3	0.1
Central	(6.7)	(6.4)	(0.3)
Surplus/(Deficit)	**(0.2)**	**(0.5)**	**0.3**

Key Indicators	Current	Annual Plan
Risk Rating	3	3
Agency Spend	£0.7m	£4.9m
FDP Delivery	£0.3m	£12.6m
Cash	£20.2m	£19.6m
Capital Spend	£0.3m	£13.2m

Agency Spend



Bank Spend



Key Issues/Risks

- Surplus/Deficit - £0.5m deficit at Mth1 which is £0.3m behind plan.
- Control Total – The Trust is forecasting delivery of its £3.5m Control Total.
- Risk Rating – The Use of Resources rating is a 3 at Mth1 & the forecast year-end rating is also a 3.
- Pay costs are £0.3m above plan at Mth1. Monthly pay spend needs to reduce if the Trust is to meet its control total.
- Main pressures - Autism Unit staffing and delivery of staffing reductions needed to deliver planned savings that haven't been achieved yet.
  Agency Spend – Agency ceiling is £8.0m and Trust planned spend is £4.9m in 18/19. Spend at Mth1 is £0.7m which is in line with the ceiling trajectory but £0.2m above plan.
- Financial Delivery Plan - Savings of £0.3m have been achieved at Mth1 which is £0.2m behind plan.
- Cash – £20.2m at Mth1 which is £1.8m above plan.
- Capital Spend - £0.3m at Mth1 which is £0.2m below plan.

6. Monthly Workforce Update April 2018

Workforce Dashboard

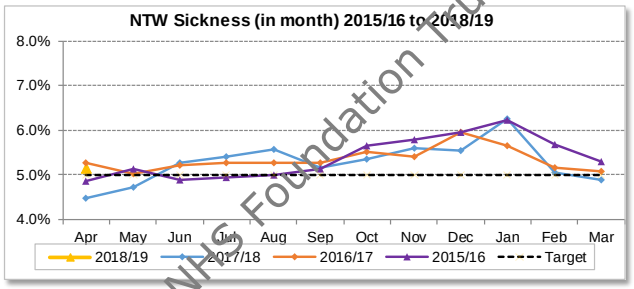
Training and Appraisals	Standard	M1 position	Overall Trend	North Locality Care Group	Central Locality Care Group	South Locality Care Group	Support & Corporate	Doctors in Training *	Staffing Solutions - Nursing	Staffing Solutions - Psychology	NTW Solutions
Fire Training	85%	89.1%	▲	90.8%	90.3%	90.1%	89.1%	38.5%	83.2%	75.0%	94.9%
Health and Safety Training	85%	93.8%	▲	95.4%	94.1%	94.8%	93.8%	43.8%	92.5%	95.8%	98.0%
Moving and Handling Training	85%	94.5%	▲	96.2%	94.0%	95.3%	94.5%	45.4%	96.8%	95.8%	98.0%
Clinical Risk Training	85%	92.1%	▲	91.5%	92.7%	93.0%			82.4%		
Clinical Supervision Training	85%	84.4%	▲	82.8%	86.0%	84.5%			80.4%		
Safeguarding Children Training	85%	92.3%	▲	93.3%	93.5%	93.6%	92.9%	43.8%	95.5%	91.7%	95.9%
Safeguarding Adults Training	85%	94.1%	▼	95.9%	95.1%	94.5%	94.1%	43.1%	95.9%	95.8%	95.7%
Equality and Diversity Introduction	85%	94.3%	▲	96.3%	94.7%	95.4%	94.3%	46.2%	92.0%	100.0%	97.7%
Hand Hygiene Training	85%	92.8%	▼	95.4%	93.3%	94.2%	92.8%	45.4%	92.0%	100.0%	89.8%
Medicines Management Training	85%	85.6%	▲	86.8%	84.9%	85.4%	85.6%		81.4%		
Rapid Tranquilisation Training	85%	78.1%	▼	82.6%	84.5%	83.1%			46.1%		
MHCT Clustering Training	85%	88.7%	▲	86.1%	86.6%	92.0%					
Mental Capacity Act/ Mental Health Act/ DOLS Combined Training	85%	76.2%	▲	76.3%	80.0%	79.8%			53.4%		
Seclusion Training (Priority Areas)	85%	92.3%	▼	92.8%	94.9%	89.6%					
Dual Diagnosis Training (80% target)	80%	86.2%	▼	93.3%	89.9%	84.7%			58.0%		
PMVA Basic Training	85%	80.1%	▼	86.5%	83.8%	81.3%			66.8%		
PMVA Breakaway Training	85%	83.2%	▲	85.8%	83.1%	81.0%					
Information Governance Training	95%	91.9%	▲	93.2%	93.2%	91.9%	91.9%	65.4%	84.1%	66.7%	98.9%
Records and Record Keeping Training	85%	98.2%	▼	99.4%	98.7%	98.5%	98.2%	75.4%	99.5%	100.0%	100.0%

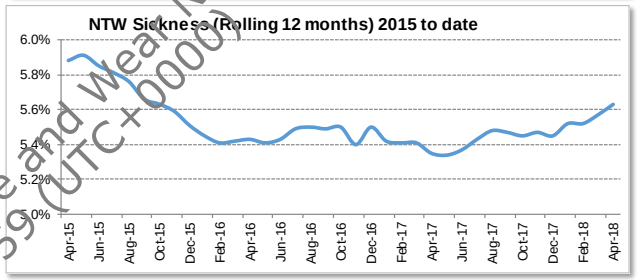
* NB Prior learning may not be reflected in these figures and is being investigated

Appraisals	85%	83.6%	▲	84.9%	84.5%	84.1%	83.6%				93.6%

Managing Attendance - includes NTW Solutions	Target	M1 position	Trend
In Month sickness	<5%	5.14%	▼
Short Term sickness (rolling)		1.53%	
Long Term sickness (rolling)		4.10%	
Average sickness (rolling)	<5%	5.63%	▼

NB - NTW Solutions Sickness absence in the month was 4.19%





Best Use of Resources	Target	M1 position	Trend
Agency Spend		£719,053	▼
Admin & Clerical Agency (included in above)		£108,603	▼
Overtime Spend		£293,283	▼
Bank Spend		£983,013	▲

Recruitment, Retention & Reward	Target	M1 position	Trend
Corporate Induction	100%	100.0%	▬
Local Induction	100%	99.2%	▼
Staff Turnover (includes NTW Solutions)	<10%	*8.61%	▲
Current Headcount		6286	

*this is a rolling 12 month figure

Behaviours and Attitudes	M1 position
Disciplinaries (new cases since 1/4/18)	20
Grievances (new cases since 1/4/18)	2

*Trainee Doctors rotate every 4-6 months and it takes approx. one month for them to complete all of the training they are required to complete. There have been issues identified relating to ESR. Time delays are incurred when receiving information from other organisations when training has been completed outside of NTW. These issues were being addressed which involved streamlining the process, part of the work involved the recent activation between ESR and Intrepid whereby an issues with Intrepid meant the data did not transfer over. The interface was due to be active in February 2018 but further issues were encountered which have since been rectified therefore the interface will be active for the rotation in August 2018 whereby the training record will move with the Doctor.

7. Quality Goals/Quality Priorities/Quality Account Update April 2018

Progress for the quarter one requirements for each of the 2018-19 quality priorities is summarised below.

All of the four priorities are currently forecast as amber against the Quarter 1 milestones.

Quality Goal:	2017-18 Quality Priority:		Quarterly Forecast Achievement:				
			Q1	Q2	Q3	Q4	Comments
Keeping you safe	1	Improving the inpatient experience					
Working with you, your carers and your family to support your journey	2	Improve waiting times for referrals to multidisciplinary teams.					
	3	Implement principles of the Triangle of Care					
Ensure the right services are in the right place at the right time to meet all your health and wellbeing needs	5	Embedding Trust values					

8. Accountability Framework

N.B reflects the revised Accountability Framework for 2017-18 which took effect from 1st April 2017

		North Locality Care Group				Central Locality Care Group				South Locality Care Group				Comments:
		Q1 forecast	Q2	Q3	Q4	Q1 forecast	Q2	Q3	Q4	Q1 forecast	Q2	Q3	Q4	
	Overall Rating	4				4				4				
Quality Governance	Performance against National Standards:	1				1				1				
	CQC Information:	2				1				1				
	Performance against Contract Quality Standards:	3				3				3				
	Clinical Quality Metrics:	3				4				4				
Use of Resources	YTD Contribution	4				4				1				
	Forecast Contribution	4				4				1				
	Agency Spend	4				1				1				

		1	2	3	4
Quality Governance	**Performance against national standards**	All Achieved or failure to meet any standard in no more than one month	Failure to meet any standard in 2 consecutive months triggered during the quarter	Failure to meet any standard in 3 or more consecutive months triggered during the quarter	Trust is assigned a segment of 3 (mandated support) or 4 (special measures)
	CQC Information	No Concerns -all core services are rated as Good or Outstanding and there are no "Must Do's" with outstanding actions.	No Concerns - all core services are rated as Good or Outstanding however there are "Must Do's" with outstanding actions.	Concerns raised – one or more core services are rated as "Requires Improvement"	Concerns raised – one or more core services are rated as "Inadequate"
	Performance against contract quality standards *(measured at individual contract level)*	All Achieved	All but a small number of contract metrics are achieved for the quarter and there is a realistic plan in place to recover the underperformance within the following quarter.	Quarterly standard breached in 2nd consecutive quarter, or there is a contract metric not achieved which is not recoverable within the following quarter.	Quarterly standard breached and contract penalties applied or are at risk of being applied.
	Clinical Quality Metrics	All Achieved	All but a small number of contract metrics are achieved for the quarter and there is a realistic plan in place to recover the underperformance within the following quarter.	Quarterly standard breached in 2nd consecutive quarter, or there is a contract metric not achieved which is not recoverable within the following quarter.	Quarterly standard breached in 3rd consecutive quarter.
Use of resources	**YTD contribution**	Exceeding or meeting plan.	Just below plan (within 1%).	Between 1% and 2% below plan	More than 2% below plan
	Forecast contribution				
	Agency Spend	Below or meeting ceiling.	Up to 25% above ceiling.	Between 25% and 50% above ceiling.	More than 50% above ceiling.
	Use of resources metrics	TBC	TBC	TBC	TBC

9. Monthly activity update (Currently in development)

10. Service User & Carer Experience Monthly Update April 2018

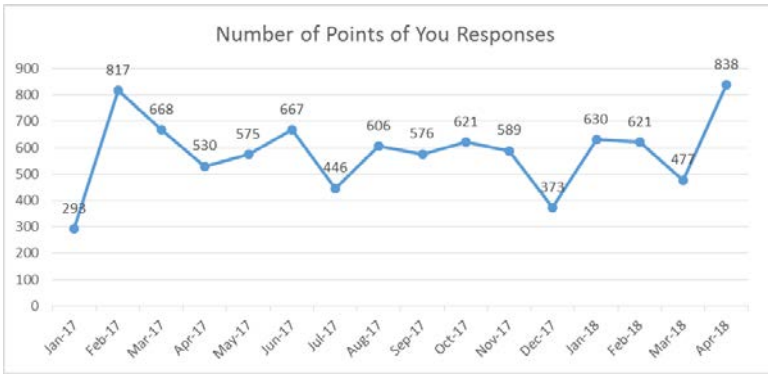
Experience Feedback:

Feedback received in the month – April 2018:

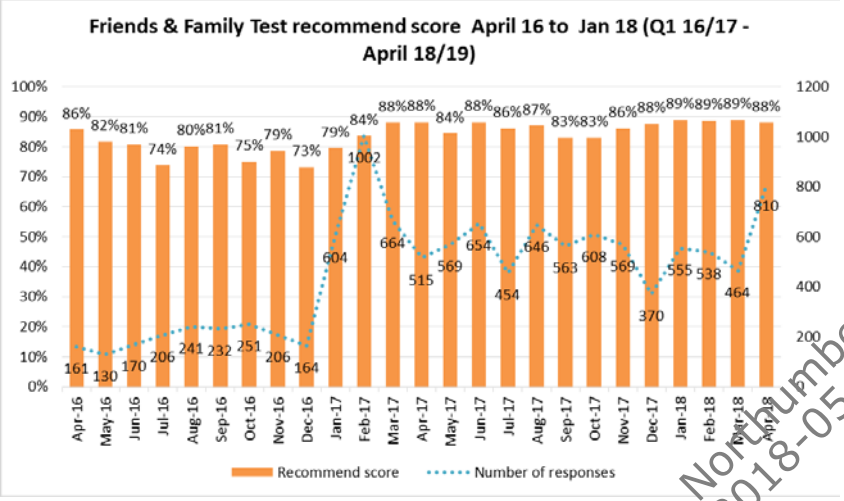
	Responses received April 2018	Results April 2018
Points of You Feedback from Service Users ('Both' option included here)	564	Overall, did we help? Scored: 8.7 out of 10* (8.7 in March)
Points of You Feedback from Carers	274	
Total Points of You responses received	838	FFT Recommend Score**: 88% (89% in March)

* score of 10 being the best, 0 being the worst
** national average recommend score resides around 89%

Graph showing Points of You responses received by month:



In April the number of Points of You responses increased compared to the previous month of March which is due to a system issue which was rectified in April. The results have decreased with 88% of respondents identifying they would recommend our services to family or friends, which is slightly below the national average of 89%.



Nb 28 of the 838 PoY responses in the month did not answer the FFT question within the survey

11. Mental Health Act Dashboard

Mental Health Act Dashboard												
Key Metrics	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
Record of Rights (Detained) Assessed within 7 days of detention start date	93.3%											
Record of Rights (Detained) Revisited in past 3 months (inpatients)	97.4%											
Record of Rights (Detained)Assessed at Section Change within the Period	92.0%											
Record of Capacity/CTT for Detained clients Part A completion within 7 days of 3 month rule Starting												
Community CTO Compliance Rights Reviewed in Past 3 months	95.7%											
Community CTO Compliance Rights Assessed at start of CTO	70.0%											

The revised local rights recording form went 'live' on the 5th June 2017. The dashboard metrics for rights have been amended to link with the structure of the new form.

The provision of 'rights' to detained and CTO patients was a Quality Priority for 2017/2018.

In April 2017 compliance with Rights assessed within 7 days of the detention start date (metric 918) – was 92%. For the month of April 2018 the dashboards show compliance as 93.3%. This equated to 98 out of105* patients (*who should have been provided with their rights) being given their rights within 7 days of the section start date.

For April 2017, compliance with rights having been revisited within a period not exceeding 3 months (metric 993) was 94.8%. For the month of April 2018 compliance was recorded on the dashboards as 97.4%. This equated to 381 out of 391* patients (*who should have been provided with a repeat of their rights) having their rights repeated within 3 months of the section start date. Compliance with the above metric has been consistently above 93 .5% since April 2017.

Compliance in relation to the provision of rights where the section the patient was detained under changed (metric 994) - in April 2017 was 87%. This metric was included within the Rights Quality Priorities for 2017/2018. For the month of April 2018 compliance was recorded as 92%. This equated to 69 out of 75* patients (*who should have been provided with their rights when the section they were detained under changed) being given their rights when there was a change of section.

Compliance in relation to the provision of rights to detained patients continues for the most part, to be good. The above rates of compliance provide assurance of this however further improvement is still needed in relation to all of the above metrics.

It has been reinforced throughout the rights awareness training that the provision of rights is a legal requirement and that we should continue to strive to ensure all detained patients receive their rights in accordance with best practice as per the MHA Code of Practice 2015.

Awareness sessions to support the introduction of the new form and the changes in practice required in relation to the provision of rights have been delivered by members of the 'MHA Local Forms and Practice Group' from June 2017 up until the end of November 2017. Registered Nurses were required to attend. The sessions have been, for the most part, well attended and feedback has been good. Some further sessions were delivered during January 2018 and some further sessions are due to be delivered in June 2018.

It is anticipated that any registered staff who have not attended an awareness session will have their session delivered via a cascade model. The development of an E learning package is almost complete and will provide an ongoing option for staff to refresh their knowledge.

In relation to CTO patients compliance with the provision of rights at the point the CTO is made (metric 988) in April 2017 was 42.9%. However significant improvement in compliance has been noted since the introduction of the revised form and associated training. For the month of November 2017 significant improvement was noted with compliance at 85.7% however compliance was lower (72.7%) in January 2018. Improvement in compliance was needed and it was therefore encouraging to note (following some additional measures having been put in place) that compliance with this metric for March 2018 was 100%. This equated to 10 out of 10* patients (*who should have been provided with their rights at the point the CTO was made) being given their rights at that time. It is disappointing to see that compliance had dropped to 70% for the month of April. This equated to 7 out of 10 patients being given their rights. This will be highlighted at the Mental Health Legislation Steering Group and at each of the three Locality Care Groups

Compliance with the provision of further explanations within a three month period (metric 985) has been consistently lower for CTO patients than the related metric for detained patients, In April 2017, compliance was 45.7%. Significant improvement in compliance has been noted since the introduction of the revised form and associated training. Compliance for the month of April 2018 is shown on the dashboards as 95.7%. This equated to 199 out of 208* patients (*who should have been provided with a repeat of their rights within 3 months of the CTO start date) being given their rights at that time.

The CTO Task and Finish Group has been merged with the Local Forms Review Group. The MHA Local Forms and Practice Group continue to monitor compliance and consider other options to improve compliance for both detained and CTO patient groups. Levels of compliance are reported at each of the CBU Quality Standards Group meetings. As the planned work in relation to rights is nearly complete ownership for ongoing monitoring of the provision of rights to detained and CTO patients will need to be transferred to these groups.

Compliance in relation to recording capacity assessments/discussions about consent to treatment (at the point of detention – metric 916) - in relation to section 58 treatment (medication for mental disorder) has been consistently under 68.3% since monitoring commenced. Work is being undertaken to align the dashboards with the revised forms so the compliance rate detailed for the month of April cannot be relied on.

Following review of the capacity/consent to treatment recording forms the revised forms went live on 08/03/18. Consideration of how to improve practice issues is also underway and the current focus of the MHA Local Forms & Practice Review Group. As with the 'The Provision of Rights' the group will strive to develop measures for improvement together with a communication strategy.

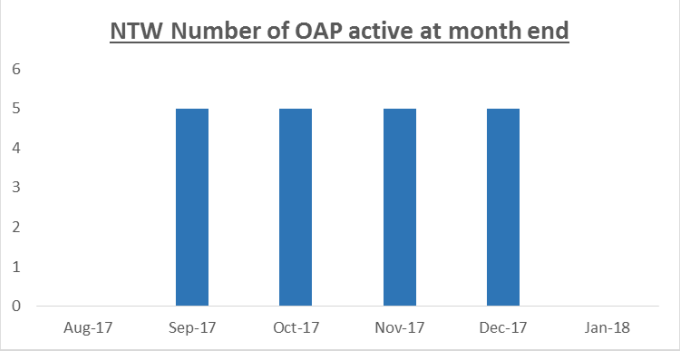
12. Outcomes/Benchmarking/National datasets Update and Other Useful Information

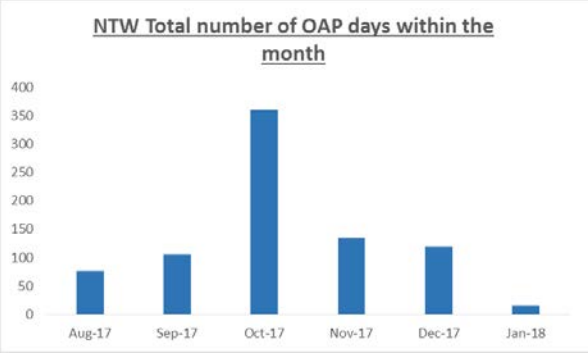
Benchmarking

The perinatal benchmarking report has been received. A separate report regarding the Eating Disorder and Learning Disability results has been submitted to CDT-Q.

Out of Area Placements (OAP)

The Government set a national ambition to eliminate inappropriate Out of Area Placements (OAPs) in mental health services for adults in acute inpatient care by 2020-21. Inappropriate OAPs are where patients are sent out of area because no bed is available for them locally which can delay their recovery. The OAP collection captures the details of all OAPs in England from both NHS and independent providers. The data is submitted on a monthly basis to NHS Digital. The graphs below represent the data relating to NTW from August 2017. The latest published data related to January 2018.





Improving Access to Psychological Therapies (IAPT)

Listed below are the Sunderland IAPT Outcome Measures for April 2018.

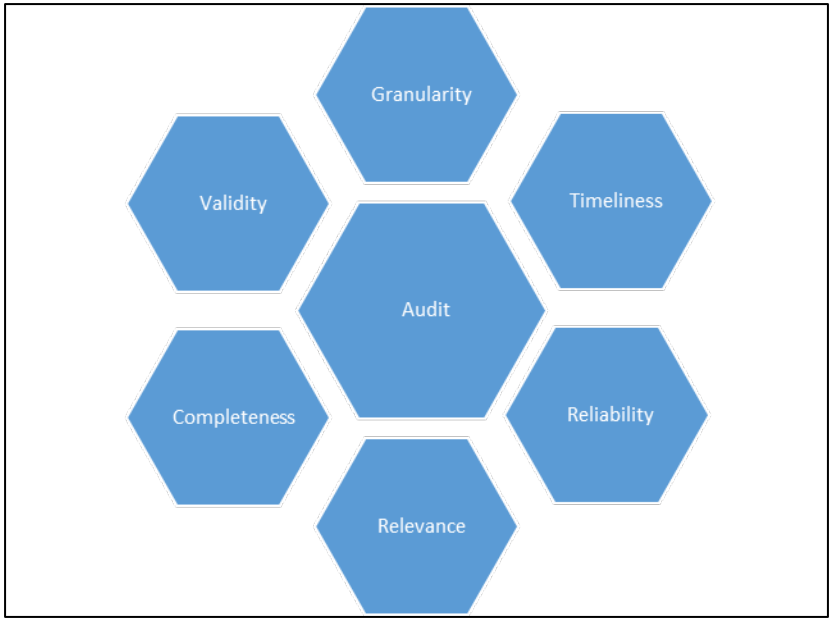
SUNDERLAND CCG PATIENTS - IAPT Only Patients - Quality Metrics in 2018-2019

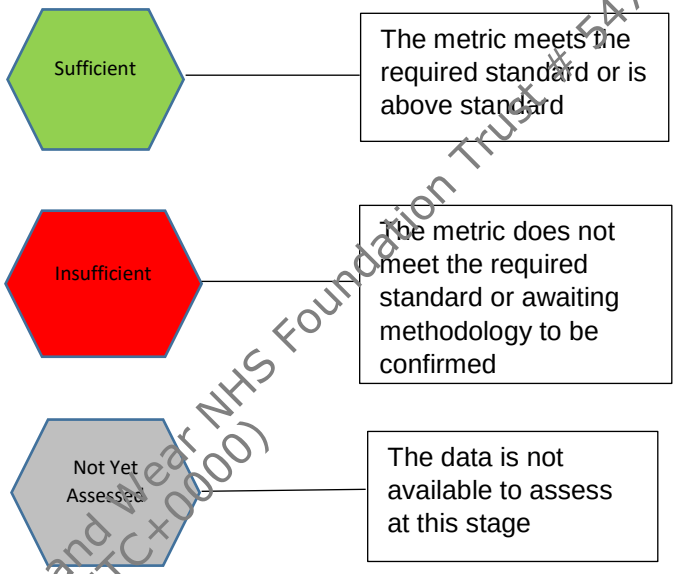
Outcome Measure	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Access - BAME (% of total service users entering treatment)	TBA	1.55%											
Access - Over 65 (% of total service users entering treatment)	TBA	6.06%											
Access - Specific Anxieties (% of total service users entering treatment)*	TBA	11.38											
Choice - % answering no	TBA	0%											
Choice - % answering partial	TBA	3.25%											
Choice - % answering yes	TBA	96.75%											
Employment Outcomes - Moved from Unemployment into Employment or Education	TBA	4											
Patient Satisfaction (Average Score)	TBA	19.70											
Recovery	50% of patients completing treatment	49.80%											
Reduced Disabilty Improved Wellbeing	TBA	35.02%											
Reliable Improvement	TBA	70.03%											
Self Referrals (% of discharges who had self referred)	TBA	74.73%											
Waiting Times	95% entering treatment within 18 weeks	99.85%											
Waiting Times	75% entering treatment within 6 weeks	99.23%											

An element of the IAPT contract payment will be linked to these outcomes from April 2018

Appendix 1 Data Quality Kite Marks

Data Quality Kite Mark Assessment





Each metric has been assessed using the seven elements listed in blue to provide assurance that the data quality meets the standard of sufficient, insufficient or Not Yet Assessed

Data Quality Kite Mark – This page provides guidance relating to how the metrics have been assessed within NHS Improvements, Single Oversight Framework and Contract Standards

Data Quality Indicator	Definition	Sufficient	Insufficient	What does it mean if the indicator is insufficient	Action if metric is insufficient
Timeliness	Is the data the most up to date and validated available within the system?	The data is the most up to date available	Data is not available for the current period due to problems with the system or process	The data is not the most up to date and decisions may be made on inaccurate data	Understand why the data was not completed within given timeframes. Report this to relevant parties as required
Granularity	Can the data be broken down to different levels e.g. Available at Trust level down to client level?	Where relevant the Trust has the ability to drill down into the data to the correct level	The Trust is unable to drill down into the data to the correct level	It is not possible to drill down to the relevant level of data to understand any issues	Work with relevant teams to ensure the data can be broken down to varying levels
Completeness	Does the data demonstrate the expected number of records for that period?	There is assurance that effective controls are in place to ensure 100% of records are included within the metrics as required and no individual records are excluded without justification	There is inadequate assurance or no assurance that effective controls are in place to ensure 100% of records are included within the metrics	Performance cannot be assured due to the level of missing data	Understand why the data was not complete and request when the data will be updated. Report this to relevant parties as required

Data Quality Indicator	Definition	Sufficient	Insufficient	What does it mean if the indicator is insufficient	Action if metric is insufficient
Validity	Is the data validated by the Trust to ensure the data is accurate and compliant with relevant rules and definitions?	The Trust have agreed procedures in place for the validation and creation of new metrics and amendments to existing metrics	A metric is added or amended to the dashboard without the correct procedures being followed	The data has not been validated therefore performance cannot be assured	The metrics are regularly reviewed and updated as appropriate
Audit	Has the data quality of the metric been audited within the last three years?	The data quality of the metric has been audited within the last three years	The metric has not been audited within the last 3 years	The system and processed have not been audited within the last three years therefore assurance cannot be guaranteed	Ensure metrics that are outside the three year audit cycle are highlighted and completed within the next year. Review the rolling programme of audit
Reliability	The process is fully documented with controls and data flows mapped	Mostly a computerised system with automated controls	Mostly a manual system with no automated controls	Process is not documented and/or for manual data production controls and validation procedures are not adequately detailed	Ensure processes are reviewed and updated accordingly and changes are communicated to appropriate parties
Relevance	The indicator is relevant to the measurement of performance against the Performance question, strategic objective, internal, contractual and regularity standards	This indictor is relevant to the measurement of performance	This indicator is no longer relevant to the measurement of performance	The metric may no longer be relevant to the measurement of standards	Ensure dashboards are reviewed regularly and metrics displayed are relevant and updated or retired if no longer relevant

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors

Meeting Date: 23 May 2018

Title and Author of Paper: Workforce Quarterly Update – Lynne Shaw, Deputy Director of Workforce and OD

E**xecutive Lead:** Lisa Crichton-Jones

Paper for Debate, Decision or Information: Information

Key Points to Note:

WORKFORCE STRATEGIC AIMS:	✓
We will develop a representative workforce which delivers excellence in patient care, is recovery focussed and champions the patient at the centre of everything we do.	✓
We will embed our values, improve levels of staff engagement, create positive staff experiences and improve involvement in local decision-making.	✓
We will lead and support staff to deliver high quality, safe care for all	✓
We will help staff to keep healthy, maximising wellbeing and prioritising absence management	✓
We will educate and equip staff with the necessary knowledge and skills to do their job	✓
We will be a progressive employer of choice with appropriate pay and reward strategies	✓

The Workforce Directorate quarterly report outlines some of the key work and developments across the Trust. The report supports the six key aims of the Workforce Strategy which was ratified by the Trust Board in summer 2015 and refreshed in March 2017.

This paper includes updates on:

1. Workforce Disability Equality Standard (WDES)
2. Workforce Race Equality Standard (WRES) - Supporting colleagues from black or minority ethnic groups to flourish within our NHS
3. Workplace Hate Crime Champions Initiative
4. Just Culture
5. Collective Leadership Programme: Joint Operational and Corporate Services Sharing and Learning Event
6. Service User and Carer Leadership Development Programme
7. "Step into Healthcare" Pledge
8. F3 Level Junior Doctors Posts
9. Sponsorship
10. Medical Visa Issues Update
11. North East Better Health at Work Award – Maintaining Excellence
12. Regional Development Programme for Workforce Staff
13. NHSI Retention Programme

In Other News:

- New Senior Team Arrangements
- Health and Care Workforce Strategy for England 2017
- Annual Increase in Tribunal Awards
- Tax Treatment of Termination Payments

Risks Highlighted: N/A

Does this affect any Board Assurance Framework/Corporate Risks? **Please state Yes or No** No

Equal Opportunities, Legal and Other Implications: Various aspects of Employment Law

Outcome Required: Information Only

Link to Policies and Strategies: Workforce Strategy

Workforce Quarterly Report

23 May 2018

Strategic Aim 1

1. Workforce Disability Equality Standard (WDES)

NHS England has published an indicative timetable for implementation of the workforce disability equality standard (WDES). The proposed standard will use data from the NHS annual staff survey and look at areas such as:

- workforce representation
- reasonable adjustments
- employment experience
- opportunities.

The WDES will be mandated via the NHS Standard Contract for 2017-19. The contract sets out that NHS Trusts and Foundation Trusts will have to implement the WDES in the first year. The indicative timetable and the reporting deadline of August 2019 are outlined below:

Date	Action
March 2018	Online Survey
March 2018	Regional Consultation Events
Autumn 2018	Publication of the WDES
Autumn/Winter 2018	NHS Trusts and Foundation Trusts review their data and reporting against the metrics
June 2019	Reporting sheet with prepopulated data sent to NHS Trusts and Foundation Trusts
August 2019	First WDES reports to be published in August 2019, based on data from the 2018/19 financial year

April/May 2020	First National WDES annual report published by NHS England

2. Workforce Race Equality Standard (WRES) - Supporting colleagues from black or minority ethnic groups to flourish within our NHS

On 24 April 2018 Lisa Crichton-Jones represented the Trust in a Roundtable event (Chaired by Jim Mackey, Chief Executive of Northumbria Healthcare NHS Foundation Trust) to discuss the Workforce Race Equality Standard (WRES). As part of the session the group heard about the low percentage of BME staff working in senior positions in the NHS as well as higher proportions of BME staff experiencing issues after raising concerns.

In the North East, NHS organisations have agreed to work together to learn from one another on this issue and to look at solutions to ensure our BME workforce is developed and supported to progress in their careers and apply for roles at higher levels. We will be linked into this regional work and will work closely with the internal BME network to take this important agenda forward.

3. Workplace Hate Crime Champions Initiative

A workshop was held at St James' Park on 26 April 2018 where the above initiative was launched. Work place hate crime champions will play a vital and dynamic role in raising awareness of hate crime and providing support and information for colleagues across organisations. Chris Rowlands (Equality and Diversity Lead) attended on behalf of the Trust. Learning from this initiative will be considered for inclusion in Trust policies.

Hate Crime Champions will:

- act as the main point of contact within organisations for colleagues who may want to discuss a hate crime or obtain advice.
- receive regular updates of what is being done to tackle hate crime in the region.
- share key information regarding hate crime with training departments to ensure the information used in training is relevant and up-to-date.
- be able to signpost colleagues to advice and support services.
- ensure that hate crime information (posters and leaflets) are displayed and available within organisations.

Northumbria Police will provide bespoke training for organisations that wish to register for this. The Equality and Diversity Lead has linked into the lead at Northumbria Police and is currently exploring how to roll this out within the Trust.

Strategic Aim 2

4. Just Culture

We have been observing the work at MerseyCare Trust on Just Culture and are starting to explore this in more detail. As part of a just culture managers are encouraged to treat staff involved in a patient safety incident in a consistent, constructive and fair way.

This supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated.

We are just starting our thinking about 'just culture', but colleagues may wish to watch the 25 minute video 'Just Culture – the movie' or read the NHSI Guide. We have agreed this work should be one of our priorities within the workforce strategy 2018 / 2019 delivery plan.

https://www.youtube.com/watch?v=bu9yhdOegm8

https://improvement.nhs.uk/resources/just-culture-guide/

We are hoping to hold an Exec to Exec meeting soon to explore sharing of work in a number of areas.

5. Collective Leadership Programme: Joint Operational and Corporate Services Sharing and Learning Event

A joint event took place on 10 May 2018. A key focus of this programme has been to support our continuous leadership development, to build the confidence and skills to lead collectively; to embed a culture of quality improvement; to secure a truly engaged and empowered workforce; and to enable more devolved decision making as close to our service users as is practical.

The joint sharing and learning event gave participants of both the operational and corporate programmes the opportunity to take stock on where we are at and how far the programme has helped the participants to continue to build on the many strengths NTW enjoys. The event was attended by 120 leaders. We spent some time exploring our collective understanding around responsibilities: "your job, my job, our job, "and learnt a great deal about where our leaders feel we are at the moment, developing a good collective understanding about the Trust's priorities. This event helped us to articulate a shared acknowledgement that we are all pointing in the same direction and hopefully will enhance the way we work together, collaboratively. The event was also attended by our Directors.

6. Service User and Carer Leadership Development Programme

We have recently facilitated a very successful four day leadership development programme for over 40 service users and carers, funded as part of the NHS Leadership Academy 'In Place' leadership innovation fund.

Emma Wakefield, one of our Peer Support Workers was seconded into the Programme Co-ordinators role and within two months had planned and helped facilitate the programme, with the support of the Head of Patient and Carer Engagement and Head of Team and People Development.

The programme has evaluated extremely well and is already demonstrating benefits. Some participants have committed to attend the service user and carer reference group and to present to Trust Board, for example, and additionally, we are working with over 15 of the delegates in developing their comfort in facilitating and running this programme. We hope to run this with the support of and via our local recovery colleges. This programme has once

again demonstrated how vital it is to embrace and empower service users and carers as leaders, and to create opportunities for them to be able to meaningfully contribute to the way we design, deliver and develop our services.

Strategic Aim 3

7. 'Step into Healthcare' Pledge

The Trust has signed the 'Step into Health' Pledge. This is a programme aimed at highlighting NHS career opportunities to those that have served in the armed forces as well as their spouses and partners. Historically, barriers such as not being shortlisted for vacancies due to not having NHS experience has made it very difficult for ex armed forces personnel to gain NHS employment. This programme will allow for work place placements to overcome such barriers.

The Pledge means that we have agreed to:

- Advertise apprenticeship opportunities through the Career Transitions Partnership (CTP) and their RightJob Board.
- Nominate a point of contact within the organisation that members of the Armed Forces community can contact directly.
- Review current recruitment practices and remove any barriers to recruiting members of the armed forces community (this means reviewing whether NHS experience essential criteria can be removed plus advertise apprenticeships and appropriate jobs through CTP).
- Use Step into Health logo.

We have also joined the NHS Employers Armed Forces Network to progress both this work and work in regard to supporting Reservists.

A reservist policy is currently being developed to support this work.

8. F3 Level Junior Doctor Posts

The Trust has recently recruited into five 'F3' posts who are Junior Doctors that have left Foundation training but not yet entered the national training scheme. These posts will offer Foundation level doctors a wider experience in psychiatry and hopefully encourage them to apply for the national training scheme and/or work for the Trust longer term. These posts also help us fill the recurring gaps in the national training scheme – 11 expected gaps in August 2018. These are brand new posts that the Trust has created to help address the immediate and longer term recruitment issues in Psychiatry.

9. Sponsorship

The Trust has recently been granted a licence to sponsor International Doctors. Each year up to five suitable international psychiatry graduates, who have never worked or trained in the NHS will be selected through a rigorous assessment and offered a three year structured training program. The program objective is to enhance clinical skills and improve competencies in NHS Leadership, Medical Education, Research, Psychotherapy, Clinical Governance and Cross-cultural Psychiatry. It is expected that they will return to their home countries upon completion of the program. Eligible candidates will have a postgraduate

qualification in Psychiatry that enables them to practise in that specialty in their home country. They will also need to have a minimum of three years (full time or equivalent) in a structured training program and have passed an exit examination including clinical skill assessment and written theory.

10. Medical Visa Issues Update

There has been recent press coverage about a Trust in Manchester having a large number of visas refused for internationally recruited Junior Doctors.

International recruitment of medical staff within the Trust has focused on SAS Doctors and Consultants. Senior medical staff earn more so are allocated more 'points' in the visa system and so are more likely to be awarded the relevant paperwork. In addition the numbers we apply for are on a much smaller scale – usually about one application every 2 to 3 months, so it would be unlikely that our application(s) alone would have a large impact on the monthly allocation of visas that are available nationally.

This situation is something that the medical support team has under regular review.

Strategic Aim 4

11. North East Better Health at Work Award – Maintaining Excellence

The North East's Better Health at work Award recognises the work that employers do to promote healthy lifestyles. The region has employers at various stages of the Award; 25 at Bronze level, 15 at Silver level, 13 at Gold, 22, Continuing Excellence and 13 at Maintaining Excellence. The Trust is proud to have been awarded Maintaining Excellence level in 2017.

A celebrating event was held on 22 March 2018 at the Crowne Plaza Hotel, Newcastle and Jacqueline Tate (Workforce Projects Manager) and Julie White (Workforce Projects Officer) attended to receive the award on behalf of the Trust.

Strategic Aim 5

12. Regional Development Programme for Workforce Staff

A two day regional development programme for workforce staff took place during February and March 2018. The aim of these initial two days was to bring together the Workforce and

OD community of the North East and Cumbria's NHS Trusts through a leadership mindset development programme which builds on the collective work of the HRD network.

The aim was to commence a journey to facilitate and empower our community to take ownership and to unleash the potential and ignite the passion of our people. Thus moving from organisational and hierarchical structures to operating creatively and influentially across the local health economy in the future.

The two days evaluated well and further development sessions are being considered at the HRD network.

In addition, the region is starting to liaise with the Healthcare People Management Association (HPMA) with regards to developing a North East Branch and access to further professional development for our workforce colleagues.

Strategic Aim 6

13. NHSI Retention Programme

The Trust is participating in cohort three of the NHSI (Workforce) Retention Initiative which is designed to support Trusts in the retention of clinical staff.

Anne Moore (Group Nurse Director – Safer Care) and Emma Rushmer (Group Head of Workforce and OD) attended a 'launch' event in Birmingham at the end of April and heard about some of the good practice and ongoing case studies which previous cohorts have had success with. Over the next 90 days NHSI will work closely with us to determine some key retention actions and KPI's, with ongoing support throughout a 12 month period.

Anne Moore will be the Clinical lead, supported by Claire Vesey from the Workforce team with actions and outcomes being reported and monitored through CDTW.

In other news:

New Senior Team Arrangements

With effect from 1 June 2018, Lisa Crichton-Jones will be seconded to the post of Director of Workforce Transformation for the North East and Cumbria Integrated Care System for an 18 month period. Lynne Shaw will be acting up into the Director of Workforce post and Michelle Gill will assume the post of Acting Deputy Director of Workforce.

Health and Care Workforce Strategy for England 2017

The consultation for the 'Facing the facts, shaping the future: a draft health and care workforce strategy for England to 2027' closed on 23 March 2018. The Trust fed in comments during the consultation period via the regional HRD network, NHS Employers, Northern LETB and HEE regional event. The final strategy is expected to be launched in July in line with the NHS70 celebrations.

Annual Increase in Tribunal Awards

The Employment Rights (Increase of Limits) Order 2018 came into effect from 6 April 2018. It contains the normal annual increases to maximum and minimum tribunal awards.

Key increases are:-

- maximum week's pay (for redundancy payments and the unfair dismissal basic award): £508 (currently £489)

- maximum compensatory award for unfair dismissal: £83,682 (currently £80,541).

Tax Treatment of Termination Payments

HMRC has introduced new rules for the taxation of termination payments. The changes came into force on 6 April 2018 and applies to terminations taking place on or after that date. Despite the changes being introduced as a means of simplifying the previous regime, the new rules are complex and further guidance from HMRC is expected.

The three key changes to be aware of:

1) Payment in Lieu of Notice (PILON)

All PILONs, irrespective of whether there is a PILON clause in the employment contract, will be treated as earnings and will be subject to deductions for income tax and employer and employee national insurance contributions (NICs). The current distinction between the treatment of contractual PILONS (which were treated as fully taxable), and non-contractual PILONs (which were capable of benefitting from the £30,000 tax exemption and were free of employer NICs), will no longer exist.

2) Termination awards and post-employment notice pay

A termination award is defined as a payment or other benefit received directly or indirectly in connection with the termination of employment. It does not include a statutory redundancy payment. Although contractual redundancy payments are not expressly excluded from the definition, HMRC has confirmed that they will also not be treated as part of the termination award.

Where an employee receives a termination award, the employer will need to calculate how much of the payment is “post-employment notice pay” (PENP).

3) Injury to feelings

From April 2018, payments relating to injury to feelings will be subject to tax, unless they relate to a psychiatric injury or other recognised medical condition. Where an injury to feelings award is made as part of a discrimination claim not related to termination, the payment will still be able to be made tax-free.

Lynne Shaw

Deputy Director of Workforce and OD

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors

Meeting Date: 23 May 2018

Title and Author of Paper: Whistleblowing/Raising Concerns Update – Lynne Shaw, Deputy Director of Workforce and OD

Executive Lead: Lisa Crichton-Jones

Paper for Debate, Decision or Information: Information

Key Points to Note:

The paper outlines the whistleblowing/concerns raised and logged by the central Workforce team between October 2017 and March 2018.

- 5 cases reported
- 2 categorised as whistleblowing
- 3 categorised as a concern

In addition, a further 16 cases have been raised with the Freedom to Speak Up Guardian during the same period.

The overall figure for the 6 months ending 31 March 2018 has increased slightly since the previous report where a total of 11 cases were reported centrally and a further 8 reported to the Freedom to Speak Up Guardian. This reporting period has seen the highest number of issues raised with the FTSU Guardian since the post was introduced in December 2015.

Risks Highlighted to Board:
No current risks highlighted.

Does this affect any Board Assurance Framework/Corporate Risks?
Please state Yes or No NO
If Yes please outline

Equal Opportunities, Legal and Other Implications:

Various employment legislation.

Outcome Required: Information

Link to Policies and Strategies:
Trust strategy, strategic ambition six – 'A Great Place to Work'
Workforce strategy
Raising Concerns policy

Whistleblowing/Raising Concerns Update

23 May 2018

Purpose

The purpose of this paper is to provide the Board of Directors with a summary of whistleblowing cases/concerns raised over the period October 2017 – March 2018.

Background

The paper aims to give an overview of cases reported centrally to the Workforce team as requested by the Trust's Raising Concerns Policy. Concerns raised with the Freedom to Speak Up Guardian are also included. Additional concerns are raised and dealt with at an informal, local level by operational managers.

Not all matters raised become subject to formal investigation under Raising Concerns or Grievance policies, an approach which was welcomed by Sir Robert Francis in his Freedom to Speak up Review.

It should be noted that the Trust has had for a number of years a clear, defined process for recording cases that fall under the scope of a policy such as whistleblowing (raising concerns), disciplinary or grievance, however, there are a number of concerns raised which do not meet the Disclosure Act's definition of whistleblowing. For these cases the workforce directorate has developed a separate recording category called "raising concerns" for reporting purposes.

Concerns Raised

This report serves to provide information on all concerns raised between October 2017 and March 2018. The concerns have emerged from different routes. It is anticipated that a greater number of concerns will continue to have been raised over the same period of time but have not been of a significant nature and therefore dealt with locally at ward/department level. This is to be encouraged but also balanced against a wider desire to understand better any themes or trends.

Between the period identified 21 issues have been raised in total centrally and with the FTSU Guardian and these have been categorised either as "whistleblowing" or "concerns" (2 and 19 respectively).

There are 10 cases still on-going which are those being overseen by the FTSU Guardian. A review of all cases logged has been undertaken and there appears that there are no trends in terms of reported concerns in specific locality/corporate area or staff group.

Of the cases raised centrally, 4 of the 5 were anonymous in nature.

Internal Audit Findings

Last year's internal audit highlighted a **good** level of assurance that the risks identified are managed effectively. A high level of compliance with the control framework was found to be taking place. All of the minor areas of remedial action have now been addressed by the Deputy Director of Workforce and OD and the Freedom to Speak Up Guardian.

Lynne Shaw
Deputy Director Workforce and OD

Appendix 1

Summary of Concerns Raised Centrally 1 October 2017 – 31 March 2018

Status	Date Submitted	Incident Summary	Type	Group/ Corporate Service Directorate	Outcome
Completed	12 October 2017	Inappropriate behaviour by a CCM	Raising Concern	North Locality	Investigation completed and no evidence to substantiate the allegations.
Completed	13 October 2017	Patient Safety	Whistleblowing	South Locality	Investigation completed by the Associate Director. Findings resulted in various actions being taken including staff moves and additional supervision.
Completed	20 October 2017	Discrimination in the recruitment process	Raising Concerns	Central Locality	Investigated by the HR Advisory Service. No further action.
Completed	24 January 2018	Cultural ward issues	Raising Concerns	Central Locality	Investigation completed. Action plan was developed including staff moves.
Completed	15 March 2018	Various Concerns	Whistleblowing	Central Locality	Investigated completed. Concerns were not substantiated. No further action.

Freedom to Speak Up Cases 1 October 2017 – 31 March 2018

Status	Date Submitted	Incident Summary	Type	Group/ Corporate Service Directorate	Outcome
Case closed; learning under review	04/10/17	Policies, procedures and processes: the new organisational structure is leading to corporate services staff being made to feel that they are not fully part of operations.	Raising a Concern	Corporate	Discussion with the Head of Team and People Development and the Director of Workforce and Organisational Development. Learning points agreed.
On-going	11/10/17	Attitudes and behaviours: bullying of a member of our staff by a doctor from another Trust in a partnership situation	Raising a Concern	External to our Trust	Discussion with FTSU Guardian from other Trust.
Closed	11/10/17	Policies, procedures and processes: use of WhatsApp to facilitate the finding of a second doctor to give a second signature led to a data breach by a consultant.	Raising a Concern	Trust-wide	Discussion with Trust Caldicott Guardian and Deputy Medical Director. Resolved locally.
Closed	12/10/17	Attitudes and behaviours: bullying culture of management style in a particular team	Raising a Concern	Community Services	These cases were determined to be linked - though they were responded to separately. Investigated locally and no further action taken.
Closed	16/10/17	Attitudes and behaviours: bullying culture of management style in a particular team	Raising a Concern	Community Services	
Closed	17/11/17	Quality and safety: patients were observed returning from a trip to a local shop with a	Raising a Concern	South Locality	Investigation conducted. CCTV was reviewed and it was concluded that allegation was not substantiated. No further action.

		member of staff, having purchased alcohol			
On-going	05/12/17	Attitudes and behaviours: staff blocking visitors in car park	Raising a Concern	Community Services	Investigation completed. Awaiting feedback.
On-going	17/01/18	Quality and safety: insufficient staffing levels at night	Raising a Concern	South Locality	Investigation completed. Awaiting final report.
On-going	07/02/18	Attitudes and behaviours: inappropriate behaviour by a manager following a training session	Raising a Concern	Trust-wide	Discussion with Manager. Investigation completed. No formal action.
On-going	13/02/18	Attitudes and behaviours of a senior member of staff	Raising a Concern	Unknown	On hold at request of individual concerned.
On-going	07/03/18	Attitudes and behaviours of a senior member of staff	Raising a Concern	Unknown	Meeting cancelled by individual following advice received. Awaiting further contact.
Case closed; learning under review	21/03/18	Patient experience: members of staff are filling in menu requests without speaking to patients first.	Raising a Concern	Central Locality	Discussion with Head of Catering. Investigated locally – retraining to be given.
On-going	22/03/18	Attitudes and behaviours: concern over sickness management	Raising a Concern	South Locality	Discussion with Workforce and OD Manager. To be resolved locally.
On-going	22/03/18	Attitudes and behaviours: a doctor publicly rebuked a nurse	Raising a Concern	South Locality	Discussion with Manager. To be addressed informally.
On-going	24/03/18	Attitudes and behaviours: staff are parking their own and Trust vehicles in the disabled car parking bays at nights and weekends	Raising a Concern	South Locality	Raised with Facilities Manager. Reminder to be circulated.
On-going	26/03/18	Attitudes and behaviours: management style	Raising a Concern	Corporate services	Investigation ongoing.

Northumberland, Tyne and Wear NHS Foundation Trust

Trust Board

Meeting Date: 23 May 2018

Title and Author of Paper:
CEDAR Programme Proposals
Mark Knowles, Programme Director

Executive Lead: James Duncan

Paper for Debate, Decision or Information:
Information, debate and approval

Key Points to Note:
- Long term ambitions
- Enabler plans
- Access to STP capital funding
- Proposed timescales

Risks Highlighted:
- Access to capital funding for schemes if not funded via STP allocation

Does this affect any Board Assurance Framework/Corporate Risks:
Please state Yes or No
If Yes please outline

Equal Opportunities, Legal and Other Implications:
Staff consultation process relating to ward moves

Outcome Required / Recommendations: For information and support from Board members to continue with plans as outlined.

Link to Policies and Strategies:
CEDAR Programme Initiation Document, NTW Capital Programme, NTW FDP, STP Capital allocation process

Northumberland, Tyne and Wear NHS Foundation Trust

CEDAR

Long Term Ambitions
&
Stage 1 Enabler Proposals

May 2018

Document Control

Purpose of this document

The purpose of this document is to present proposals for Stage 1 actions developed by the CEDAR Programme Board.

Version Control

Date	Version	Status	Author	Update Comments
19.3.18	Draft 1	Draft	Mark Knowles	
30.4.18	Draft 2	Draft	Mark Knowles	Adjusted following agreements at April 2018 CEDAR Board
16.5.18	Draft 3	Final	Mark Knowles	Adjusted following further developments.

Document Approval

Date of Approval **17.5.18**	Date of Submission **17.5.18**

1. Introduction

Within the development of the Trust Strategy a number of “major development” schemes were identified as key priorities to take the organisation forward and ensure the delivery of high quality sustainable services for the long term. Three of these major developments required significant capital investment, and are intrinsically linked to our emerging site strategy. Whatever is agreed with regards to any one of the schemes will inevitably have consequences for the others as well as the wider capital programme.

All three major development capital schemes are linked to much wider care model developments and national reviews. The newly formed Locality Care Groups will be developing these care models along with relevant partners and stakeholders as follows:

- New Care Models for Adult Secure Services – (Central)
- NHS England National Adolescent MSU review – (North)
- Newcastle & Gateshead Delivering Together – (Central)

All of these schemes will influence commissioning intentions with regards to the inpatient bed footprint across the organisation and it is important that any needs analysis relating to bed provision continues to be developed by the locality sponsors in conjunction with these wider programmes of work.

In November 2017 The Trust Board gave approval for the establishment of the Care Environment Development & Re-provision (CEDAR) Programme Board which will direct, oversee and monitor progress against the 3 NTW “major development” capital schemes as well as a number of other similar schemes and developments.

The CEDAR Programme Board meets monthly and the inaugural meeting took place on Thursday 21st December 2017. Reporting directly to the Trust Board via quarterly updates along with recommendations regarding the distribution of capital funds and resources for the schemes within scope.

An outline programme timeline has been agreed which will form the basis of the programme plan. This describes the programme duration over a 5 year period starting from June 2017 and ending in November 2022 with the expectation that business cases relating to all of the long term ambitions will be submitted to the Trust Board for approval in the summer of 2018. It is understood that whilst these timescales are extremely challenging it is important to maintain a degree of pace in line with key milestones and the STP capital bidding processes.

The CEDAR Programme Board have now established an understanding of the long term strategic thinking relating to the services within the scope of the programme and this has formed the basis upon which the long term ambitions and enabler proposals have been developed.

2. Long Term Ambitions

Secure Services
Following due consideration of information gathered and options presented by operational leads the general consensus of the central operational group and the CEDAR Programme Board membership is that the longer term plans for secure services should revolve around the development of an integrated single site, most likely at Northgate Hospital in Northumberland. In this single site model concept it is envisaged that the Northgate site would accommodate all of NTW's adult locked rehabilitation services, low secure services, adult medium secure services, and adolescent medium secure services along with a small number of other specialist inpatient services.

It is believed that this development would make efficient use of current secure service estate on that site as well as provide opportunities to consider economies of scale with regards to capital requirements, expert workforce and support services. It is assumed that this approach would also provide essential flexibility with regards to the anticipated and fluctuating demands for secure learning disability and mental health beds across the age ranges. Most importantly it is envisaged that such a development would deliver environments and therapeutic surroundings that are more conducive to the delivery of high quality and safe medium / long term secure care.

Achieving the aim of a single integrated site would involve the transfer of mental health medium and low secure services currently situated at the Bamburgh Clinic, Alnwood and Bede Ward from the St Nicholas Hospital site up to the Northgate hospital site. Vacating wards on the St Nicholas hospital site would then free up the necessary facilities to accommodate adult acute admission wards serving the Newcastle & Gateshead locality.

Transferring secure wards from the St Nicholas Hospital site to the Northgate site would be a highly complex, large scale scheme that could take anything up to four years to achieve.

Newcastle & Gateshead Adult Acute Services
With regards to the current adult inpatient facilities there is a general consensus across all stakeholders and providers that the existing rented estate at the Tranwell Unit and the Hadrian Clinic is no longer fit for purpose and that the environmental issues and risks associated with these buildings are rapidly becoming insurmountable.

Based upon the outcomes of the "Delivering Together" consultation and feedback from the central operational teams, the central operational group and the CEDAR Programme Board membership believe that the most appropriate long term option for adult acute admission services is to re-provide services from the Tranwell Unit in Gateshead and the Hadrian Clinic in Newcastle onto the St Nicholas Hospital site utilising the footprint of the Bamburgh Clinic and Bede Ward facilities. It is believed that these two facilities could be upgraded and developed in order to provide good quality, safe acute admission ward environments that match those provided within other localities of the trust.

Newcastle Older People's Services
With regards to the current Newcastle older people's functional and organic inpatient facilities there is a general consensus across all stakeholders and providers that the existing estate is no longer fit for purpose and that the environmental issues and risks associated with the rented buildings are rapidly becoming insurmountable.

Based upon the outcomes of the "Delivering Together" consultation and feedback from the central operational teams, the central operational group and the CEDAR Programme Board membership support the long term ambition of a locally situated, purpose built Older People's Inpatient facility. This would involve the transfer of services currently provided from wards at the Centre for Age and Vitality (CAV) into new purpose built assessment and treatment facilities.

A number of options for longer term provision are under consideration but the Trust is currently exploring linking this scheme with the development of an intermediate care hub, which is being jointly proposed by Newcastle Hospitals NHS Foundation Trust, Newcastle Council, and Newcastle Gateshead CCG. This would see the development of an integrated care and support facility for older people on the CAV site. The Trust is now working alongside partners in developing the outline strategic case for this proposal with the view to planning a new build which would entail NTW assessment & treatment wards being co-located alongside other provider services.

It is believed that this development would provide opportunities to consider economies of scale with regards to capital requirements, expert workforce and support services. It is assumed that this approach would also provide essential flexibility with regards to the anticipated and fluctuating demands for older people's mental health inpatient beds. It would enable the development of an integrated approach across mental, physical and social care to address the needs of older people across Newcastle, in line with the Trust strategic aims and the aims of the developing Integrated Care System. Finally, it is envisaged that such a development would deliver environments that are more conducive to the delivery of high quality and safe care which equate to similar specialist facilities within the trust's portfolio.

.
Adolescent Medium Secure Services
It is the view of the north operational group and the CEDAR Programme Board membership that the long term ambition for a new purpose built facility would be incorporated into the thinking of the single integrated secure site at Northgate hospital.

It is envisaged that co-locating adolescent MSU services alongside other national secure services would make efficient use of current secure service estate on that site as well as provide opportunities to consider economies of scale with regards to capital requirements, expert workforce and support services. It is assumed that this approach would also provide essential flexibility with regards to the anticipated and fluctuating demands for adolescent secure learning disability and mental health beds. Most importantly it is envisaged that such a development would deliver environments and therapeutic surroundings that are more conducive to the delivery of high quality and safe medium / long term secure care.

Funding
In order to take forward these longer term ambitions the Trust has submitted an outline proposal for capital funding through the Integrated Care System process, which will allocate limited funding that is available nationally. The proposal is for a £57m scheme delivering all of the needs identified above, apart from Older People's in-patient services for Newcastle, partly funded through a £10m land sale on the Northgate site. This proposal has got through the first stage of shortlisting and a final submission is required by June 13th. If successful in being shortlisted at an ICS level a strategic outline case will be submitted for assessment at a national level in July 2018, with final approval expected around November 2018. At the same time Newcastle Hospitals is leading on the development of the business case for the integrated care facility for older people in Newcastle, working alongside partners including the Trust. A range of options are being considered for funding this development.

The Trust will also look to identify alternative options for funding, although it is likely that none will represent the same value for money as the ICS funding route. It is likely that they will also require a longer timescale to complete, impacting on the outline timescales described below; however, this development is seen as critical to the long term future of the Trust and therefore a range of options and opportunities will be considered

3. Stage 1 Enabler Plan Proposals

Due to the overall complexity of the programme and the interdependence of the schemes there is a need to develop interim enabler plans. This will involve shorter term actions that are deemed necessary to mitigate immediate risks and support the achievement of long term ambitions.

The majority of the interim enabler plans focus upon the urgent need to mitigate identified patient safety risks associated with sub-standard environments in the Newcastle & Gateshead inpatient services at the Tranwell Unit, Hadrian Clinic and Centre for Age & Vitality (CAV).

The need for environmental improvement within these areas is such that it would not be feasible to do nothing or to wait until the longer term ambitions have been realised therefore a (Stage 1 Plan) is proposed as follows:

a) Relocation of services from Bede Ward SNH to appropriate accommodation on the Northgate site as the first stage of the single integrated secure site development

b) Undertake refurbishment of Bede Ward in line with the requirements for an adult acute admission ward

c) Transfer Collingwood ward from the Hadrian Clinic into Bede Ward at St Nicholas Hospital in line with long term re-provision plan

d) Commence improvement scheme of works at the Hadrian Clinic with Lowry Ward remaining in situ

e) Relocate Fellside and Lamesley adult acute admission wards from the Tranwell Unit, Gateshead over to refurbished facilities in the Hadrian Clinic

f) Review interim options for Older People's Wards currently located on the Centre for Aging and Vitality, given concerns about the quality of the environment. Options include remaining in the current wards, re-location of services temporarily on the CAV site, and utilisation of spare capacity on the St George's Park site.

4. Time Line Summary

This is based on current knowledge and estimates therefore potentially subject to change:

May 2018

- Outline strategic plans and proposed actions to be submitted to Trust Board for information and comment

June 2018

- Outline business cases to be submitted to Trust Board for final approval for interim schemes.

- Outline business case to be submitted to Trust Board for long term development of Integrated Secure Service Site and Delivering Together. Submission of proposal to be assessed through ICS capital bidding process

- Outline Business case to be submitted to Trust Board for co-location of Older People Mental Health Assessment and Treatment wards with Intermediate Care Hub for Newcastle

July 2018

- Commence any necessary staff consultations with affected services
- Shortlisting by ICS of bids to put forward to national process
- If required commence process for identifying alternative sources of funding

August 2018

- Commence Hadrian refurbishment Programme

September 2018

- Transfer Bede Ward from SNH to Northgate

October 2018

- Transfer Collingwood Ward from Hadrian to Bede Ward at SNH

November 2018

- Expected Timeline for approval of ICS capital bids through national process
- Development of final business case for long term development of Integrated Secure Service Site and Adult Delivering Together
- Commence capital planning for transfer of secure services from Bamburgh to Northgate
- Development of final business case for co-location proposal for Newcastle Older People's service
- Commence capital planning for development

February 2019

- Transfer Gateshead adult services from Tranwell Unit to Hadrian Clinic – **Vacate Tranwell**

Spring / Summer 2019

- Commencement on site for long term development projects

November 2021

- Transfer services from Bamburgh to Northgate Hospital
- Completion of Integrated Care Provision for Older People in Newcastle

November 2022

- Transfer services from Hadrian Clinic to Bamburgh – **Vacate Hadrian Clinic**

Recommendation

The Board are asked to consider the proposals included within the paper, and note the expected timelines for progress over the coming months based upon current knowledge and expectations.

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 23 May 2018

Title and Author of Paper: NTW Quality Account 2017-18 Anna Foster, Deputy Director of Commissioning and Quality Assurance

Executive Lead: Lisa Quinn, Executive Director of Commissioning & Quality Assurance

Paper for Debate, Decision or Information: Decision

Key Points to Note: • To approve the content of the Quality Account 2017-18 • To approve the Statement of Directors' Responsibilities (see Appendix 3 (page 91) of the Quality Account document) • The latest version of the document was considered by Audit Committee on 16th May 2018

Risks Highlighted to Board : none

Does this affect any Board Assurance Framework/Corporate Risks? Please state Yes or **No** If Yes please outline

Equal Opportunities, Legal and Other Implications: None

Outcome Required: The Board of Directors is requested to approve: o the content of the Quality Account 2017-18, o the Statement of Directors' responsibilities

Link to Policies and Strategies: N/A

Northumberland, Tyne and Wear NHS Foundation Trust

BOARD OF DIRECTORS MEETING

23 May 2018

Quality Account 2017-18

PURPOSE

The purpose of this paper is:

- to present the Board of Directors with the Quality Account 2017-18 (to be known as "Quality Report" within the Annual Report),
- to present the Statement of Directors' Responsibilities in respect of the content of the 2017-18 Quality Report for inclusion in the published 2017-18 Quality Report within the annual report, and
- to present the Statement of Directors' Responsibilities in respect of the 2017-18 performance indicators included in the Quality Report to provide to auditors.

BACKGROUND

The 2017-18 Northumberland, Tyne & Wear NHS Foundation Trust Quality Account will be submitted to NHS Improvement by midday on Thursday 31st May 2018 and uploaded to the NHS Choices website by 30th June 2018 in line with national requirements.

The 2018-19 Quality Priorities were approved by the Trust Board in March 2018 and are included within the Quality Account.

The working drafts of the Quality Account have been shared widely both internally (with the Corporate Decisions Team Quality Sub Group, the Audit Committee, the Trust Quality & Performance Committee and the Council of Governors) and externally (with CCG's, NHS England, Health Overview & Scrutiny Committees, Local Healthwatch and external audit).

Comments received from local partners will be included in the published Quality Account.

EXTERNAL ASSURANCE

The content of the Quality Account has been audited to ensure it complies with legislation and NHS Improvement requirements, additionally 3 performance indicators have also been audited to assess the accuracy of the systems and processes used to report performance information.

A limited assurance audit report is to be presented to the Audit Committee on 16th May 2018.

STATEMENTS OF DIRECTORS' RESPONSIBILITIES

A statement of directors' responsibilities in relation to the Quality Account/Report is required:

- in respect of the content of the 2017-18 Quality Report for inclusion in the published 2017-18 Quality Report within the annual report
- in respect of the 2017-18 performance indicators included in the Quality Report to be provided to auditors (but not included within the annual report)

This statement (to cover **both** of the above requirements) is included at Appendix 3 (page 91) of the Quality Account document.

In considering the draft statement the Board of Directors are asked to refer to the Integrated Commissioning and Quality Assurance Report, Annual Governance Statement and Annual Plan information.

The Board of Directors are asked to approve this statement.

RECOMMENDATIONS

The Board of Directors are asked to:

1. Approve the 2017-18 Quality Account
2. Approve the Statement of Directors' Responsibilities:
    a. in respect of the content of the 2017-18 Quality Report
    b. in respect of the 2017-18 performance indicators included in the Quality Report.

Anna Foster
Deputy Director of Commissioning & Quality Assurance
May 2018

Northumberland, Tyne and Wear NHS Foundation Trust

Quality Account

v2.6 16/05/2018

Northumberland, Tyne and Wear NHS Foundation Trust

2017/18

Caring | Discovering | Growing | **Together**

Northumberland, Tyne and Wear NHS Foundation Trust at a glance...

Northumberland, Tyne and Wear NHS Foundation Trust 2017/18 in numbers:

87%

The proportion of 6,500 service users and carers who responded to the Friends and Family Test and would recommend our services

16

The average number of bed days per month that local service users were inappropriately admitted out of area per month between January to March 2018

2

The number of mental health and disability trusts rated “Outstanding” by the Care Quality Commission

84%

The number of people with a first episode of psychosis begin treatment with a NICE recommended care package within two weeks of referral.

64%

The response rate to the 2017 staff survey, which was 12% above the national average and 19% higher than the previous year

42,500

The number of service users cared for by the Trust on 31 March 2018

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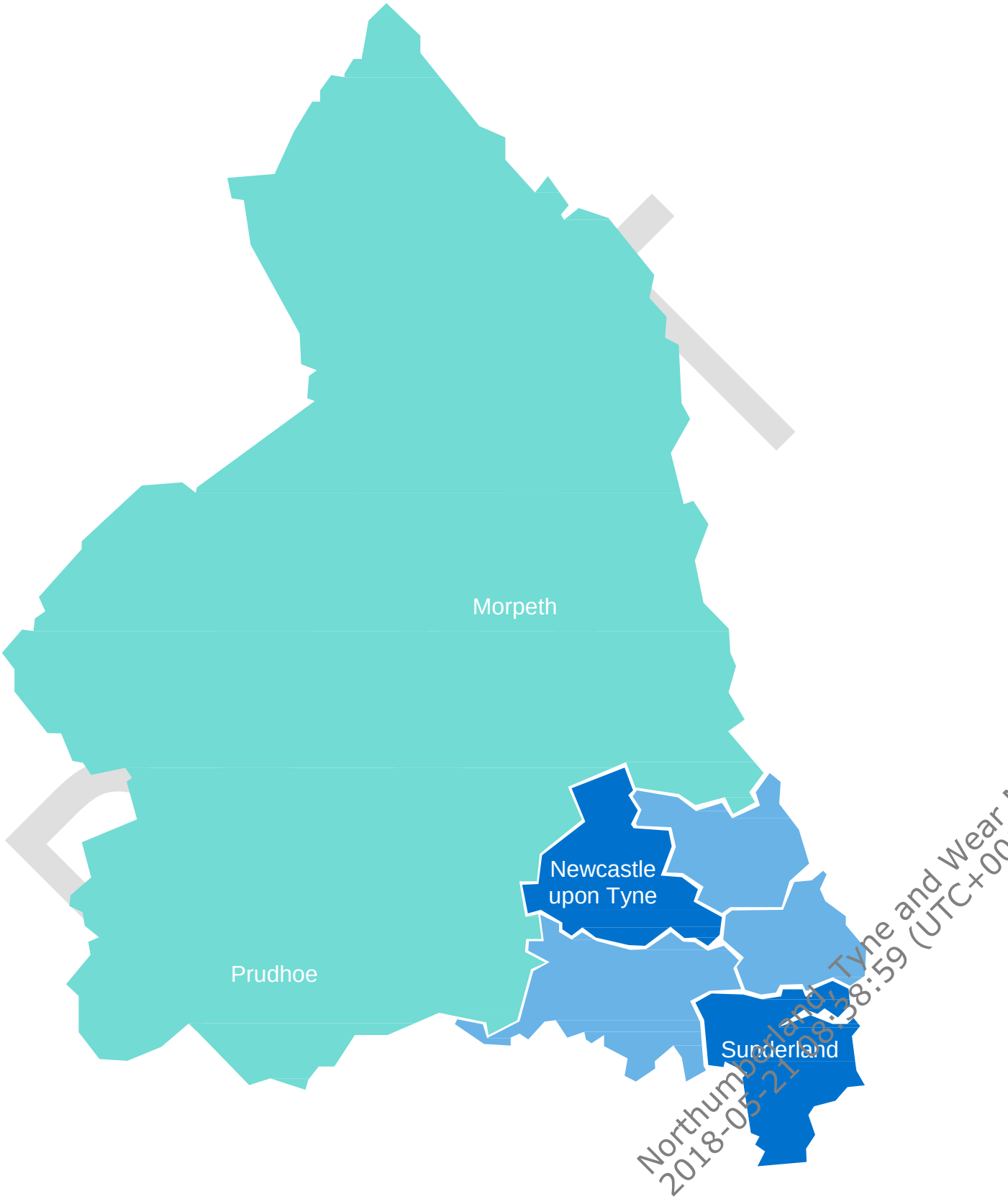
Part 2c

Part 3

Appendices


Morpeth
Prudhoe
Newcastle upon Tyne
Sunderland
Northumberland, Tyne and Wear
2018-05-21 08:28:59 (UTC+00

Part 1

Welcome and Introduction to the Quality Account

Northumberland, Tyne and Wear NHS Foundation Trust was established in 2006, is one of the largest mental health and disability organisations in the country and has an annual income of more than £300 million.

We provide a wide range of mental health, learning disability and neuro-rehabilitation services to a population of 1.4 million people in the North East of England. We employ over 6,000 staff, operate from over 60 sites and provide a range of comprehensive services including some regional and national services.

We support people in the communities of Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland working with a range of partners to deliver care and support to people in their own homes and from community and hospital based premises. Our main hospital sites are:

- Walkergate Park, Newcastle upon Tyne
- St. Nicholas Hospital, Newcastle upon Tyne
- St. George's Park, Morpeth
- Northgate Hospital, Morpeth
- Hopewood Park, Sunderland
- Monkwearmouth Hospital, Sunderland
- Ferndene, Prudhoe

What is a Quality Account?

All NHS healthcare providers are required to produce an annual Quality Account, to provide information on the quality of services they deliver.

We welcome the opportunity to outline how we have performed over the course of 2017/18, taking into account the views of service users, carers, staff and the public, and comparing ourselves with other Mental Health and Disability Trusts. This Quality Account outlines the good work that has been undertaken, the progress made in improving the quality of our services and identifies areas for improvement.

To help with the reading of this document we have provided explanation boxes alongside the text.

This is an "explanation" box

It explains or describes a term or abbreviation found in the report.

Statement of Quality from the Chief Executive

Thank you for taking the time to read our 2017-18 Quality Account, reflecting upon another busy year.

We have set out in this document how we have performed against local and national priorities - including how we have progressed with our Quality Priorities for 2017-18. We have also set out in this document our Quality Priorities for 2018-19, and look forward to reporting our progress against these in next year's Quality Account.

We were delighted this year to be awarded the prestigious "Provider of the Year" award by the Health Service Journal. This award is dedicated to all our staff who do such an amazing job supporting the people we serve, helping them to live the best lives they possibly can. Every member of our staff, regardless of their role played their part and winning this award is testament to their hard work and compassion.

Other achievements this year include the launch of our NTW Nursing Academy to ensure that we can address current and future workforce issues, and we are one of the first trusts in the country to develop exciting new "nursing associate" posts. We have also been awarded "Global Digital Exemplar" funds, which will enable us to use technology innovations to improve service user experiences.

This year has not been without challenges, and I am proud that despite the pressures we have faced, we have continued to receive positive feedback from service users and carers, consistent with our CQC outstanding status and we continue to achieve the requirements of NHS Improvement's Single Oversight Framework. We also ensure that we listen to those who have had a poor experience of care in our services to learn how we can make improvements.

In February we were delighted to welcome our new chair, Ken Jarrold to the Trust and look forward to working together towards our vision of being a leader in the delivery of high quality care and a champion for those we serve. I hope you will find the information in the document useful. To the best of my knowledge, the information in this document is accurate.

John Lawlor
Chief Executive

The Northumberland, Tyne and Wear NHS Foundation Trust is often referred to as "NTW" or "NTWFT".

Statement from Executive Medical Director and Executive Director of Nursing & Chief Operating Officer

We were proud this year to redesign our leadership model at Northumberland, Tyne and Wear NHS Foundation Trust to ensure that the service user is at the forefront of everything we do.

Our locality care group based management structure ensures that decisions are made as close as possible to the service user, and that services meet the needs of local communities. This year we have focussed upon the following quality priorities:

- Improving waiting times to access services
- Embedding the Positive and Safe (Violence Reduction) Strategy
- Embedding the Principles of the "Triangle of Care" (a carer initiative)
- Ensuring that care plans are co-produced and personalised
- Ensuring that service users subject to the Mental Health Act are reminded of their rights

In September we published our "Learning from Deaths" policy, setting out how we will approach the review of deaths of service users, and this learning will be used to improve the health of service users who, as a group, die between 15-20 years earlier than the general population. The policy also sets out how we will also support bereaved relatives and carers.

We have faced challenges throughout the year, particularly pressures on inpatient bed availability, increases in some waiting times and we have also been affected by the national shortage of medical staff. In the coming year we will ensure that we prioritise these areas to ensure that we continue to deliver high quality services, and we are also developing a "Creating Capacity to Care" initiative, to ensure that staff are able to spend as much time as possible delivering care to service users.

Dr Rajesh Nadkarni
Executive Medical Director

Gary O'Hare
Executive Director of Nursing & Chief Operating Officer

People receiving treatment from NTW are often referred to as "patients", "service users" or "clients". To be consistent, we will mostly use the term "service users" throughout this document.

Statement of Quality from Council of Governors Quality Group

The Council of Governors scrutinises the quality of services provided by Northumberland, Tyne and Wear NHS Foundation Trust via a Quality Group who meet every two months. The group considers all aspects of quality, with a particular emphasis on the Trust's annual quality priorities.

During 2017-18 the group received a number of presentations from Trust representatives on varied topics including:

- Mental Health Act reading of rights
- Personalisation & co-production of care plans
- Triangle of Care initiative
- Discharge planning in Northumberland
- Waiting times in services for Children and Young People
- Staff wellbeing
- Willow View Carer Support Group
- Collingwood Court Mutual Help Meetings

The presentations provided Governors with a valuable opportunity to engage with staff, understand ongoing initiatives and to evaluate the quality of services provided.

Members of the group have continued to attend the Trust Quality and Performance Committee and we have also played a valuable role in developing the 2018-19 Trust Quality Priorities.

In 2018-19 we will continue to monitor progress towards Quality Priorities and hope to participate in visits to Trust services, to further enhance our understanding of issues impacting on the quality of services provided.

Margaret Adams

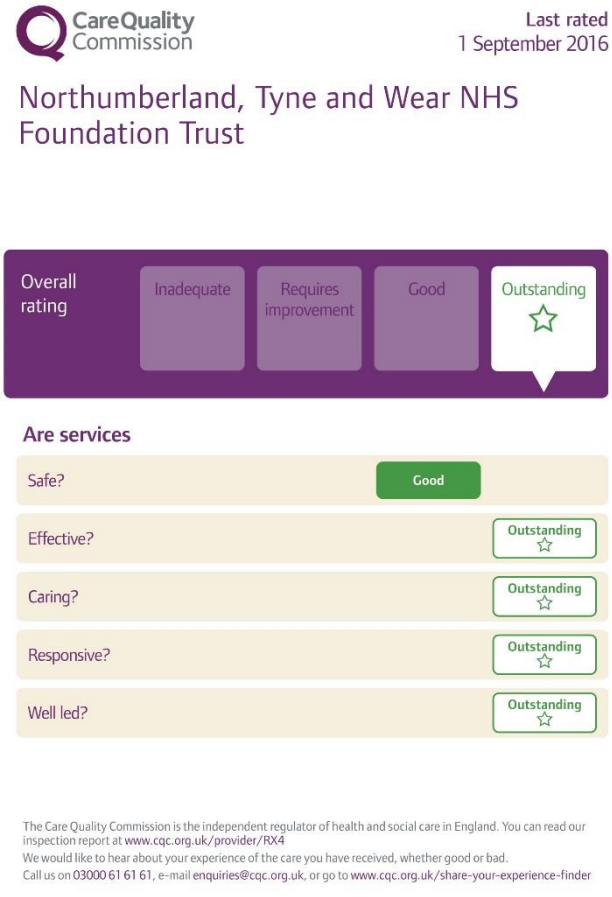
Chair, Northumberland, Tyne and Wear NHS Foundation Trust Council of Governors Quality Group

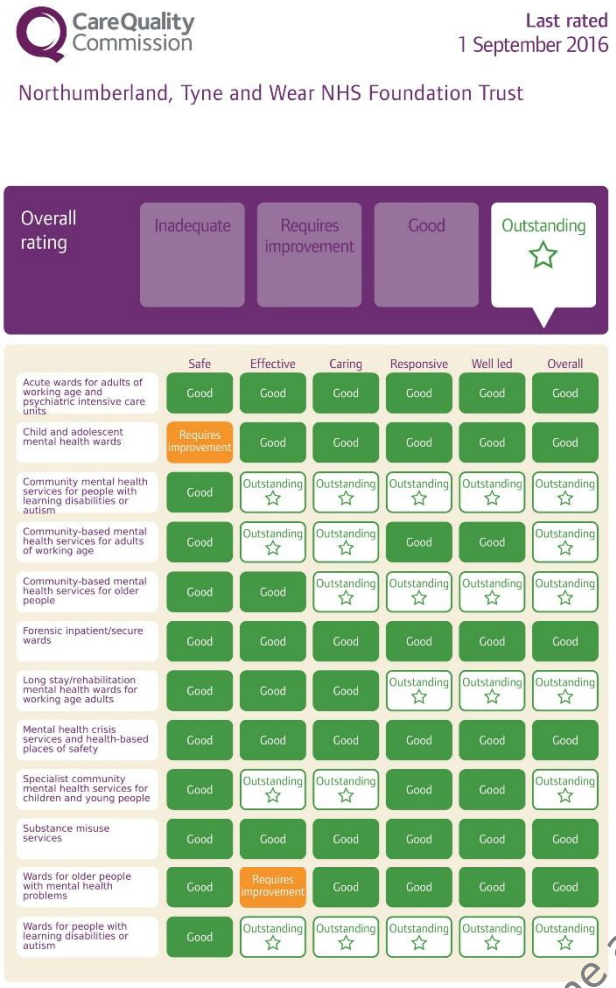
Information in this Quality Account includes NTW Solutions, a wholly owned subsidiary company of NTW

Care Quality Commission (CQC) Findings

In June 2016, the Care Quality Commission (CQC) conducted a comprehensive inspection of our services and rated us as “Outstanding”, and we remain one of only two Mental Health and Disability Trusts in the country to be rated as such.

All of our core services are rated as either “Good” or “Outstanding” overall, and we aim to protect, build upon and share our outstanding practice, while addressing all identified areas for improvement. Our 2017/18 Quality Priorities were closely linked to CQC findings.





Northumberland, Tyne and Wear NHS Foundation Trust aim at all times to work in accordance with our values:

Caring and compassionate	Respectful	Honest and transparent
Put ourselves in other people's shoes	Value the skill and contribution of others	Have no secrets
Listen and offer hope	Give respect to all people	Be open and truthful
Focus on recovery	Respect and embrace difference	Accept what is wrong and strive to put it right
Be approachable	Encourage innovation and be open to new ideas	Share information
Be sensitive and considerate	Work together and value our partners	Be accountable for our actions
Be helpful		
Go the extra mile		

Our values ensure that we will strive to provide the best care, delivered by the best people, to achieve the best outcomes. Our concerns are quality and safety and we will ensure that our values are reflected in all we do:

Our Strategy for 2017 to 2022

Our strategy takes into account local and national strategies and policies that affect us, and our ambitions are:

Caring	Discovering	Growing
Providing excellent care, supporting people on their personal journey to wellbeing	Doing everything we can to prevent ill health and offering support early	A centre of excellence for mental health and disability support
A great place to work	Striving for joined up services	Sustainable services that are good value for money

Together

Our long term Quality Goals are based on safety, service user and carer experience, and clinical effectiveness. Each year we set Quality Priorities to help us achieve our long term Quality Goals:

Trust Overview of Service Users

At any time the Trust is caring for approximately 42,500 people. Table 1 below shows the number of current service users as at 31 March 2018 by locality, with a comparison of the same figures from the last 2 years:

Table 1: Service Users by locality 2015/16 to 2017/18

Clinical Commissioning Group (CCG)	2015/16	2016/17	**2017/18**
Durham Dales Easington & Sedgefield CCG	375	475	**474**
North Durham CCG	578	653	**633**
Darlington CCG	111	134	**110**
Hartlepool & Stockton CCG	137	184	**193**
Newcastle & Gateshead CCG (Total)	12,879	13,210	**13,195**
Newcastle	8,741	8,592	**8,533**
Gateshead	4,138	4,618	**4,662**
North Tyneside CCG	3,996	4,093	**4,013**
Northumberland CCG	10,361	9,584	**9,671**
South Tees CCG	198	232	**223**
South Tyneside CCG	3,990	3,684	**3,713**
Sunderland CCG	9,020	9,443	**9,711**
Other areas	310	611	**636**
Total Service Users	**41,955**	**42,303**	**42,572**

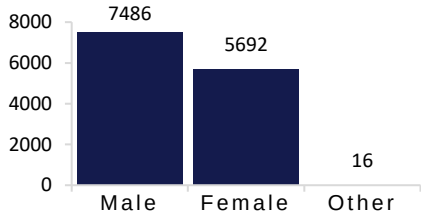
Data source: NTW

Breakdown of service users by age, gender, ethnicity (by CCG)

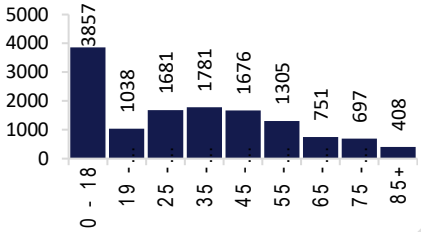
Figure 1: Gender, age and ethnic group breakdown of service users for main CCGs

Newcastle & Gateshead CCG

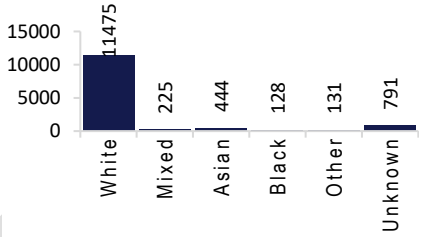
Gender Breakdown



Age Breakdown

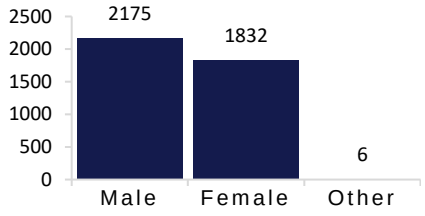


Ethnicity Breakdown

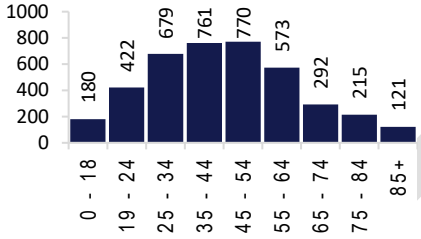


North Tyneside CCG

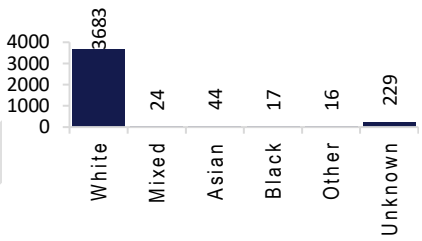
Gender Breakdown



Age Breakdown

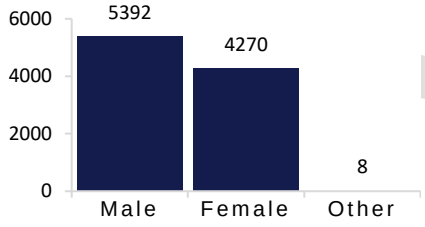


Ethnicity Breakdown



Northumberland CCG

Gender Breakdown



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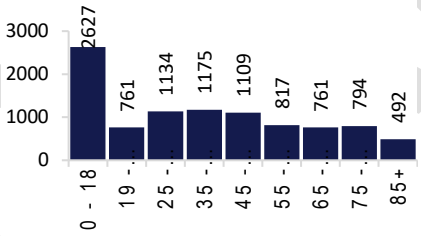
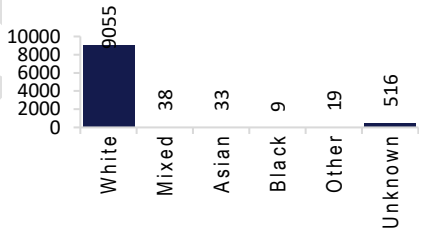
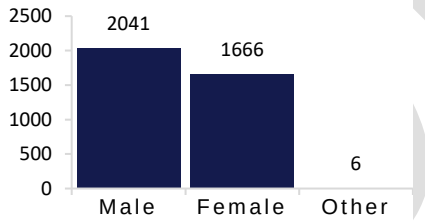


Ethnicity Breakdown

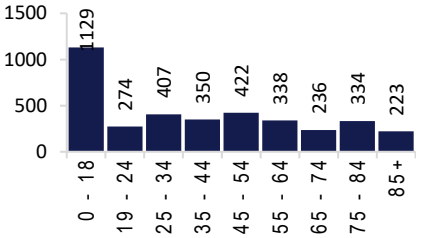


South Tyneside CCG

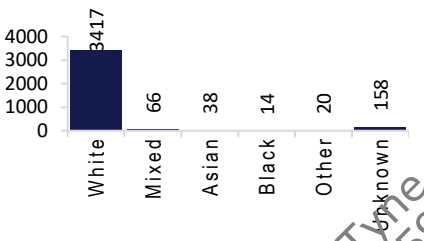
Gender Breakdown



Age Breakdown

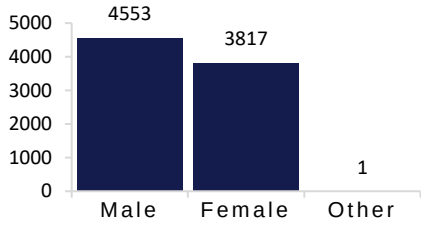


Ethnicity Breakdown

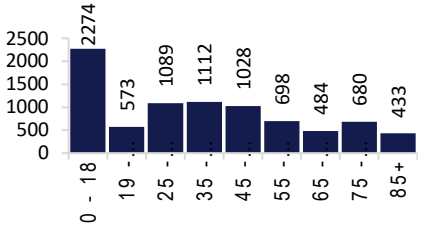


Sunderland CCG

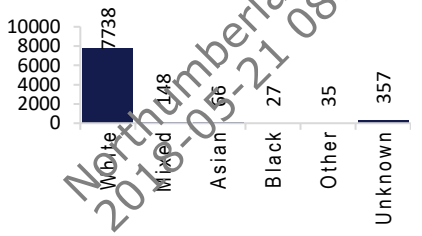
Gender Breakdown



Age Breakdown



Ethnicity Breakdown



Data source: NTW

Part 2a

Looking Ahead – Our Quality Priorities for Improvement in 2018/19

This section of the report outlines the annual Quality Priorities identified by the Trust to improve the quality of our services in 2018/19.

Each year we set annual Quality Priorities to help us to achieve our long term Quality Goals. The Trust has identified these priorities in partnership with service users, carers, staff and partners from their feedback, as well as information gained from incidents, complaints and learning from Care Quality Commission findings.

We sought views from our stakeholders on our suggested Quality Priorities, asking whether they reflected the greatest pressures that the organisation is currently facing.

The Council of Governors and the Service User & Carer Reference forum jointly hosted an engagement session in November 2017, inviting governors, service users, carers, staff, commissioners and other stakeholders to hear about the progress at that point against the current quality priorities and to seek views on proposals for new quality priorities. The presentations from this session were made available on our website and we also conducted a survey to seek wider views.

How have we acted on feedback about our quality priorities engagement processes?

- We have provided an in year update of progress against our quality priorities
- We are reporting waiting times throughout the year, rather than at 31 March only (starting with services for Children and Young People)
- We recognise that discussions about resources, capacity and the availability of beds can generate anxiety and we have ensured that we consider the potential impact on quality of any decisions that we make.
- We try to use plain English and minimise the use of acronyms
- Increased reporting of service user and carer feedback

The Quality Priorities to be progressed during 2018/19 are:

Safety

Clinical Effectiveness

Improving the Inpatient Experience

We will:

1. Reduce the number of service users being admitted to inpatient beds outside of the Trust because we have no beds available.
2. Reduce bed occupancy rates so that beds are always available.
3. Reduce the number of service users who are admitted to our beds outside of their home locality.
4. Monitor the feedback we receive from inpatients about their experience of being cared for on our wards.

Embedding Trust Values

We will identify and reduce instances where we are not displaying the Trust values of being caring and compassionate, respectful, honest and transparent.

We will align themes and monitor complaints and feedback from staff, service users and carers to measure the progress of this Quality Priority.

Improving Waiting Times

We will improve waiting times for adult and older people's services so the 18 week Trust standard is achieved.

We will improve waiting times for children and young people to ensure that the 18 week treatment standard is achieved by the end of the year.

We will report waiting times for specialised services separately.

Embedding the Principles of Triangle of Care

We will continue to embed the Triangle of Care, ensuring that we work in partnership with service users and carers.

We will roll out the use of the Triangle of Care to services for Children and Young People.

We will closely monitor feedback from carers to measure the impact of this initiative.

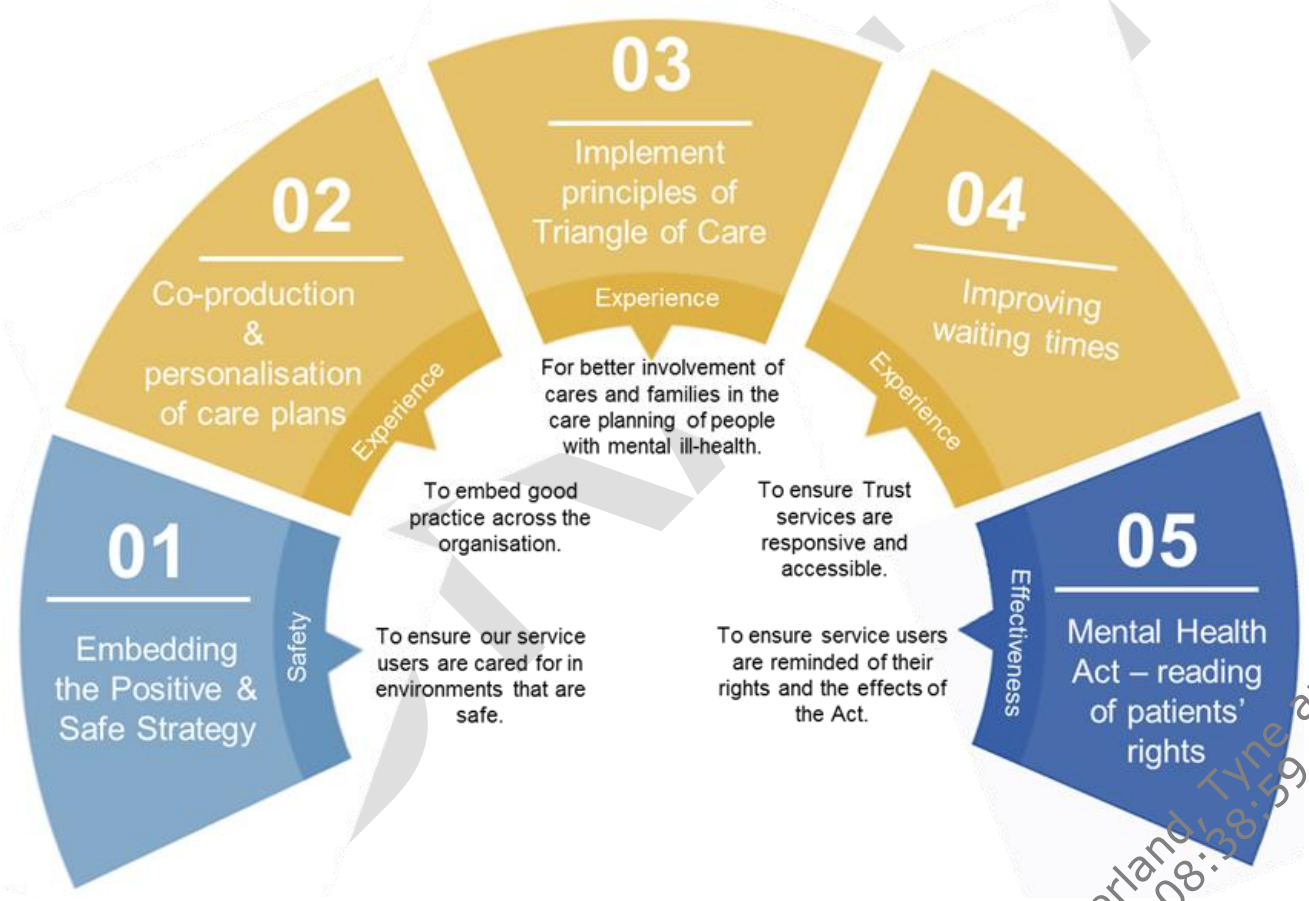
Service User & Carer Experience

Part 2b

Looking Back – Review of Quality Goals and Quality Priorities in 2017/18

In this section we will review our progress against our 2017/18 **Quality Priorities** and consider the impact they may have made on each overarching **Quality Goal**.

Our 2017/18 Quality Priorities were:



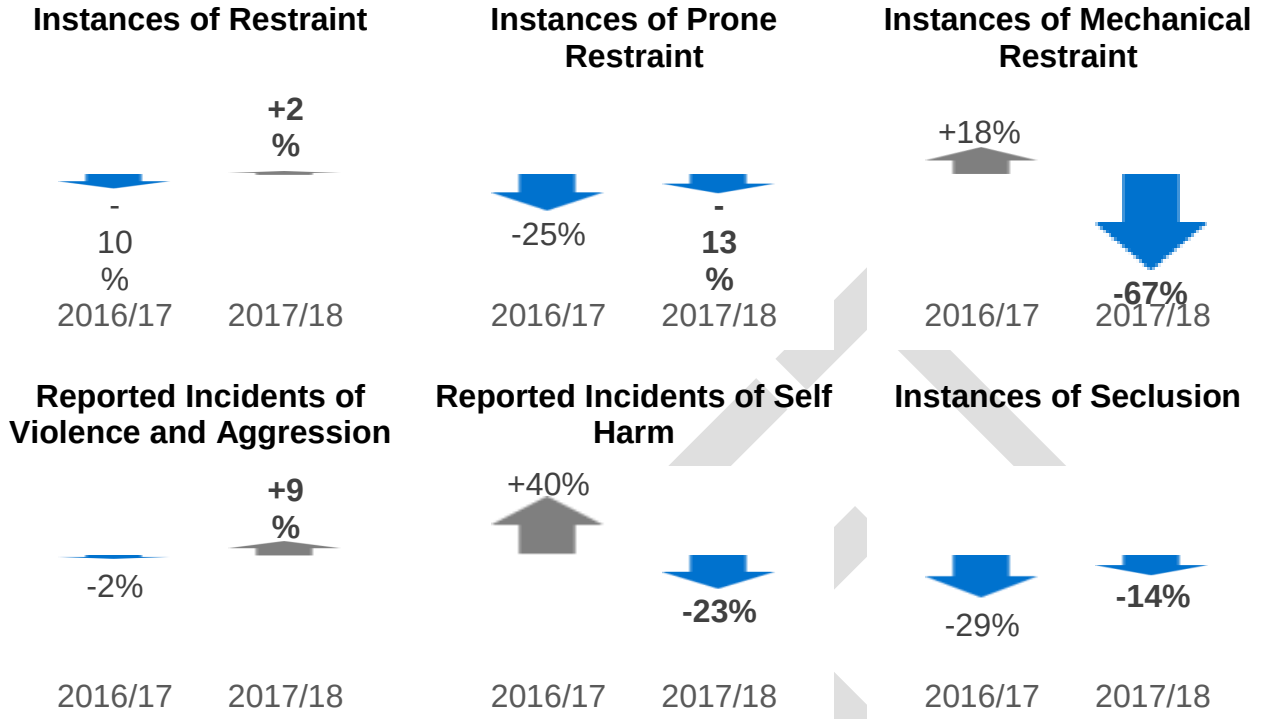
Safety 2017/18 Quality Priority:

Embedding the Positive & Safe Strategy

Target	**The strategy continues to be embedded across the organisation, to ensure our service users are cared for in environments that are safe, where service users and staff work together to develop solutions in order to promote positive change, underpinned by best evidence**
Progress	**Met** During 2017/18 we have continued to embed the Positive and Safe Strategy, which is our approach to reducing instances of violence and aggression across the organisation. As part of embedding the strategy we have: • Ensured all wards have completed their induction days and they are all enrolled in the "Talk 1st" programme • Planned to undertake a deep dive into the increased levels of harm noted in 2016/17 this has not been undertaken however self harm has significantly reduced in 2017/18 therefore we are no longer planning to undertake this analysis. • Ensured all wards have undertaken "Talk 1st" review days. • Implemented routine assurance reporting into safer care reports. • Continued to develop the "Talk 1st" dashboard functionality and ensure that clinical services utilise data to support the reduction of restrictive interventions across the Trust. This initiative was the winner of a staff excellence award. • Monitored service user responses to the "feeling safe" question within our Points of You feedback survey to demonstrate a high stable satisfaction level. • Begun an ongoing exercise to review the organisational cost of violence. • Established a Positive and Safe intranet page which has proven a useful resource for teams to share relevant information and learning Trust wide. • Implemented the post incident and debrief policy, all service users and staff have access to evidence based approaches in order to provide support and contribute to ongoing learning with regards to incidents. • Ensured that each clinical group has implemented a "Positive and Safe" meeting Throughout the year we have also continued delivering "Risk of Harm to Others" training, and at 31 March 2018, 87.2% of applicable staff had received this training, meeting the 85% standard.

Positive and Safe Strategy impact in numbers:

Figure 2: Change in Talk 1st data 2017/18 on previous year



Data source: NTW

The Positive and Safe strategy continues to deliver positive change in relation to the reduced use of restrictive interventions across NTW.

Reductions in the use of seclusion, prone restraint and mechanical restraint have been noted.

Small increases have been noted in the areas of violence and aggression and restraints overall, this is largely attributable to a small number of highly complex patients across the trust and improved reporting systems. It is encouraging to note that despite the rise in the aforementioned fewer restrictive interventions overall are being used as a result.

Inpatient and community teams across the trust are engaged in the Talk 1st programme which aims to reduce violence and aggression by ensuring our environments are positive, inclusive and person centred. This approach has been embraced by the teams and has resulted in a number of positive practice examples, some of which have received national recognition as best practice.

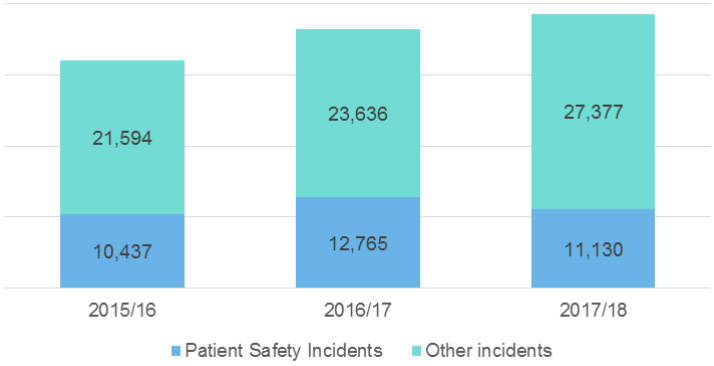
Information from the Positive and Safe Strategy can be viewed in relation to the Staff Survey results, especially for staff experiencing physical violence from patients, relatives or the public in last 12 months on page 14

How has the “Embedding the Positive and Safe Strategy” Quality Priority helped support the Safety Quality Goal of “Keeping You Safe”?

We aim to demonstrate success against this quality goal by reducing the severity of incidents and the number of serious incidents across the Trust’s services.

Figure 3 below shows the total number of patient safety incidents reported by the Trust over the past 3 years:

Figure 3: Number of reported patient safety incidents and total incidents 2015/16 to 2017/18



Data source: NTW

Compared with the previous year, there has been a 13% decrease in the number of patient safety incidents. Patient safety incidents represent 29% of the total number of incidents reported for the year, which totalled 38,507 (an increase of 6% from the previous year – this increase is partly attributed to a change in the safeguarding reporting process).

Table 2: Number and percentage of patient safety incidents by impact 2015/16 to 2017/18

Number of Patient Safety incidents reported by impact:	2015/16		2016/17		**2017/18**	
No Harm	4,800	46.0%	6,626	52.0%	**6,616**	**59.4%**
Minor Harm	4,937	47.0%	5,181	40.5%	**3,683**	**33.1%**
Moderate Harm	597	6.0%	770	6.0%	**749**	**6.7%**
Major Harm	23	0.2%	79	0.6%	**37**	**0.3%**
Catastrophic, Death	80	0.8%	109	0.9%	**45***	**0.4%**
Total patient safety incidents	10,437	100.0%	12,765	100.0%	**11,130**	**100.0%**

Data source: NTW

Note, annual totals for previous years may differ from previously reported data due to on-going data quality improvement work and to reflect coroner’s conclusions when known. Data is as at 7 April 2018.

**The reported deaths reduced in 2017/18 following changes to national reporting rules to cease reporting deaths of unknown cause, we are now only required to report actual self-harm related deaths.*

The “no harm” or “minor harm” patient safety incidents remain 92.5% of reported patient safety incidents, however this year has seen a shift from “minor harm” to “no harm”.

Table 3: Total incidents 2017/18 by CCG, includes patient safety and non-patient safety incidents

Total incidents by CCG	1. No Harm	2. Minor Harm	3. Moderate Harm	4. Major Harm	5. Catastrophic, Death
NHS Gateshead CCG	1,808	569	110	2	61
NHS Newcastle CCG	4,551	2,115	274	24	226
NHS North Tyneside CCG	2,108	597	112	6	104
NHS Northumberland CCG	7,914	1,939	315	16	185
NHS Sunderland CCG	4,760	1,655	275	17	279
NHS South Tyneside CCG	1,770	656	146	4	149
Total for local CCGs	**22,911**	**7,531**	**1,232**	**69**	**1,004**

Data source: NTW

Note that column 5 includes all deaths including by natural causes, and that there are also incidents relating to service users from other non-local CCGs, the trust total deaths for NTW is 1,037. There is more information on Learning from Deaths on page 59.

Openness and Honesty when things go wrong: the Professional Duty of Candour

All healthcare professionals have a duty of candour which is a professional responsibility to be honest with service users and their advocates, carers and families when things go wrong. The key features of this responsibility are that healthcare professionals must:

- Tell the service user (or, where appropriate, the service user's advocate, carer or family) when something has gone wrong.
- Apologise to the service user. Offer an appropriate remedy or support to put matters right (if possible).
- Explain fully to the service user the short and long term effects of what has happened.

At NTW we try to provide the best service we can. Unfortunately, sometimes things go wrong. It is important that we know about these so we can try to put things right, and stop them from going wrong again.

If you wish to make a complaint you can do so by post to: Complaints Department, St. Nicholas Hospital, Gosforth, Newcastle upon Tyne NE3 3XT

By email: complaints@ntw.nhs.uk

By phone: 0191 245 6672

A key requirement is for individuals and organisations to learn from events and implement change to improve the safety and quality of care. We have implemented the Duty of Candour, developed a process to allow thematic analysis of reported cases, raised

awareness of the duty at all levels of the organisation and we are also reviewing how we can improve the way we learn and ensure that teams and individuals have the tools and opportunities to reflect on incidents and share learning with colleagues. Healthcare professionals must also be open and honest and take part in reviews and investigations when requested. All staff are aware that they should report incidents or raise concerns promptly, that they must support and encourage each other to be open and honest, and not stop anyone from raising concerns.

We have reviewed our approach to Duty of Candour, in light of the national publications on death reviews and have been applying this new approach since April 2017.

From April 2017, the Trust reviewed its internal and external safety reporting, and created a suite of safety and learning reports under the banner of Safer Care, this meant that the reports were included in the formal governance of the Trust from floor to board, as well as to commissioners through the formal quality review groups. As a transparent organisation all the safety related board reports including Learning from Deaths have been public board documents, for wider sharing and learning. As part of the clinical re-organisation that took place in the Trust in October 2017, a Safer Care Directorate was created to further integrate the support for front line clinical and operational services, led by a Group Medical Director and Group Nurse Director, and supported by subject experts in the field of Safeguarding , Infection Control, Health , Safety , Security and Emergency Preparedness, as well as responsibilities for key corporate processes such as serious incidents, complaints, claims and mortality reviews.

Service User & Carer Experience 2017/18 Quality Priority:

Improving waiting times for referrals to multi-disciplinary teams

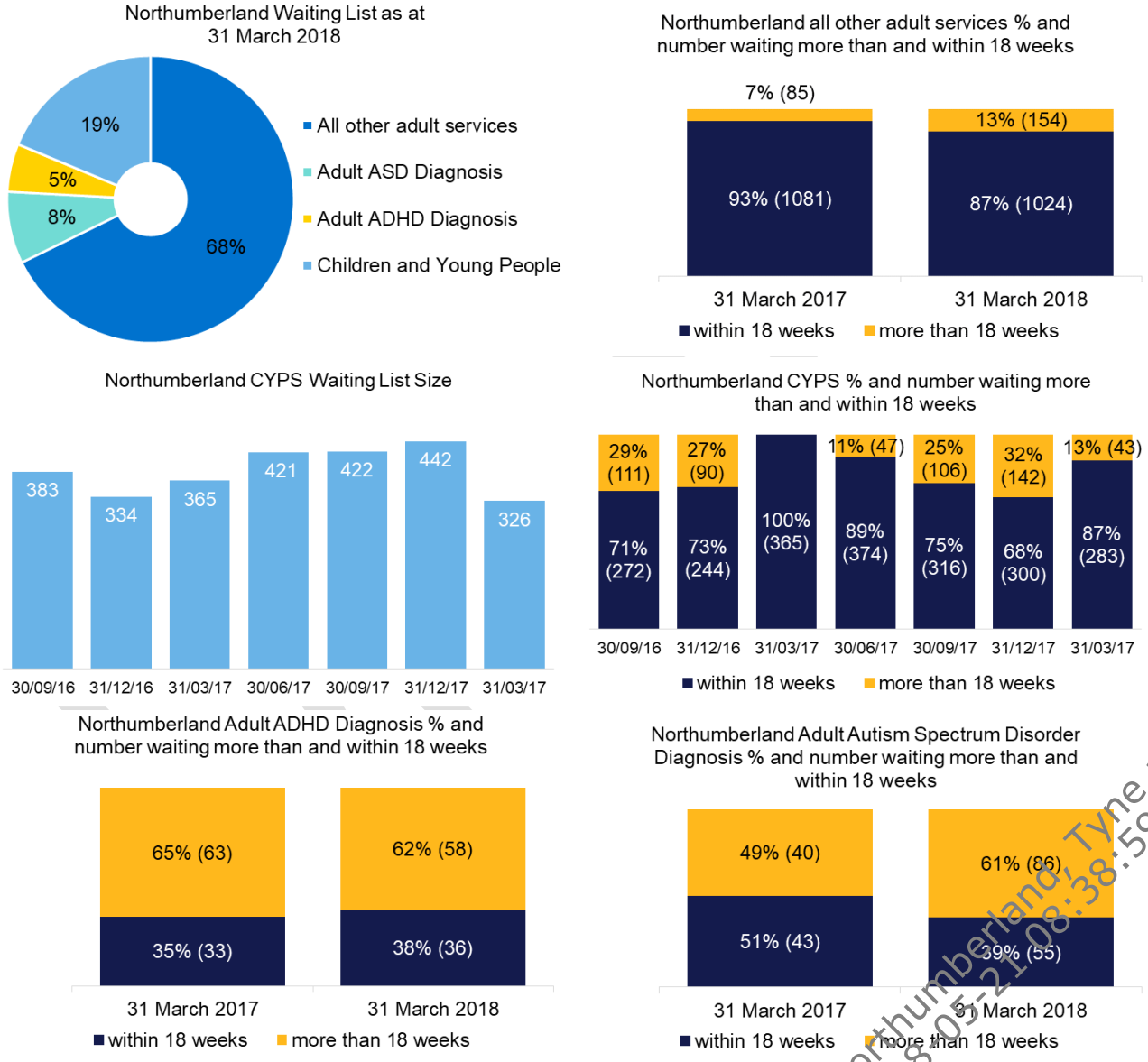
Target	**To ensure that 100% of service users will wait no longer than 18 weeks for their first contact with all services, with the exception of the following services:** • **Community Services for Children and Young People – waiting time to treatment is measured and should be no more than 18 weeks** • **Adult Autism Spectrum Disorder (ASD) Diagnosis service - waiting times to be reduced** • **Adult Attention Deficit Hyperactivity Disorder (ADHD) Diagnosis service - waiting times to be reduced** • **Adult Gender Identity Service – waiting times to be reduced**
Progress	**Not Met** Our aim remains that no-one should wait more than 18 weeks for their first contact with a community service. In line with nationally reported 18 weeks data, we measure progress against this by looking at the waiting list at the end of the year, and calculating how many of those service users waiting had been waiting for more or less than 18 weeks at that point. Referrals which are regarded as a priority or emergency by the clinical team would not be expected to wait 18 weeks for first contact. The definition of what constitutes a priority or emergency referral differs per service. We encourage service users, carers and referrers to keep in touch with us while they are waiting for their first contact and to let us know if anything about their situation changes. This year we have not seen the improvements in waiting times that we would have hoped for. Services have experienced continuing challenges and as a result some waiting times are longer than this time last year, most notably in services for children and young people South of Tyne and in the adult autism spectrum disorder diagnosis service. Within community services for adults and older people, the number of people waiting more than 18 weeks for their first contact with a service at 31st March 2018 was 285, which is an increase of 20% when compared with the same date last year. The longest waiting times for these services are in Northumberland and Sunderland.

Waiting times analysis at locality level

In **Northumberland**, waiting times for adult service have lengthened, with 13% waiting more than 18 weeks as at 31 March 2018.

Within services for Children and Young People (CYPS), the waiting list is currently smaller than at any time in the last eighteen months and the proportion waiting more than 18 weeks for treatment is currently 13%, which is a deterioration compared with the same time last year but an improvement on more recent months. Waiting times for the adult attention deficit hyperactivity disorder diagnosis services have remained broadly the same and waits for the adult autism spectrum disorder diagnosis service have lengthened.

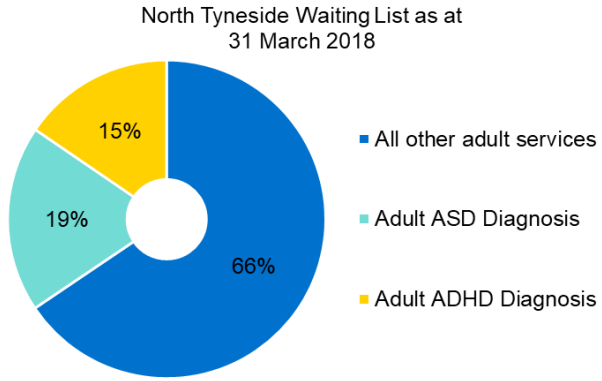
Figure 4a-f: Northumberland CCG waiting lists, assorted metrics

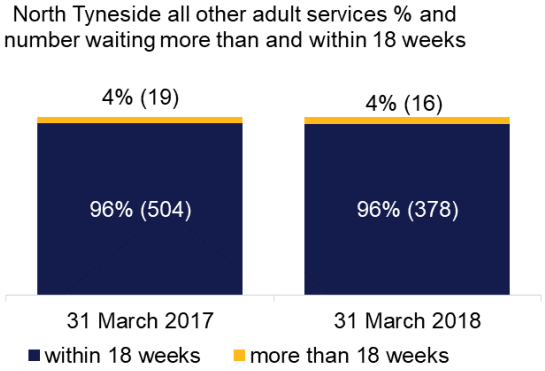


Data source: NTW

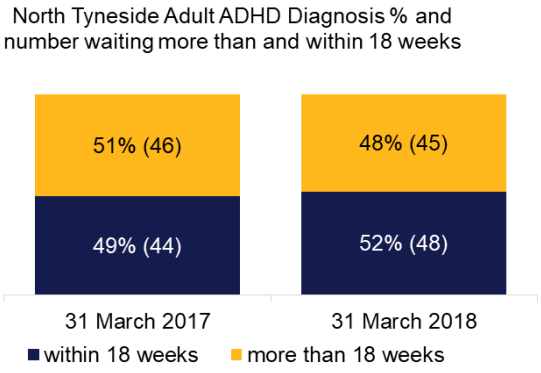
In **North Tyneside**, the waiting times for adult services have slightly lengthened. There has been some improvement in the adult attention deficit hyperactivity disorder diagnosis services and waits for the adult autism spectrum disorder diagnosis service have lengthened.

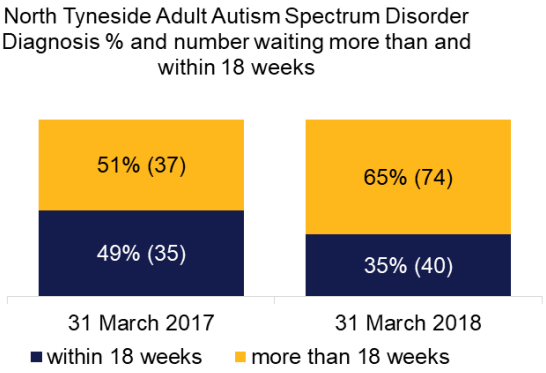
Figure 5a-d: North Tyneside CCG waiting lists, assorted metrics





NTW does not provide community services for children and young people in North Tyneside, this service is provided by Northumbria Healthcare NHS Foundation Trust.





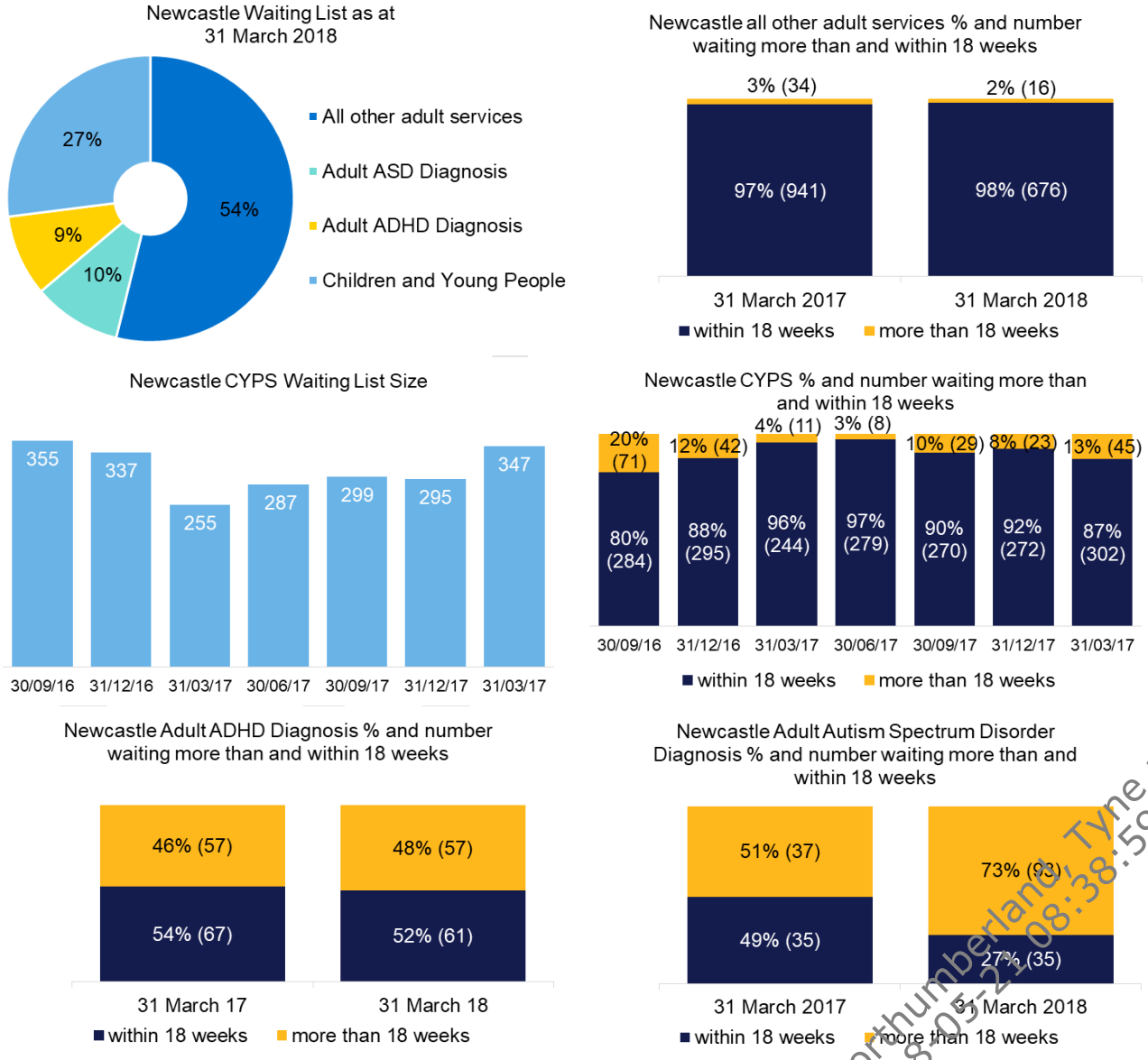
Data source: NTW

In **Newcastle**, there has been improvements in the waiting times for adult services.

The improvements made last year in reducing the number of children and young people waiting to access services in Newcastle have not been sustainable and waiting times have consequently increased during the year. Waiting times to treatment have lengthened, with 13% of people waiting to access these services on 31 March 2018 having waited longer than 18 weeks as of that date.

There has been no significant change in the waiting times for the adult attention deficit hyperactivity disorder diagnosis services, and for the adult autism spectrum disorder diagnosis service waiting times have lengthened.

Figure 6a-f: Newcastle locality waiting lists, assorted metrics

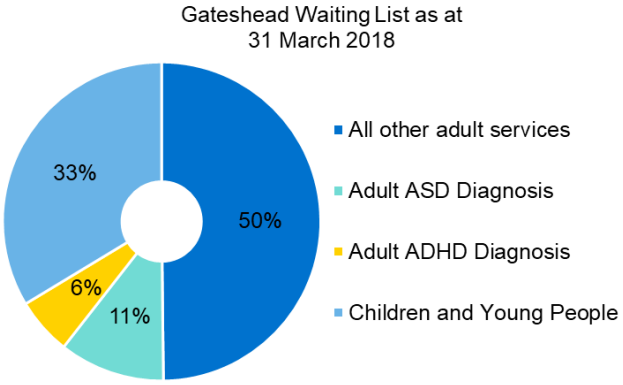


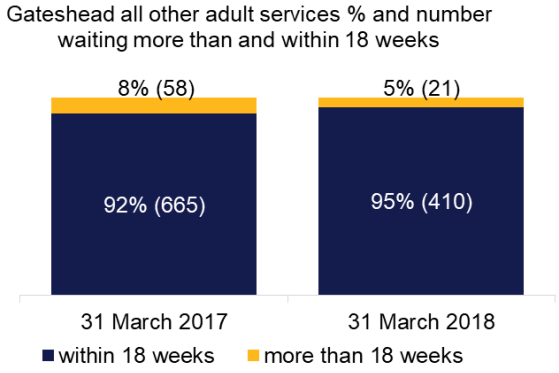
Data source: NTW

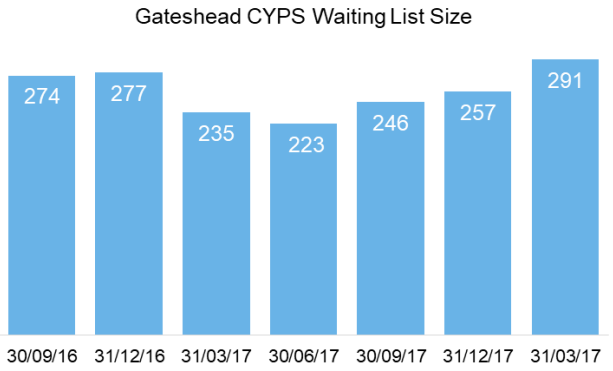
In **Gateshead**, there has been improvements in the waiting times for adult services.

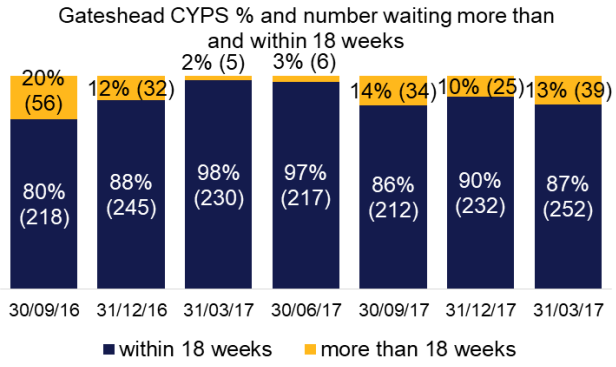
Last year's improvements in waiting times for children and young people waiting to access services have not been maintained and waits have lengthened. There has been no significant change for access to the adult attention deficit hyperactivity disorder diagnosis service and there has been an increase in the waiting times for access to the adult autism spectrum disorder diagnosis service.

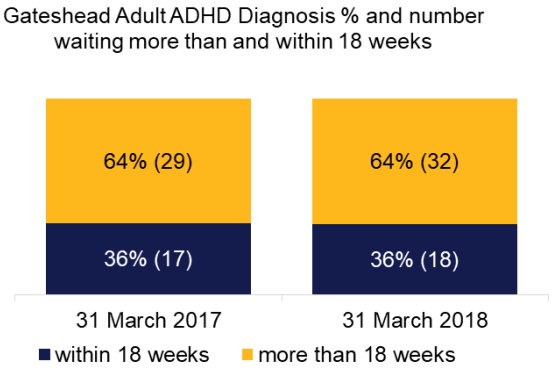
Figure 7a-f: Gateshead locality waiting lists, assorted metrics

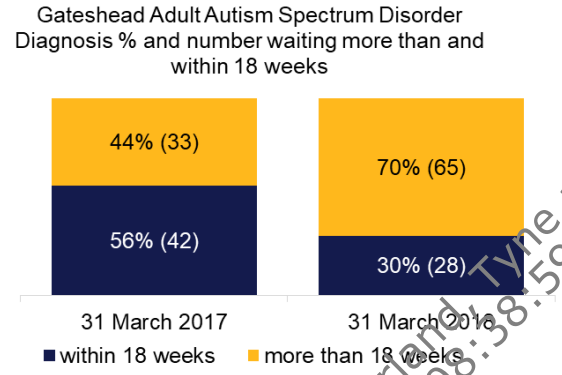












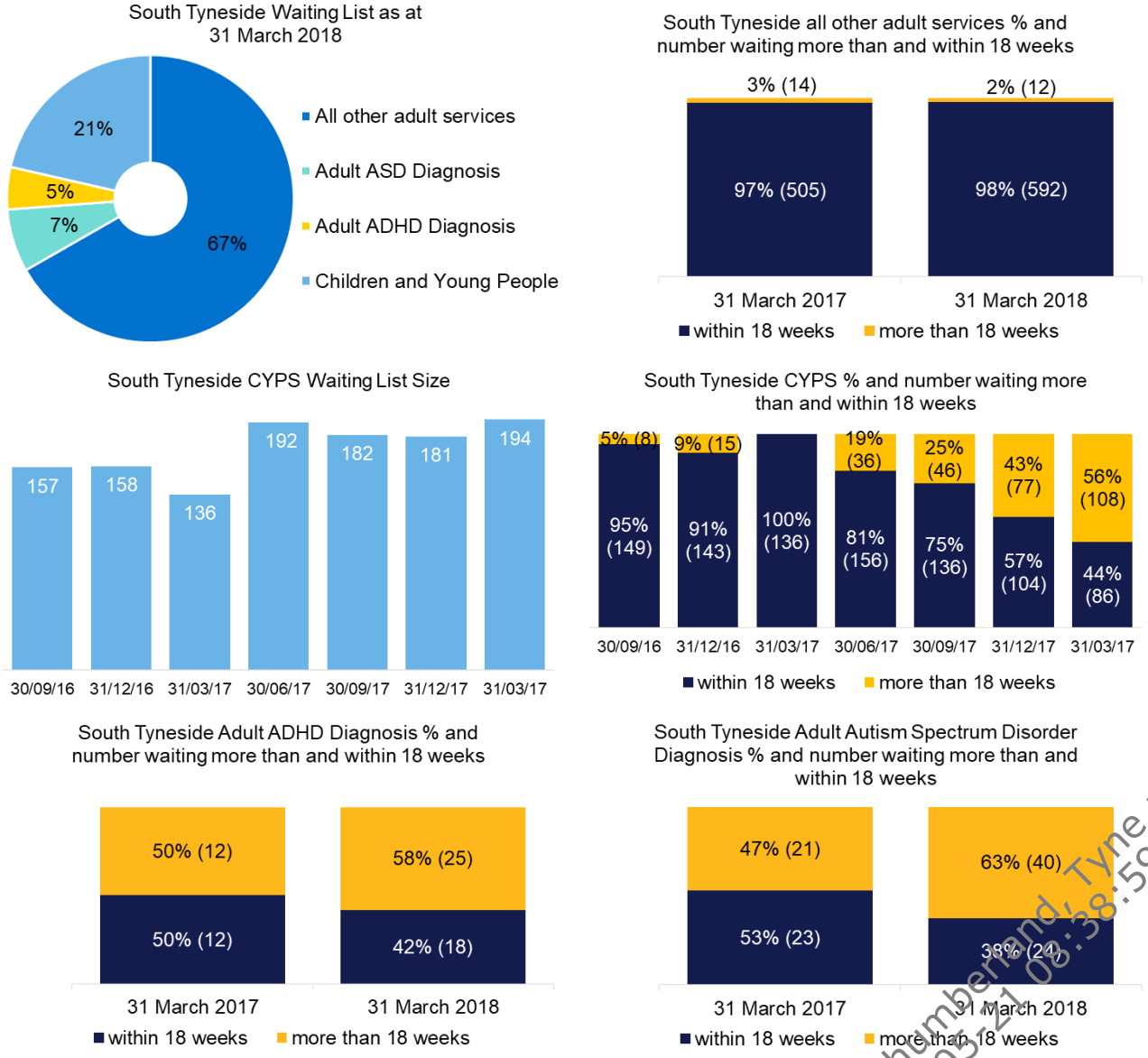
Data source: NTW

In **South Tyneside**, there has been improvements in the waiting times to first contact for adult services.

Last year's improvements in waiting times for children and young people waiting to access services have not been maintained and waits have significantly lengthened, with 56% waiting more than 18 weeks as at 31 March 2018.

There has been a deterioration in waits to access to both the adult attention deficit hyperactivity disorder diagnosis service and the adult autism spectrum disorder diagnosis service.

Figure 8a-f: South Tyneside CCG waiting lists, assorted metrics



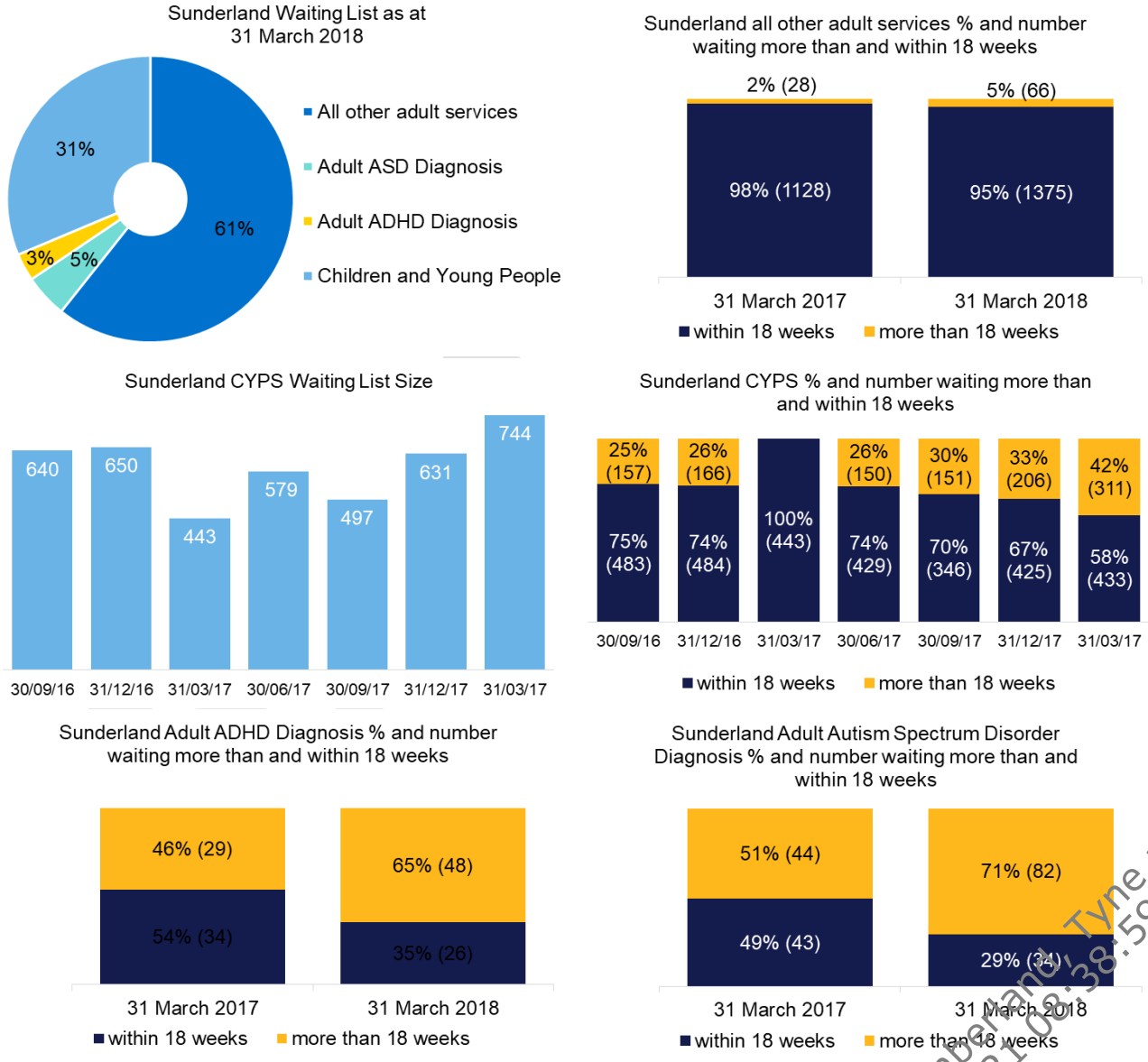
Data source: NTW

In **Sunderland**, waiting times for adult services have slightly deteriorated.

Waiting times for children and young people have significantly lengthened, with 42% waiting more than 18 weeks as at 31 March 2018.

There has been a deterioration in waits to access to the adult attention deficit hyperactivity disorder diagnosis service and the adult autism spectrum disorder diagnosis service.

Figure 9a-f: Sunderland CCG waiting lists, assorted metrics



Data source: NTW

The **Gender Identity Service** is a regional service commissioned by NHS England, therefore the data for this service is not displayed at Clinical Commissioning Group (CCG) level.

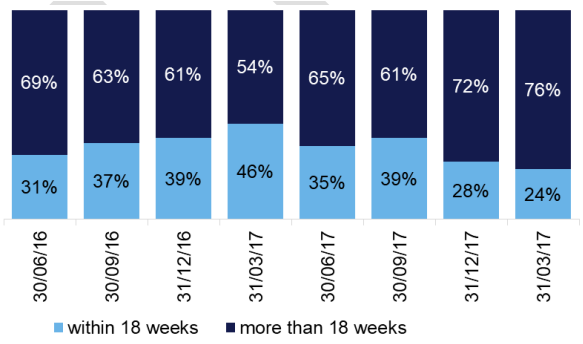
Figure 10: Gender identity service waiting list, end of quarter snapshots

Data source: NTW

The overall waiting list for this service has varied between 300 and 375 people during the last two years.

The 18 week standard is not being achieved. Waiting times for this service improved in 2016/17 however this has not been sustained and waits have been lengthening during 2017/18, with three quarters of those waiting to access the service having waited longer than 18 weeks as at 31 Mach 2018.

Figure 11: Gender identity service, percentage of service users waiting less than 18 weeks, end of quarter snapshots



Data source: NTW

NTW data for **Five Year Forward View for Mental Health** waiting time standards:

Table 4: Five Year Forward View for Mental Health waiting times data 2017/18

Area	Waiting time measure	Minimum standard	**NTW data**	Data period
Early Intervention in Psychosis (EIP)	% starting treatment within two weeks of referral	50%	**95.2%**	April 2017 to March 2018
Improving Access to Psychological Therapies (IAPT)	% entering treatment within 6 weeks	75%	**99.6%**	April 2017 to March 2018
	% moving to recovery	50%	**52.4%**	
Children and young people with an eating disorder	% urgent cases starting treatment within one week of referral	*95% by 2020/21*	**93.7%**	Quarter 4 2017/18
	% routine cases starting treatment within four weeks of referral		**82.1%**	

Service User & Carer Experience 2017/18 Quality Priority:

Implementing the principles of the Triangle of Care

Target	**To improve the way we relate, communicate and engage with carers to involve them within care and support planning.** **Progress will be measured by monitoring carer feedback for an increase in quantity and quality of feedback due to increased engagement.**
Progress	**Met** During 2017/18 we have refreshed the carer awareness training for inpatient and community services and a programme to cascade this training is under development. The original carer training is still ongoing until the refreshed training is launched. Systems are in place to record and monitor the number of staff who attend the training. We have developed systems and these are reviewed and updated regularly for all carer champions. A trust wide Rapid Improvement Process Workshop has taken place to review the Trust's approach to engaging with carers, "Getting to Know You". All services have developed action plans to implement the Triangle of Care principles, which are monitored and reviewed at carer champion forums within groups. A Trust wide position of all action plans are monitored through the Trust wide Triangle of Care Steering Group which was established this year.

What are the principles of Triangle of Care?

The six key principles are:

1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter

2) Staff are 'carer aware' and trained in carer engagement strategies

3) Policy and practice protocols re: confidentiality and sharing information, are in place

4) Defined post(s) responsible for carers are in place

5) A carer introduction to the service and staff is available, with a relevant range of information across the care pathway

6) A range of carer support services are available

Service User & Carer Experience 2017/18 Quality Priority:

Co-production and personalisation of care plans

Target	**In 2017/18 our aim was to learn from actions undertaken in Older People's Inpatient Services and to embed good practice in relation to the co-production and personalisation of care plan across all inpatient services.**
Progress	**Met** During 2017/18 we reflected on work that had been undertaken within the older people's service to help us understand what needed to be taken forward. Further development was required to build on the audit tool that had been developed in the older people's service to allow the creation of a useable tool for adult services, with a baseline audit being undertaken. Care plan training is being delivered to all qualified nurses working on an inpatient ward using the training material that had been developed for older people services as a basis for designing a bespoke package for adult services. These are co-facilitated by a senior nurse and clinical nurse manager via a continuing cycle of mandatory workshops. Care plan clinics have been introduced and these are facilitated by senior clinicians and attended by qualified nurses. The workshops have been based on the principle of sharing best practice and evidence based interventions. A bespoke supervision workshop has been introduced and tailored for lead nurses to develop caseload reflective supervision incorporating person centred care planning which are due April 2018. A monthly ward care planning audit takes place using the registered care plan audit led by clinical leads and ward managers. The results are shared with the ward team and any lessons/themes are shared within each Clinical Business Unit. Outcomes are fed back to individuals via clinical supervision. A quarterly Clinical Business Unit clinical audit has been undertaken and results have been shared via the Locality Care Group Quality Standards meetings and Group Directors. A further quarterly audit is underway and the results will be collated, shared and reviewed against the current action plans.

How have the three Service User & Carer Experience 2017/18 Quality Priorities helped support the Service User & Carer Experience Quality Goal to “work with you, your carers and your family to support your journey”?

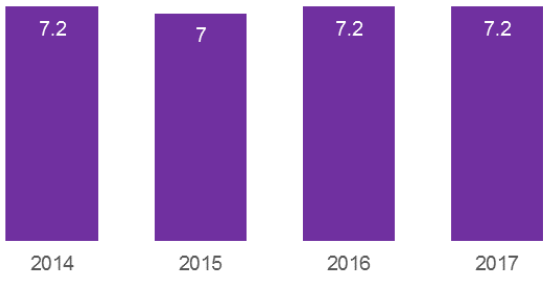
We aim to demonstrate success against this Quality Goal by improving the overall score achieved in the annual CQC survey of adult community mental health services and by reducing the number of complaints received. We will also review the feedback received from our Points of You survey which includes the national “Friends and Family Test”.

CQC Community Mental Health Service User Survey 2017

This national survey gathered information from over 12,000 adults across England who were in receipt of community mental health services between September 2016 and November 2016. NTW’s response rate was in line with the national response rate of 26%.

Overall, the Trust scored 7.2 (out of 10) in response to the question about overall experience of care. This was within the expected range for the Trust and remains unchanged from the 2016 survey. The NTW result for this question has been relatively static for the last four years (see Figure 29).

Figure 12: NTW's overall experience of care score 2014 to 2017



Data source: CQC

When comparing results with other providers, CQC identifies whether a Trust performed “better”, “worse” or “about the same” as the majority of trusts for each question. There are two areas in 2017 where NTW performed better than other trusts to an extent that is not considered to be through chance. These relate to involving carers and explaining changes in who people see. There is also one area where NTW performed worse than expected, which is providing advice and support in finding support for financial advice or benefits.

While most questions remain within the expected ranges for the Trust, many saw slightly decreased scores compared with last year – most notably in the section focusing on “reviewing care”. There was one area of improvement compared with 2016, in the section “changes in who you see”. None of the year on year score changes are considered statistically significant.

Table 5: National Mental Health Community Patient Survey results for 2016 and 2017

Survey section	2016 NTW score (out of 10)	**2017 NTW score (out of 10)**	2017 NTW lowest – highest question score	2017 Position relative to other mental health trusts
1. Health and Social Care Workers	7.9	**7.8**	6.4 – 8.1	About the Same
2. Organising Care	8.6	**8.5**	7.8 – 9.0	About the Same
3. Planning Care	7.0	**7.0**	6.0 – 7.5	About the Same
4. Reviewing Care	7.9	**7.4**	6.2 – 8.3	About the Same
5. Changes in who you see	6.0	**6.7**	4.6 – 7.3	About the Same
6. Crisis Care	6.5	**6.2**	5.1 – 7.3	About the Same
7. Treatments	7.6	**7.6**	6.3 – 8.2	About the Same
8. Support & Wellbeing	5.3	**5.1**	3.5 – 5.9	About the Same
9. Overall Views of Care and Services	7.6	**7.4**	5.9 – 7.9	About the Same
Overall Experience	**7.2**	**7.2**	**5.9 – 7.5**	

Data source: CQC

Mental Health Inpatient Survey 2017

A separate survey of mental health inpatients has also taken place during 2017, which, unlike the community mental health survey, is not mandated by CQC, resulting in lower trust participation. CQC do not publish the results of this survey. As with the community mental health survey, this is an opportunity to compare results with the findings of our Points of You process and explore issues in further detail.

Individuals age 16-64 who had been admitted to an NTW acute mental health ward for at least 48 hours in the period 1st July 2016 to 31st December 2016 were surveyed and 22% responded.

Two areas of improvement identified were in relation to delayed transfers of care and service users feeling that that they were not always not listened to carefully by psychiatrists. High scoring areas in comparison to other trusts were cleanliness of bathrooms and toilets, availability of activities at evenings and weekends, and service users being aware how to make a complaint. There was also some areas of significant improvement compared to the last time the trust participated in this survey (2015), most notably in responding to specific dietary needs, explaining the purpose and side effects of medication and the reading of rights.

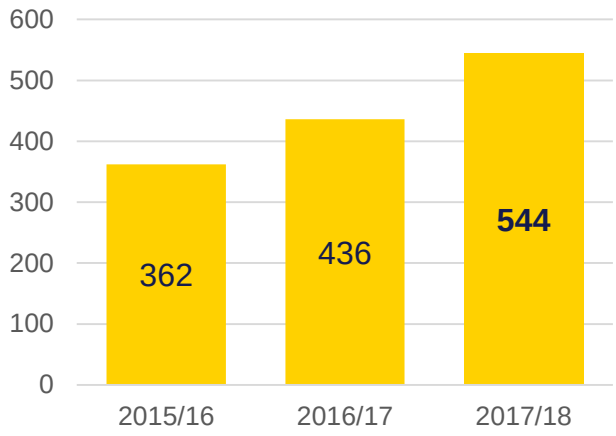
Quantitative comments made by participants of both surveys have been received and found to be broadly in line with the thematic analysis of Points of You comments received.

Complaints

Information gathered through our complaints process is used to inform service improvements and ensure we provide the best possible care to our service users, their families and carers.

Complaints have increased during 2017/18 with a total of 544 received during the year. This is an increase of 108 complaints (25%) from 2016/17. Although complaints are very individual, there has been a general increase in dissatisfaction with new ways of working (episodic care). This has a focus on recovery and has in some cases impacted on benefit levels where it is felt the person no longer requires long term care co-ordination. Other themes identified include waiting times in community services for children and young people, multiple assessments and a general lack of communication around progress or diagnosis.

Figure 13: Number of complaints received 2015/16 to 2017/18



Data source: NTW

A new Learning and Improving group has recently been established to look at ways of embedding learning across the organisation incorporating learning from complaints, claims and incidents. Lessons learned are disseminated across services with the aim of improving the quality of care.

The Patient Advice and Liaison Service (PALS) gives service users and carers an alternative to making a formal complaint. The service provides advice and support to service users, their families, carers and staff, providing information, signposting to appropriate agencies, listening to concerns and following up concerns with the aim of helping to sort out problems quickly.

Table 6: Number of complaints received by category 2015/16 to 2017/18

Complaint Category	2015/16	2016/17	**2017/18**
Patient Care	76	124	**157**
Communications	72	75	**83**
Values and Behaviours	58	64	**109**
Facilities	6	29	**7**
Prescribing	24	26	**31**
Admissions and Discharges	24	21	**37**
Appointments	22	20	**22**
Clinical Treatment	15	20	**21**
Trust Admin/ Policies/ Procedures	11	17	**17**
Other	15	13	**13**

Complaint Category	2015/16	2016/17	**2017/18**
Privacy, Dignity and Wellbeing	9	12	**4**
Access to Treatment or Drugs	9	7	**10**
Restraint	9	4	**2**
Waiting Times	10	3	**17**
Commissioning	0	1	**0**
Consent	1	0	**1**
Integrated Care	1	0	**1**
Staff Numbers			**2**
Total	**362**	**436**	**544**

Data source: NTW

Outcomes of complaints

Within the Trust there is continuing reflection on the complaints we receive, not just on the subject of the complaint but also on the complaint outcome. In 2017/18 we responded to complaints in line with agreed timescales in 89% of cases. Table 7 indicates the numbers of complaints and the associated outcomes for the 3 year reporting period:

Table 7: Number (and percentage) of complaint outcomes 2015/16 to 2017/18

Complaint Outcome	2015/16	2016/17	**2017/18**
Closed – Not Upheld	91 (25%)	135 (31%)	**150 (27%)**
Closed – Partially Upheld	89 (25%)	107 (25%)	**163 (30%)**
Closed – Upheld	76 (21%)	87 (20%)	**80 (15%)**
Comment			**1 (0%)**
Complaint withdrawn	29 (8%)	50 (11%)	**48 (9%)**
Decision not to investigate	3 (1%)	5 (1%)	**3 (1%)**
Still awaiting completion	51 (14%)	34 (8%)	**72 (13%)**
Unable to investigate	23 (6%)	17 (4%)	**27 (5%)**
Total	**362**	**436**	**544**

Data source: NTW

Complaints referred to the Parliamentary and Health Service Ombudsman

If a complainant is dissatisfied with the outcome of a complaint investigation they are given the option to contact the Trust again to explore issues further. However, if they choose not to do so or remain unhappy with responses provided, they are able to refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO).

The role of the PHSO is to investigate complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England.

Outcome of complaints considered by PHSO, as at 31 March 2018 there were 10 cases still ongoing and their current status at the time of writing is as follows:

Table 8: Outcome of complaints considered by the PHSO

Enquiry	4
Draft – partially upheld	2
Draft – not upheld	1
Intention to investigate	3

Data source: NTW/PHSO

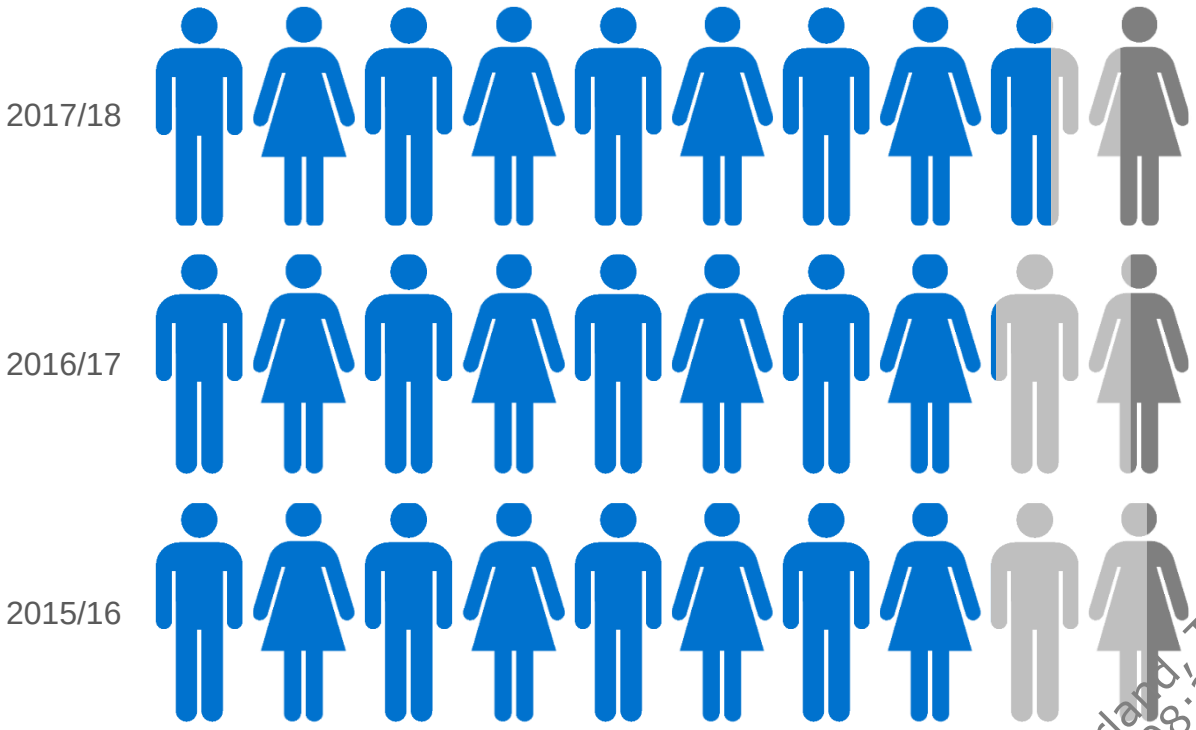
Friends and Family Test – Service Users and Carers

The NHS Friends and Family Test is a national service user and carer experience feedback programme. The Friends and Family Test question asks:

"How likely are you to recommend our service to friends and family if they needed similar care or treatment?"

There are 5 possible answer options ranging from extremely likely to extremely unlikely (with an additional option of 'don't know').

Figure 14: Percentage of respondents who would or would not recommend the services they received to their friends and family 2015/16 to 2017/18



Data source: NTW

During 2017/18, 6,563 responses to the Friends and Family Test question were received which was a 63% increase in responses compared to 2016/17 (4,031 responses received). Of respondents, 87% said they would recommend the service they received (rating of extremely likely or likely), this score has increased compared to 2016/17. Seven percent of respondents indicated they would not recommend the service they received (ratings of extremely unlikely or unlikely) which is a small increase compared to 2016/17.

Points of You Survey

We use the Points of You survey to gather feedback from service users and carers about their experience of our services.

The below Table 9 shows the questions asked in the survey and the results for the period January to March 2018, when we received feedback from approximately 1,200 service users and 500 carers:

Table 9: Points of You responses January to March 2018

Question	Score: (out of ten)
How kind and caring were staff to you?	9.4
Were you encouraged to have your say in the treatment or service received and what was going to happen?	8.5
Did we listen to you?	8.9
If you had any questions about the service being provided did you know who to talk to?	8.7
Were you given the information you needed?	9.2
Were you happy with how much time we spent with you?	8.4
Did staff help you to feel safe when we were working with you?	9.2
Overall did we help?	8.8

Data source: NTW

This data can be displayed by service type, as per Table 10 below:

Table 10: Points of You responses by service type, January to March 2018

	Number of Responses Q4	Q2 - Kind and caring	Q3 - Have your say	Q4 - Listen to you	Q5 - Know who to talk to	Q6 - Information you needed	Q7 - Time we spent with you	Q8 - Feel safe	Q9 - Did we help
Trust	**1729**	**9.4**	**8.5**	**8.9**	**8.7**	**9.2**	**8.4**	**9.2**	**8.8**
Neuro Rehab Inpatients (Acute Medicine)	28	9.6	9.0	9.3	9.3	9.3	8.9	9.7	9.5
Neuro Rehab Outpatients (Acute Outpatients)	158	9.8	9.4	9.6	9.3	9.8	9.3	9.8	9.5
Community mental health services for people with learning disabilities or autism	57	9.6	8.7-	9.0	7.1	8.9	8.4	9.3	8.7

	Number of Responses Q4	Q2 - Kind and caring	Q3 - Have your say	Q4 - Listen to you	Q5 - Know who to talk to	Q6 - Information you needed	Q7 - Time we spent with you	Q8 - Feel safe	Q9 - Did we help
Community-based mental health services for adults of working age	321	9.0	9.0	9.4	9.5	9.2	8.9	9.7	9.5
Community-based mental health services for older people	430	9.7	8.9	9.2	8.8	9.4	8.7	9.5	9.2
Mental health crisis services and health-based places of safety	86	8.7	8.0	8.5	7.8	8.4	7.9	8.4	8.0
Acute wards for adults of working age and psychiatric intensive care units	48	9.1	7.0	7.4	7.3	7.9	7.1	8.1	7.8
Child and adolescent mental health wards	21	9.0	7.1	8.4	9.5	9.4	7.6	8.5	8.4
Forensic inpatient/secure ward	1	10.0	7.5	10.0	10.0	10.0	7.5	10.0	10.0
Long stay/rehabilitation mental health wards for working age adults	36	9.6	8.8	9.0	9.7	9.7	8.5	9.5	9.2
Wards for older people with mental health problems	29	9.4	8.1	8.4	8.5	8.8	8.6	9.3	8.8
Wards for people with learning disabilities or autism	10	9.0	8.5	8.0	10.0	8.9	7.5	8.0	7.5
Children and Young Peoples Community Mental Health Services	156	8.9	8.1	8.5	8.5	9.0	7.9	9.1	7.4
Substance Misuse	153	9.7	8.8	9.0	9.3	9.6	8.5	9.4	9.5
Other	195	9.5	8.0	9.1	9.1	9.5	8.6	9.5	9.2

Data source: NTW

Key:

Score 8-10 (highest score)	Score 6-7.9	Score 4-5.9	Score 2-3.9	Score 1.9-0 (lowest score)

2017/18 Clinical Effectiveness Quality Priority:

Use of the Mental Health Act – Reading of Rights

Target	Staff must remind service users of their rights and the effects of the Mental Health Act (MHA) from time to time, ensuring that staff explain service users' rights to them on admission and routinely thereafter as outlined in the Mental Health Act Code of Practice. We must ensure that patients subject to Community Treatment Orders (CTOs) are read their rights at regular intervals as outlined in the Mental Health Act Code of Practice
Progress	**Met** During 2017/18 the process for recording the reading of rights in our electronic patient record system (RiO) has been reviewed and updated to support practice and to comply with the requirements of the MHA Code of Practice. A communication and engagement plan was developed to support the launch of the new form and to highlight/embed practice requirements to all relevant staff. Compliance reports are currently reviewed at relevant groups across the organisation including the individual Clinical Business Unit Quality Standards Groups. The Mental Health Act dashboard, showing compliance with requirements has been enhanced during the year and planned targets which were set for the year have been exceeded, as below: 1. Record of Rights assessed at section change (Quarter 4) – 86.9% 2. Record of rights assessed at the point of CTO (Quarter 4) – 81.8% 3. Record of Rights (CTO) reviewed in the past 3 months (Quarter 4) – 96.3% Awareness sessions have been delivered throughout the year and an E-Learning package is currently under development along with a 'Rights' poster for both detained and Community Treatment Order service users – this has been circulated for display in relevant areas. It is intended that an evaluation of the impact of these actions will be carried out in 2018/19.

How has the “Use of the Mental Health Act – Reading of Rights” Quality Priority helped support the Clinical Effectiveness Quality Goal of “ensuring the right services are in the right place at the right time to meet all your health and wellbeing needs”?

Underpinned by the organisation’s approach to delivering the Clinical Effectiveness Strategy, we will demonstrate success by delivering improvements in service delivery.

Service Improvement and Developments throughout 2017/18

These are some of the key service improvements and developments that the Trust implemented during 2017/18:

Trustwide:

Chill Out Rooms and Sensory Strategies.

Following the implementation of chill out rooms and sensory strategies on the adult inpatient wards, this has now been extended to older people’s inpatient wards. NTW is leading the way with access on all adult and older people’s wards to sensory techniques and equipment. The chill out rooms provide a space to develop sensory strategies and coping mechanisms. Techniques are also demonstrated using everyday equipment that can be purchased on discharge for example coloured lights.

These spaces can also be used by staff for debrief sessions or to provide a safe, calm environment for carers, particularly on the older people’s organic wards where carers may be distressed following a visit.

New Services

We successfully secured the contract to provide addictions services within HMP Haverigg from 2018.

Working in partnership with Changing Lives on a social impact bond for entrenched rough sleepers, commenced November 2017.

Newcastle / Gateshead

Developing Biopsychosocial formulations in older peoples inpatient units

Staff in the older people’s functional and organic inpatient units across NTW were trained in either the 5Ps plus plan biopsychosocial formulation or the Newcastle model of formulation.

The aim was to enable a more holistic picture of every service user's difficulties and strengths and to use this to guide more individualised person centred care plans. In Newcastle on the functional inpatient units staff try, where possible, to develop the formulation directly with service users as well as with the wider multidisciplinary team in weekly formulation meetings. Goals of admission and individualised care plans are then developed from the information gathered in the formulation. These are done together with service users when they are able to, as well as with the multidisciplinary team.

An evaluation of the 5Ps training on two of NTW's units found significant changes in staff empathy towards the service user and a significant increase in their understanding of and feelings of confidence about working with that person.

On the organic unit in Newcastle where many service users are less able to engage in developing a formulation the multidisciplinary team meet to develop a biopsychosocial formulation based on the Newcastle model. This looks at what needs might be being expressed by a person's behaviour. Information is also gathered from family and carers and an individualised needs led care plan developed to try to meet those needs in the least restrictive way. The care plan is reviewed during the person's stay on the unit and amended as necessary. It is shared with community staff and families and with care home staff at discharge. This helps to ease the transition from hospital to community and to reduce readmissions.

Psychiatric Liaison Services

Working in partnership with both Newcastle and Gateshead CCGs, there is now 24/7 service provision in both Newcastle's Royal Victoria Infirmary (RVI) and Gateshead's Queen Elizabeth Hospital (QE) to enable those presenting to an acute hospital to receive assessment and appropriate ongoing support for mental health difficulties.

Sunderland

Implementation of a Multi-Disciplinary Support Model in the Organic Older People's Pathway in the South.

The Trust has implemented a multi-disciplinary support model in the organic older persons pathway in the South to enhance inter agency working with social services to ensure appropriate and timely admissions and discharges to and from our organic wards. The model has delivered tangible benefits in reducing bed occupancy level on the wards and out of locality placements improving the care and experience for service users, carers and families. The learning from the success of the scheme has been shared, and has elicited similar improvements in the older people's functional pathway.

Northumberland

Within the Northumberland Locality we have been working jointly with our primary care colleagues to develop an e-referral form to be utilised by our GP practices. The aspiration

is that NTW will be able to provide bespoke advice and guidance and respond to GPs within 48 hours of referral.

Psychiatric Liaison Services

Working in partnership with Northumberland CCGs, there is now 24/7 service provision in Northumbria Specialist Emergency Care Hospital to enable those presenting to an acute hospital to receive assessment and appropriate ongoing support for mental health difficulties.

South Tyneside

Delivering integration through the co-location of Mental Health and Social Services.

The South Tyneside community adult mental health team and South Tyneside local authority have been co-located at the Jane Palmer Community Hospital since June 2017. The co-location has brought opportunities for joint, integrated working, to ensure that coordinated and less fragmented care packages addressing mental, physical and social health are developed and wrapped around the service user. The close proximity allows the services to liaise more efficiently about referrals, ensuring that the most appropriate service completes the assessment and that the information is shared with the referring agency. As a result there has been a reduction in the duplication of assessments, which is beneficial for the service user.

North Tyneside

The team is working with the Local Authority on fast track training for Mental Health Social Workers (Think Ahead programme) who are working within the community mental health teams under a more integrated model.

New Care Models in Tertiary Mental Health Services

The Trust submitted an application as a secondary mental health provider to manage care budgets for adult secure mental health services in partnership with Tees, Esk and Wear Valleys NHS Foundation Trust. This is part of a process aimed at admission avoidance, shorter lengths of stay, and repatriating service users from out of area placements.

NICE Guidance Assessments Completed 2017/18

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. During 2017/18 the Trust undertook the following assessments against appropriate guidance to further improve the quality of services provided.

Table 11: NICE Guidance Assessments Completed in 2017/18

Ref	Topic Details / Objective	Compliance Status/ main actions
NG 51	Sepsis: recognition, diagnosis and early management	Partial Compliance. Final Audit scheduled for April 2018 to review amendments made to policies and Sepsis awareness
NG 53	Transition between inpatient mental health settings and community or care home settings	Compliant to guidance There is an action plan in place with some quality improvements.
NG55	Harmful sexual behaviour among children & young people	Compliant to guidance. There is an action plan in place with some quality improvements
CG28	Depression in children and young people: Identification and management in primary, community and secondary care	Partial Compliance. Clinical audit planned to reassess
QS 97	Drug allergy: diagnosis and management	Partial Compliance. Policy has been amended. Final action around Electronic prescribing
QS102	Bipolar disorder, psychosis and schizophrenia in children and young people	Partial Compliance Actions include systems to improve monitoring of the physical health of children prescribed antipsychotics.
QS 133	Children's Attachment	Partial Compliance. Actions in place around improvements to recording and specialist training and assessments
QS 113	Healthcare-associated infections	Full compliance- Action plan complete April 2017
PH 48	Smoking Cessation	Full compliance- Action plan complete April 2017
PH 52	Managing Overweight and obesity in adults	Full compliance- Action plan complete May 2017
QS121	Antimicrobial Stewardship	Full compliance- Action plan complete June 2017
NG 15	Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use	Full compliance- Action plan complete June 2017

Ref	Topic Details / Objective	Compliance Status/ main actions
QS 90	Urinary tract infections in adults	Full compliance- Action Plan complete June 2017
QS140	Transition from children's to adults' services	Full compliance at Baseline assessment June 2017
QS 11	Quality Standard for Alcohol dependence	Full compliance Action plan May 2017
QS 120	Medicines Optimisation	Full compliance- Action Plan complete July 2017
CG 42	Dementia	Full compliance- Action Plan complete Sept 2017
QS 86	Falls in older people: assessment after a fall and preventing further falls	Full compliance- Action plan complete March 2018

Data source: NTW

Part 2c

Mandatory Statements relating to the Quality of NHS Services Provided

Review of Services

During 2017/18 the Northumberland, Tyne and Wear NHS Foundation Trust provided and/or sub-contracted 179 NHS Services.

The Northumberland, Tyne and Wear NHS Foundation Trust have reviewed all the data available to them on the quality of care in all 179 of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 100 per cent of the total income generated from the provision of relevant health services by the Northumberland, Tyne and Wear NHS Foundation Trust for 2017/18.

Participation in clinical audits

During 2017/18, 7 national clinical audits covered relevant health services that Northumberland, Tyne and Wear NHS Foundation Trust provides.

The national clinical audits eligible for participation by Northumberland, Tyne and Wear NHS Trust during 2017/18 are shown in Table 12.

The Trust participated in 100% of national clinical audits which Northumberland, Tyne and Wear NHS Foundation Trust were eligible to participate in during the 2017/18 period.

The national clinical audits that Northumberland, Tyne and Wear NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed in Table 13 below alongside the number of cases submitted to each audit, and as a percentage of the number of registered cases required by the terms of that audit if applicable.

Table 12: National Clinical Audits 2017/18

1	POMH-UK Topic 17a: Use of depot / long-acting anti-psychotic injections for relapse prevention
2	POMH-UK Topic 15b: Prescribing Valproate for Bipolar Disorder
3	Specialist Rehabilitation for Patients with Complex Needs following Major Injury: Response Times for Assessment and Admission, Functional Gain and Cost-Efficiency
4	National Clinical Audit of Anxiety & Depression (NCAAD)
5	National Clinical Audit of Psychosis (NCAP)
6	CCQI Early Intervention in Psychosis Network: Self-Assessment Audit 2017-2018
7	POMH-UK Topic 16b: Rapid Tranquilisation

Data source: NTW

Table 13: Cases submitted for National Clinical Audits 2017/18

National Clinical Audits 2017/18		Cases submitted	Cases required	%
1	POMH-UK Topic 17a: Use of Depot / long-acting anti-psychotic injections for relapse prevention (CA-17-0008)	Sample provided: 220 POMH-UK report due July 2018	-	-
2	POMH-UK Topic 15b: Prescribing Valproate for Bipolar Disorder (CA-17-0011)	Sample provided: 254 POMH-UK report due July 2018	-	-
3	Specialist Rehabilitation for Patients with Complex Needs following Major Injury: Response Times for Assessment and Admission, Functional Gain and Cost-Efficiency (CA-17-0018)	Sample provided: Ward 1: 35 Wards 3 & 4: 63 Total: 98 Final report and action plan September 2017	All Patients: 98	100%
4	National Clinical Audit of Psychosis (NCAP) (CA-17-0017)	Sample provided per CCG as follows: South Tyneside: 50 Sunderland: 49 Newcastle: 50 Gateshead: 50 North Tyneside: 51 Northumberland: 50 Total: 300 National Report due June 18	300	100%
5	CCQI Early Intervention in Psychosis Network: Self-Assessment Audit 2017-2018 (CA-17-0023)	Sample provided per EIP Service as follows: South Tyneside: 68 Sunderland: 107 Newcastle: 139 Gateshead: 105 North Tyneside: 68 Northumberland: 79 Total: 566 National Report due July 18	566	100%

Data source: NTW

The reports of 4 national clinical audits were reviewed by the provider in 2017/18, and Northumberland, Tyne and Wear NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Table 14: Actions to be taken in response to National Clinical Audits

Project		Actions
1	Topic 16a: Rapid Tranquilisation (CA-16-0040)	Rapid Tranquilisation policy/e-learning package updated
2	Topic 7e: Monitoring of Patients Prescribed Lithium (CA-16-0045)	Awareness raising via Medicines Management Committee Newsletter and updated checklist put in place.

Project		Actions
3	Topic 11c: Prescribing antipsychotic medication for people with dementia (CA-16-0046)	Review of existing RiO initiation, prescribing tools, electronic updates and prescribing forms.
4	Specialist Rehabilitation for Patients with Complex Needs following Major Injury: Response Times for Assessment and Admission, Functional Gain and Cost-Efficiency (CA-16-0084)	Appointment of an additional consultant, and the increased session support provided by another, have now addressed issues

Data source: NTW

Additionally, 104 local clinical audits were reviewed by the provider in 2017/18 and the details can be found in Appendix 2.

Research

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Northumberland, Tyne and Wear NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 1,661.

This is a 22% increase on last year's recruitment figure and is above the year on year average (10% increase since 2010/2011).

The Trust was involved in 75 clinical research studies in mental health, dementia, learning disability and neuro-rehabilitation related topics during 2017/18, of which 52 were National Institute for Health Research (NIHR) portfolio studies.

This is a 4% increase from last year's figure and is slightly below the year on year average (7% increase since 2010/2011).

During 2017/18, 50 clinical staff employed by the trust participated in ethics committee approved research.

We have continued to work closely with the NIHR Clinical Research Networks North East and North Cumbria Local Clinical Research Network to support national portfolio research and have achieved continued success with applications for large-scale research funding in collaboration with Newcastle and Northumbria Universities.

According to the latest NIHR Clinical Research Network annual league tables NTW are the 3rd most research active mental health and disability trust based on number of active research studies

Goals agreed with commissioners

Use of the Commissioning for Quality & Innovation (CQUIN) framework

The CQUIN framework aims to embed quality improvement and innovation at the heart of service provision and commissioner-provider discussions. It also ensures that local quality improvement priorities are discussed and agreed at board level in all organisations. It

enables commissioners to reward excellence by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

A proportion of Northumberland, Tyne and Wear NHS Foundation Trust income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between Northumberland, Tyne and Wear NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at www.ntw.nhs.uk.

For 2017/18, 6.4m of Northumberland, Tyne and Wear NHS Foundation Trust's contracted income was conditional on the achievement of these CQUIN indicators (£6.4m in 2016/17).

CQUIN Indicators

All CQUIN requirements for 2017/18 are fully delivered for quarters 1 to 3 and pending agreement for quarter 4. A summary of CQUIN indicators for 2017/18 and 2018/19 is shown in Table 15 to Table 17 below, with a summary of the actions completed for each indicator.

Note that the CQUIN indicators are either mandated or developed in collaboration with NHS England and local Clinical Commissioning Groups (CCGs), the current CQUIN programme spans two years 2017/18 and 2018/19. The range of CQUIN indicators can vary by commissioner, reflecting the differing needs and priorities of different populations.

Table 15: CQUIN Indicators to improve Safety

CQUIN Indicators to improve Safety
Reducing Restrictive Practices within adult low and medium secure inpatient services
Our Recovery & Engagement Lead Nurse continued to work with service users, carers and Peer Support Staff to embed the Recovery College and enable development of co-production. This has provided a platform for service user and carer voice in relation to service delivery. All wards / teams have attended Talk 1st cohort training. Positive & Safe dashboard data is available to all staff within secure services and is now analysed by the services at local groups and within service user meetings. Staff have undertaken training to ensure they are aware of their role in supporting service users to have choice, involvement and participation in planning their day, this has improved staff and service user relations. Changes include establishing mini shops and the café cart continues to be a huge success giving service users enhanced access to confectionery, various barista coffees and choice of sandwiches, cakes etc. that are made by service users and sold to fund the delivery of this user-led service.

CQUIN Indicators to improve Safety
Improving Staff Health & Wellbeing
The Trust was required to achieve a 5% point improvement in two of the three NHS annual staff survey questions on health and wellbeing, musculoskeletal problems (MSK) and stress. Although we did not achieve the required improvement on our previous result we were significantly above the national average response rate on two questions (health and wellbeing, and stress) and matched the national average on MSK. The trust achieved all of the requirements of the health food survey and have already met some of the 18/19 requirements. This includes; • prohibiting price promotions, advertisements on NHS premises, and locating at checkouts of sugary drinks and foods high in fat, sugar or salt • Ensuring that healthy options are available at any point including for those staff working night shifts • As of 1 January 2017 the trust only sells Diet, Skinny, Zero, Sugar Free etc. versions of canned and bottled drinks • All pre-packed sandwiches and other savoury meals contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g. 73.5% of frontline workers received the 'flu vaccine (70% target).
Improving physical healthcare to reduce premature mortality in people with Severe Mental Illness
Inpatient Wards, EIP teams and Community Mental Health Teams worked to ensure service users with Severe Mental Illness have been screened for cardiometabolic factors in line with the Lester Tool recommendations and received an appropriate intervention when required. To ensure that safe care is provided to service users who are receiving care from both primary care and the Trust, shared care agreements are now in place detailing organisational responsibility for care.
Preventing ill health by risky behaviours – alcohol and tobacco
The Trust has developed systems to ensure all inpatient service users are screened in relation to smoking and alcohol consumption. If required NTW has offered a brief intervention and or referral to specialist alcohol and smoking cessation services.

Table 16: CQUIN Indicators to improve Patient Experience

CQUIN Indicators to improve Service User & Carer Experience
Health & Justice – Patient Experience
The Points of You feedback survey has been rolled out in Liaison and Diversion services with work ongoing to improve the response rates. Regular meetings & drop in sessions have been set up and Q3 saw the introduction of Coram Voice which has been embedded positively into the service and will support in the process of young people giving feedback as well as feeding back to the young people about changes to service. Work is ongoing in relation to the accessible information standard with this being regularly reviewed and updated where necessary.

Table 17: CQUIN Indicators to improve Clinical Effectiveness

CQUIN Indicators to improve Clinical Effectiveness
Development of Recovery Colleges for adult medium and low secure inpatients
A variety of courses are provided for service users with regular review of how they have engaged & enjoyed the courses. Of the service users that enrolled from Northgate we had a 90% attendance rate and from St Nicholas hospital we had an 80% attendance rate.
Transitions out of Children and Young People's Community Mental Health Services
We have developed and refined the transitions practice guidance note for young people. A "moving on" pack has been created and this will be rolled out. An audit of those transitioning from the mental health care pathway was completed in Q4 and has identified that all young people were involved in their transition planning however there is further work to do on the involvement of parents and carers and in the consideration of wider issues such as housing and employment.
Children and Young People's Inpatient Transitions
All 5 areas have been achieved to date: • Plan for discharge/transition at the point of admission • Involve the young person in all discussions and decisions (as much as possible/appropriate) • Involve the family/carers in all discussions and decisions (as much as possible/appropriate) • Liaise early with other agencies • Numbers of delayed discharges: – this has been tracked on a monthly and internally weekly basis and work on planning for discharge at the point of admission is well embedded. Action plans to support timely discharge were evident in all cases where a delay had been recorded.
Specialised Services Discharge & Resettlement
Systems are now in place to record and report estimated discharge dates in Forensic services. Delayed discharges are regularly monitored and a system is in place to flag when service users are approaching their target discharge dates to enable monitoring and review prior to becoming a delay. Weekly meetings are held to discuss and review complex cases. A small fund has been set up to support discharges that may otherwise be delayed due to issues relating to small items of expenditure (for example, a service user requiring a fridge).
Improving services for people with mental health needs who present to A&E
NTW has worked in partnership with Acute Trust colleagues to identify service users who would benefit from a multi-agency care plan with the aim of reducing the number of A&E attendances. This has successfully reduced attendance for this cohort of service users by more than 20% in all localities.

Data source (Table 15 to Table 17): NHS England and NTW

Statements from the Care Quality Commission (CQC)

Northumberland, Tyne and Wear NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions and therefore licensed to provide services. The Care Quality Commission has not taken

enforcement action against Northumberland, Tyne and Wear NHS Foundation Trust during 2017/18.

Northumberland, Tyne and Wear NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2017/18. We have, however participated in a number of inspections and Mental Health Act visits as follows:

In April 2017 Northumberland, Tyne and Wear NHS Foundation Trust participated in a focused CQC Mental Health Act visit considering assessment, transport and admission to hospital.

In May 2017 Northumberland, Tyne and Wear NHS Foundation Trust participated in a CQC focused inspection visit to two core services (acute wards for adults of working age/psychiatric intensive care units, and long stay rehabilitation mental health wards for work working age adults. The publication of these reports are awaited.

In October 2017, Northumberland, Tyne and Wear NHS Foundation Trust participated in a system-wide thematic inspection focusing on mental health services for children and young people across South Tyneside.

The Care Quality Commission conducted a comprehensive inspection of Northumberland, Tyne and Wear NHS Foundation Trust in 2016 and rated the Trust as “Outstanding”.

Northumberland, Tyne and Wear NHS Foundation Trust intends to take the following actions to address the conclusions or requirements reported by the CQC:

- We will ensure that care plans in wards for older people are more personalised, and
- We will reduce the use of mechanical restraint in wards for children and young people.

Care Quality Commission

Last rated
1 September 2016

Northumberland, Tyne and Wear NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good
Child and adolescent mental health wards	Requires improvement	Good	Good	Good	Good	Good
Community mental health services for people with learning disabilities or autism	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆
Community-based mental health services for adults of working age	Good	Outstanding ☆	Outstanding ☆	Good	Good	Outstanding ☆
Community-based mental health services for older people	Good	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆
Forensic inpatient/secure wards	Good	Good	Good	Good	Good	Good
Long stay/rehabilitation mental health wards for working age adults	Good	Good	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Good	Good
Specialist community mental health services for children and young people	Good	Outstanding ☆	Outstanding ☆	Good	Good	Outstanding ☆
Substance misuse services	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Requires improvement	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆

External Accreditations

The Trust has gained national accreditation for the quality of services provided in many wards and teams.

78% of adult and older people's mental health wards have achieved the Accreditation for Inpatient Mental Health Services (AIMS).

100% of the adult forensic medium and low secure wards have been accredited by the Quality Network for Forensic Mental Health Services.

87% of children and young people's wards have been accredited by the Quality Network for Inpatient Children and Adolescent Mental Health Services (CAMHS).

Table 18: Current clinical external accreditations (March 2018)

External Accreditation	Ward/Department	Location
Accreditation for Inpatient Mental Health Services (AIMS)	Bluebell Court (Rehab)	St George's Park
	Embleton	St George's Park
	Kinnersley (Rehab)	St George's Park
	Newton (Rehab)	St George's Park
	Warkworth	St George's Park
	Collingwood	Campus for Ageing and Vitality
	Elm House (Rehab)	Bensham
	Fellside	Queen Elizabeth Hospital
	Lamesly	Queen Elizabeth Hospital
	Lowry	Campus for Ageing and Vitality
	Willow View (Rehab)	St Nicholas Hospital
	Mowbray (OP)	Monkwearmouth Hospital
	Roker (OP)	Monkwearmouth Hospital
	Akenside (OP)	Campus for Ageing and Vitality
	Hauxley (OP)	St George's Park
	Aldervale (Rehab)	Hopewood Park
	Beckfield (PICU)	Hopewood Park
	Clearbrook (Rehab)	Hopewood Park
	Longview	Hopewood Park
	Shoredrift	Hopewood Park
	Springrise	Hopewood Park

External Accreditation	Ward/Department	Location
	Cleadon (OP)	Monkwearmouth Hospital
Quality Network for Forensic Mental Health Services (QNFMHS)	Bamburgh Clinic	St Nicholas Hospital
	Bede Ward	St Nicholas Hospital
	Kenneth Day Unit	Northgate Hospital
Quality Network for Inpatient CAMHS (QNIC)	Stephenson	Ferndene
	Fraser	Ferndene
	Riding	Ferndene
	Redburn	Ferndene
	Alnwood	St Nicholas Hospital
Quality Network for Community CAMHS (QNCC)	Newcastle & Gateshead CYPS	Benton House
	Northumberland CYPS	Villa 9, Northgate Hospital
	South Tyneside and Sunderland CYPS	Monkwearmouth Hospital
ECT Accreditation Scheme (ECTAS)	Hadrian Clinic	Campus for Ageing and Vitality
	Treatment Centre	St George's Park
Psychiatric Liaison Accreditation Network (PLAN)	Self Harm and Liaison Psychiatry Service	Newcastle
	Northumberland Liaison Psychiatry and Self Harm Team	Northumberland
	Psychiatric Liaison Team	Sunderland
Quality Network for Perinatal Mental Health Services (QNPMH)	Beadnell Mother and Baby Unit	St George's Park
Quality Network for Eating Disorders (QED)	Ward 31a	Royal Victoria Infirmary
Home Treatment Accreditation Scheme (HTAS)	Newcastle Crisis Resolution and Home Treatment Team	Ravenswood Clinic
	Sunderland Crisis Resolution and Home Treatment Team	Hopewood Park
	South Tyneside Crisis Resolution and Home Treatment Team	Palmers Community Hospital
	Gateshead Crisis Resolution and Home Treatment Team	Tranwell Unit
	Northumberland Crisis Resolution and Home Treatment Team	St George's Park

Data source: NTW

Data Quality

Good quality information underpins the effective delivery of care and is essential if improvements in quality of care are to be made. The Trust has already made extensive improvements in data quality. During 2017/18 the Trust will build upon the actions taken to ensure that we continually improve the quality of information we provide.

Table 19: Actions to be taken to improve data quality

Clinical Record Keeping	We will continue to monitor the use of the RiO clinical record system, learning from feedback and incidents, measuring adherence to the Clinical Records Keeping Guidance and highlighting the impact of good practice on data quality and on quality assurance recording. We will continue to improve and develop the RiO clinical record system in line with service requirements.
NTW Dashboard development	We will continue to review the content and format of the existing NTW dashboards, to reflect current priorities including the development and monitoring of new and shadow metrics that are introduced in line with national requirements. We will continue to develop the Talk 1st and Points of You dashboards.
Data Quality Kitemarks	We will continue to roll out the use of data quality kitemarks in quality assurance reports further.
Data Quality Group	We will implement a Trust wide data quality group.
Mental Health Services Dataset (MHSDS)	We will continue to understand and improve data quality issues and maintain the use of national benchmarking data. We will seek to gain greater understanding of the key quality metric data shared between MHSDS, NHS Improvement and the Care Quality Commission. We will improve our data maturity index score and understand areas where improvement is required.
Consent recording	We will continue to redesign the consent recording process in line with national guidance and support the improvement of the recorded consent status rates.
ICD10 Diagnosis Recording	We will continue to increase the level of ICD10 diagnosis recording across community services.
Mental Health Clustering	We will increase the numbers of clinicians trained in the use of the Mental Health Clustering Tool and improve data quality and data completeness, focusing on issues such as cluster waiting times analysis, casemix analysis, national benchmarking and HoNOS 4-factor analysis to support the consistent implementation of outcomes approaches in mental health.
Contract and national information requirements	We will continue to develop quality assurance reporting to commissioners and national bodies in line with their requirements.
Quality Priorities	We will develop a robust reporting structure to support the quality priorities relating to waiting times and improving inpatient care.
Outcome Measures	We will enhance the current analysis of outcome measures focusing on implementing a system for reporting information back to clinical teams.

	We will also focus on Improving Access to Psychological Therapies (IAPT) outcomes to ensure preparedness for the introduction of IAPT outcomes based payment in 2018-19.
Sexual orientation monitoring information standard	We will work towards meeting the requirements of the sexual orientation monitoring standard.
Electronic Staff Record (ESR)	We will develop data quality monitoring of ESR data and develop action plans to address issues identified.

Data source: NTW

North East Quality Observatory (NEQOS) Retrospective Benchmarking of **2016/17** Quality Account Indicators

The North East Quality Observatory System (NEQOS) provides expert clinical quality measurement services to many NHS organisations in the North East.

NTW once again commissioned NEQOS to undertake a benchmarking exercise, comparing the Trust's Quality Account 2016/17 with those of 56 other NHS Mental Health and Disability organisations. A summary of frequent indicators found in all Quality Accounts has been provided in Table 20 below:

Table 20: Nationally available Quality Account indicators for 2016/17

Quality Account Indicators		Target	Average	Peer*	**NTW**	Number of Trusts
1	Staff who would recommend the trust to their family/friends (%)	-	3.64	3.65	**3.87**	56
2	Admissions to adult urgent care wards gatekept by Crisis Resolution Home Treatment Teams (%) Q4 16/17	95%	98.8	98.5	**99.5**	55
3	Inpatients receiving follow up contact within 7 days of discharge (%) Q4 16/17	95%	96.8	96.9	**97.6**	55
4	Incidents of severe harm/death (%)	-	1.1	1.6	**1.5**	53
5	CPA formal review within 12 months (per March 2017)	95%	82.7	80.1	**87.5**	49
6	EIP patients treated within 2 weeks March 2017	50%	73.7	72.3	**85.3**	54

Data source: North East Quality Observatory

*Table 20 includes data for a peer group of similar trusts: Birmingham and Solihull Mental Health NHS Foundation Trust; Cheshire and Wirral Partnership NHS Foundation Trust; Lancashire Care NHS Foundation Trust; North East Essex Mental Health NHS Trust; Oxford Health NHS Foundation Trust; South London and Maudsley NHS Foundation Trust; Sussex Partnership NHS Foundation Trust; and Tees, Esk and Wear Valleys NHS Foundation Trust

Learning from Deaths

The Serious Incident Framework (2015) forms the basis for the Trusts Incident Policy which guides/informs the organisation about reporting, investigating and learning from incidents including deaths. The Learning from Deaths policy approved by the organisation in September 2017 supports and enhances this learning and investigation process. We report all deaths of people with learning disabilities who are service users to the Learning Disabilities Mortality Review (LeDeR) Programme for further investigation, from which we have received no feedback to date.

During 2017/18 1,037 of Northumberland, Tyne and Wear NHS Foundation Trust's patients were reported to have died, with the majority of these being natural deaths in nature.

This comprised the following number of deaths which occurred in each quarter of that reporting period: 213 in the first quarter; 241 in the second quarter; 280 in the third quarter; 303 in the fourth quarter.

Of the 1,037 deaths, and in line with our Incident Policy – NTW(O)05 and our Learning From Deaths Policy – NTW(C)12, 225 of these deaths would fit the criteria for further investigation.

Of the 225 deaths subject to an investigation, 57 have been subject to a mortality case record review and 168 have been or are subject to a level 1 (After Action Review) or level 2 (full serious incident) investigation.

By 11 April 2018, the following investigations were carried out and completed in each quarter, 47 in the first quarter; 56 in the second quarter; 73 in the third quarter. For the 4th quarter of the year and acknowledging the 60 working day timescale to investigate 49 deaths requiring investigation in the fourth quarter, these will be completed in line with appropriate policy, and if the timescales cannot be achieved an appropriate extension will be agreed with Commissioners.

Eight representing 0.8% of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 2 representing 0.94% for the first quarter;
- 1 representing 0.41% for the second quarter;
- 3 representing 1.07% for the third quarter;
- 2 representing 0.67% for the fourth quarter.

These numbers have been estimated using the findings from Serious Incident investigations. Where there has been either a root or contributory cause found from the incident review then this has been used as a way to determine if the patient death may have been attributable to problems with care provided. There is currently no agreed or validated tool to determine whether problems in the care of the patient contributed to a death within mental health or learning disability services so we are using this approach until

such a tool becomes available. This means that currently mental health and learning disability organisations are using differing ways of assessing this. The Royal College of Psychiatrists is developing a tool which NTW anticipates adopting in the future.

Over the last twelve months our investigations have identified five main areas of **learning**:

Risk Assessment

When looking at cases it has been identified that when assessing the risk of the patient this has been underscored. Also risks identified at assessment have not been included into a risk management plan. In some investigations past risk has not been considered when developing a new risk management plan.

Trust wide risk training has been updated and added to following investigation findings, looking at “Harm to Others” training and updating suicide risk training

Physical Health

The management of problems relating to physical health conditions has been identified in several cases reviewed and covers policy’s not being followed and awareness of clinical symptoms. This is linked to the correct management of diabetes and the correct prescribing of anti-psychotic medication.

A full learning programme in relation to diabetic management and clinical management has been produced in conjunction with practice guidance notes to support. A programme of audit in relation to the use of Acuphase medication was commissioned and actions have come out of this to support learning and change practice.

CAS alerts and learning bulletins have also been actioned to raise staff awareness.

Prescribing of Medication

Lack of understanding about certain drugs prescribed and their possible side effects and the awareness of the potential for misuse of prescribed drugs by patients.

The use of emergency drugs for patients prescribed or misusing drugs which can save lives and how we teach patients to use these emergency drugs for themselves.

CAS alerts, articles, Key Cards and Safety Bulletins have been used to raise awareness and training for staff on inpatients and training for patients provided with such drugs.

Record Keeping Standards

This is a theme/issue that is often picked up as an incidental finding as part of any investigation, and is about records not being completed properly, accurately and within a timely fashion.

Regular audit programmes, supervision and case note management supervision is ongoing.

Carers’ Support

Investigations have identified that carers fatigue is not always recognized and acted upon, and carers' are not always used to get the best outcome from an assessment.

Staff engaged in a trust wide Rapid Process Improvement Workshop over a week in January 2018 to specifically address the "Getting To Know You" process which is integral to the patient's pathway to support carers and families.

Dissemination of Learning

Learning has been both trust wide and individual/team specific and the trust uses a variety of methods to share the learning across the organisation. This includes discussing the learning within team meetings, learning groups and individual supervision of staff. The trust has several newsletters which focus on learning, and a Central Alert System which is used when a message is so important it needs to go across all the organisation very quickly.

Making sure the learning becomes part of practice within the organisation and across the organisation is done in several different ways. The organisation has a variety of audit programmes running which will check if the learning from deaths is put into practice. Changes made from learning are introduced into policies which are regularly reviewed. Training programmes are changed and updated following learning from incident investigation findings. Teams have learning at the top of their agenda for meetings to ensure awareness raising is constantly maintained and becomes part of everyday culture. Learning groups use incident findings to inform their agendas to check out staffs understanding of learning and the impact on their service areas.

NTW has introduced a formal Learning and Improvement Group to monitor all of the above and evaluate the impact of actions identified from incident and complaint investigations.

We will commence reporting the number of case record reviews or investigations completed in-year which related to deaths during the previous year from 2018/19.

NHS Number and General Medical Practice Code Validity

Northumberland, Tyne and Wear NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data for April 2017 to March 2018.

The percentage of records in the published data- which included the patient's valid NHS number was:

99.6% for admitted patient care; and 99.5% for outpatient care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

99.8% for admitted patient care; and 99.8% for outpatient care.

Information Governance Toolkit attainment

The Northumberland, Tyne and Wear NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 75% and was graded green (satisfactory).

Clinical Coding error rate

Northumberland, Tyne and Wear NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

Performance against mandated core indicators

The mandated indicators applicable to Northumberland, Tyne and Wear NHS Foundation Trust are as follows:

The percentage of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period (data governed by a national definition)

The Northumberland, Tyne and Wear NHS Foundation Trust considers that this data is as described for the following reason - we have established, robust reporting systems in place through our electronic patient record system (RiO) and adopt a systematic approach to data quality improvement.

The Northumberland, Tyne and Wear NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services by ensuring clinicians are aware of their responsibilities to complete these reviews.

Table 21: 7 day follow up data 2015/16 to 2017/18 (higher scores are better)

7 day follow up %	2015/16				2016/17				**2017/18**			
	Q1	Q2	Q1	Q2	Q1	Q2	Q1	Q2	**Q1**	**Q2**	**Q3**	**Q4**
NTW	99.1%	98.5%	99.1%	98.5%	99.1%	98.5%	99.1%	98.5%	**96.0%**	**97.5%**	**97.4%**	**97.7%**
National Average	97.0%	96.8%	97.0%	96.8%	97.0%	96.8%	97.0%	96.8%	**96.7%**	**96.7%**	**95.4%**	**95.5%**
Highest national	100%	100%	100%	100%	100%	100%	100%	100%	**100%**	**100%**	**100%**	**100%**
Lowest national	88.9%	83.4%	88.9%	83.4%	88.9%	83.4%	88.9%	83.4%	**71.4%**	**87.5%**	**69.2%**	**68.8%**

Data source: NHS England

The percentage of admissions to acute wards for which the Crisis Home Treatment Team acted as a gatekeeper during the reporting period (data governed by a national definition)

The Northumberland, Tyne and Wear NHS Foundation Trust considers that this data is as described for the following reasons - we have established, robust reporting systems in place through our electronic patient record system (RiO) and adopt a systematic approach to data quality improvement.

The Northumberland, Tyne and Wear NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services by closely monitoring this requirement and quickly alerting professionals to any deterioration in performance.

Table 22: Gatekeeping data 2015/16 to 2017/18 (higher scores are better)

Gate-Keeping %	2015/16		2016/17						2017/18			
	Q2	Q3	Q2	Q3	Q2	Q3	Q2	Q3	**Q1**	**Q2**	**Q3**	**Q4**
NTW	100%	100%	100%	100%	100%	100%	100%	100%	**99.8%**	**100%**	**100%**	**99.7%**
National Average	97.0%	97.4%	97.0%	97.4%	97.0%	97.4%	97.0%	97.4%	**98.7%**	**98.6%**	**98.5%**	**98.7%**
Highest national	100%	100%	100%	100%	100%	100%	100%	100%	**100%**	**100%**	**100%**	**100%**
Lowest national	48.5%	61.9%	48.5%	61.9%	48.5%	61.9%	48.5%	61.9%	**88.9%**	**94.0%**	**84.3%**	**88.7%**

Data source: NHS England

The score from staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends

The Northumberland, Tyne and Wear NHS Foundation Trust consider that this data is as described for the following reasons – this is an externally commissioned survey.

The Northumberland, Tyne and Wear NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services by continuing to hold multidisciplinary staff engagement sessions at Trust and local levels regarding the results of the staff survey and identifying actions for improvement.

"If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation"

Table 23: NHS staff survey data (question 21d)

% Agree or Strongly Agree	2015	2016	**2017**
NTW %	65%	72%	**68%**
National Average %	69%	69%	**70%**
Highest national %	93%	95%	**93%**
Lowest national %	37%	45%	**42%**

Data source: Survey Coordination Centre

‘Patient experience of community mental health services’ indicator score with regard to a patients experience of contact with a health or social care worker during the reporting period

The Northumberland, Tyne and Wear NHS Foundation Trust considers that this data is as described for the following reasons – this is an externally commissioned survey.

The Northumberland, Tyne and Wear NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services by constantly engaging with service users and carers to ensure we are responsive to their needs and continually improve our services.

Table 24: Community Mental Health survey scores, 2015 to 2017

Health and social care workers	2015	2016	**2017**
NTW	7.6	7.9	**7.8**
Compared with other Trusts	About the Same	About the Same	**About the Same**

(score out of 10, higher are better)

Data source: CQC

The number and, where available the rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death (data governed by a national definition)

The Northumberland, Tyne and Wear NHS Foundation Trust considers that this data is as described for the following reasons – this is data we have uploaded to the National Reporting and Learning System (NRLS).

The Northumberland, Tyne and Wear NHS Foundation Trust has taken the following actions to improve this rate/number/percentage, and so the quality of its services by ensuring all serious Patient Safety Incidents are robustly investigated and lessons shared throughout the organisation (including the early identification of any themes or trends).

Table 25: Patient Safety Incidents, National Reporting and Learning System

Indicator	Performance	2015/16 Q1-Q2	2015/16 Q3-Q4	2016/17 Q1-Q2	2016/17 Q3-Q4	**2017/18 Q1-Q2**	**2017/18 Q3-Q4**
Number of PSI reported (per 1,000 bed days)	NTW	38.6	37.2	48.5	51.6	**42.7**	
	National average	38.6	38.3	42.1	41.5	**48.2**	
	Highest national	83.7	85.1	89.0	88.2	**126.5**	
	Lowest national*	0	14.0	10.3	11.2	**16.0**	
Severe PSI (% of incidents reported)	NTW	0.4%	0.7%	0.8%	0.5%	**0.4%**	
	National average	0.3%	0.3%	0.3%	0.3%	**0.3%**	
	Highest national	2.5%	2.3%	2.9%	1.8%	**2.0%**	
	Lowest national*	0.0%	0%	0%	0%	**0%**	
PSI Deaths	NTW	0.9%	0.7%	0.8%	1.0%	**0.5%**	
	National average	0.8%	0.8%	0.8%	0.8%	**0.7%**	
	Highest national	3.2%	5.2%	10.0%	3.8%	**3.4%**	

Indicator	Performance	2015/16 Q1-Q2	2015/16 Q3-Q4	2016/17 Q1-Q2	2016/17 Q3-Q4	**2017/18 Q1-Q2**	**2017/18 Q3-Q4**
(% of incidents reported)	Lowest national*	0.0%	0.1%	0.1%	0%	**0%**	

Data source: NHS Improvement

*note that some organisations report zero patient safety incidents, national average for mental health trusts

Part 3

Review of Quality Performance

In this section we report on the quality of the services we provide, by reviewing progress against indicators for quality improvement, including the NHS Improvement Single Oversight Framework, performance against contracts with local commissioners, statutory and mandatory training, staff sickness absence and staff survey results.

We have reviewed the information we include in this section to remove duplication and less relevant data compared to previous quality accounts. We have included key measures for each of the quality domains (safety, service user experience and clinical effectiveness) that we know are meaningful to our staff, our Council of Governors, commissioners and partners.

NHS Improvement Single Oversight Framework

The NHS Improvement Single Oversight Framework identifies NHS providers' potential support needs across five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability

Individual trusts are “segmented” by NHS Improvement according to the level of support each trust needs. In 2017/18 NTW has been assigned a segment of “1 – maximum autonomy”.

Table 26: Self-assessment against the Single Oversight Framework as at March 2018 (previous year data in brackets where available)

	Period	Trustwide	Newcastle Gateshead CCG	Northumberland CCG	North Tyneside CCG	South Tyneside CCG	Sunderland CCG
Patient Safety Quality Indicators							
Admissions to adult facilities of patients under 16	2017/18	0	0	0	0	0	0
CPA follow up - proportion of discharges from hospital followed up within 7 days	2017/18 *(2016/17)*	97.2% *(97.3%)*	96.3% *(97.2%)*	98.1% *(98.2%)*	96.1% *(98.1%)*	97.4% *(98.5%)*	98.6% *(95.1%)*
Inappropriate Out of Area Placements	Quarter 4 average per month	16	28	-	13	-	7
Clinical Effectiveness Quality Indicators							
% clients in settled accommodation	2017/18 *(2016/17)*	77.3% *(76.8%)*	79.9% *(78.1%)*	74.7% *(76.1%)*	79.8% *(80.8%)*	81.9% *(75.0%)*	73.9% *(73.5%)*
% clients in employment	2017/18 *(2016/17)*	6.5% *(7.0%)*	6.3% *(6.0%)*	8.9% *(10.8%)*	6.8% *(5.7%)*	4.7% *(5.8%)*	4.3% *(5.5%)*
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:							
• Inpatient wards	31/03/2018 *(Qtr4 16/17)*	85.0% *(85%)*					
• Early intervention in psychosis services	31/03/2018 *(Qtr4 16/17)*	76.7% *(97%)*					
• Community mental health services (people on care programme approach)	31/03/2018 *(Qtr4 16/17)*	58.8% *(83%)*					
Data Quality Maturity Index (DQMI)	Qtr2 17/18	91.7%					
IAPT- Proportion of people completing treatment who move to recovery	March 2018 *(Qtr4 16/17)*	52.4% *(53.5%)*					52.4% *(53.5%)*
Service User Experience Quality Indicators							
RTT Percentage of Incomplete (unseen) referrals waiting less than 18 weeks*	2017/18 *(2016/17)*	99.6% *(98.7%)*	98.6% *(96.9%)*	100% *(100%)*	100% *(100%)*	100% *(100%)*	100% *(100%)*
People with a first episode of psychosis begin treatment with a NICE recommended care package within two weeks of referral	2017/18 *(2016/17))*	83.9% *(78.8%)*	76.7% *(71.4%)*	81.6% *(73.1%)*	74.0% *(75.0%)*	95.7% *(94.3%)*	95.1% *(91.6%)*
IAPT Waiting Times to begin treatment – incomplete							
• 6 weeks	March 2018 *(Qtr4 16/17)*	99.6% *(99.6%)*					99.6%
• 18 weeks	March 2018 *(Qtr4 16/17)*	100% *(100%)*					100%

Data source: NTW. *Note that this relates only to a small number of consultant-led services

Performance against contracts with local commissioners

During 2017/18 the Trust had a number of contractual targets to meet with local clinical commissioning groups (CCG's). Table 27 below highlights the targets and the performance of each CCG against them for quarter four 2017/18 (1 January 2018 to 31 March 2018).

Table 27: Contract performance targets 2017/18 Quarter 4 (2016/17 Quarter 4 in brackets)

CCG Contract performance targets Quarter 4 2017/18 (target in brackets)	Newcastle Gateshead CCG	Northumberland CCG	North Tyneside CCG	Sunderland CCG	South Tyneside CCG
CPA Service Users reviewed in the last 12 months (95%)	97.4% *(95.6%)*	93.3% *(97.1%)*	95.8% *(95.7%)*	98.0% *(98.2%)*	98.1% *(98.4%)*
CPA Service Users with a risk assessment undertaken/reviewed in the last 12 months (95%)	99.0% *(97.0%)*	95.8% *(98.1%)*	93.5% *(97.6%)*	99.5% *(98.0%)*	98.5% *(98.9%)*
CPA Service Users with identified risks who have at least a 12 monthly crisis and contingency plan (95%)	96.3% *(95.2%)*	93.6% *(96.0%)*	93.4% *(95.8%)*	95.6% *(97.1%)*	95.9% *(97.2%)*
Number of inpatient discharges from adult mental health illness specialties followed up within 7 days (95%)	97.1% *(98.7%)*	97.8% *(98.1%)*	96.1% *(98.1%)*	100% *(94.4%)*	100% *(97.7%)*
Current delayed transfers of care -including social care (<7.5%)	1.5% *(3.2%)*	2.6% *(3.0%)*	0.0% *(0.0%)*	0.9% *(0.0%)*	3.2% *(3.8%)*
RTT percentage of incomplete (unseen) referrals waiting less than 18 weeks (92%) Note that this relates only to a small number of consultant-led services	98.6% *(96.9%)*	100% *(100%)*	100% *(100%)*	100% *(100%)*	100% *(100%)*
Current service users aged 18 and over with a valid NHS Number (99%)	99.9% *(99.9%)*	99.7% *(99.9%)*	99.8% *(99.9%)*	99.7% *(99.8%)*	99.9% *(99.0%)*
Current service users aged 18 and over with valid Ethnicity completed (90%)	91.8% *(91.1%)*	93.9% *(94.4%)*	92.7% *(91.2%)*	96.2% *(94.4%)*	95.5% *(93.4%)*
The number of people who have completed IAPT treatment during the reporting period (50%)	n/a	n/a	n/a	54.9% *(52.9%)*	n/a

Data source: NTW

Statutory and Mandatory Training for 2017/18

It is important that our staff receive the training they need in order to carry out their roles safely.

Table 28: Training position as at 31 March 2018

Training Course	Trust Standard	*Position at 31/03/2017*	**Position at 31/03/2018**
Fire Training	85%	*88.3%*	**88.6%**
Health and Safety Training	85%	*92.2%*	**93.6%**
Moving and Handling Training	85%	*93.4%*	**94.4%**
Clinical Risk Training	85%	*91.3%*	**91.8%**
Clinical Supervision Training	85%	*82.3%*	**83.6%**
Safeguarding Children Training	85%	*95.3%*	**95.1%**
Safeguarding Adults Training	85%	*92.9%*	**94.2%**
Equality and Diversity Introduction	85%	*94.0%*	**94.0%**
Hand Hygiene Training	85%	*92.4%*	**93.2%**
Medicines Management Training	85%	*89.9%*	**83.8%**
Rapid Tranquilisation Training	85%	*86.7%*	**78.3%**
MHCT Clustering Training	85%	*87.8%*	**90.3%**
Mental Capacity Act / Mental Health Act / DOLS Combined Training	85%	*82.8%*	**74.3%**
Seclusion Training (Priority Areas)	85%	*94.5%*	**92.7%**
Dual Diagnosis Training	80%	*88.3%*	**89.2%**
PMVA Basic Training	85%	*76.4%*	**80.6%**
PMVA Breakaway Training	85%	*92.3%*	**82.3%**
Information Governance Training	95%	*92.5%*	**95.0%**
Records and Record Keeping Training	85%	*98.6%*	**98.3%**

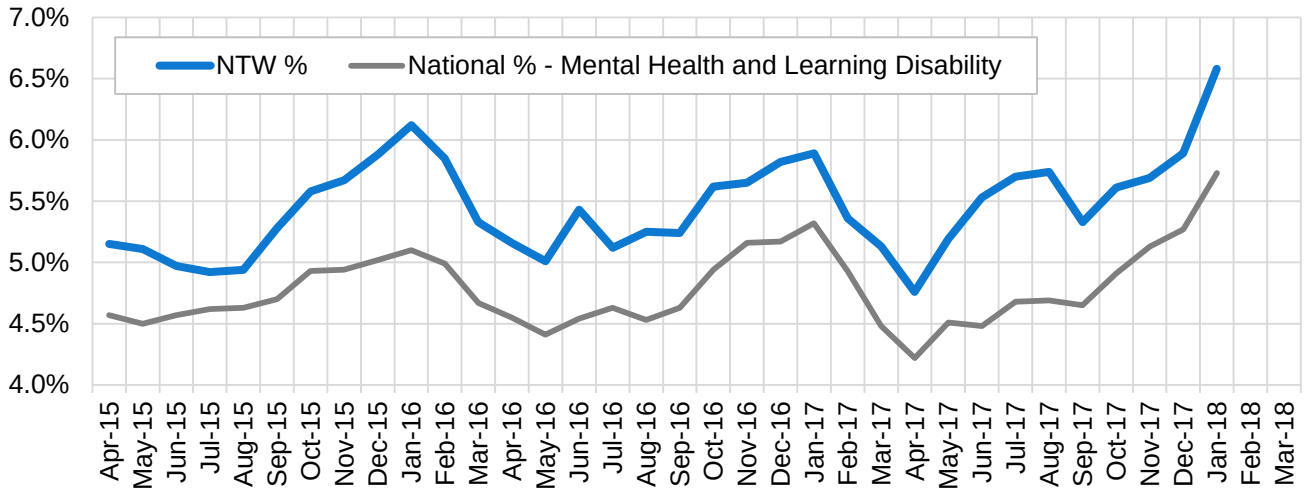
Data source: NTW. Data includes NTW Solutions, a wholly owned subsidiary company of NTW.

Performance at or above target
Performance within 5% of target
Under Performance greater than 5%

Staff Absence through Sickness Rate

High levels of staff sickness impact on service user care: therefore the Trust monitors sickness absence levels carefully.

Figure 15: Monthly staff sickness, NTW and national, April 2015 to January 2018

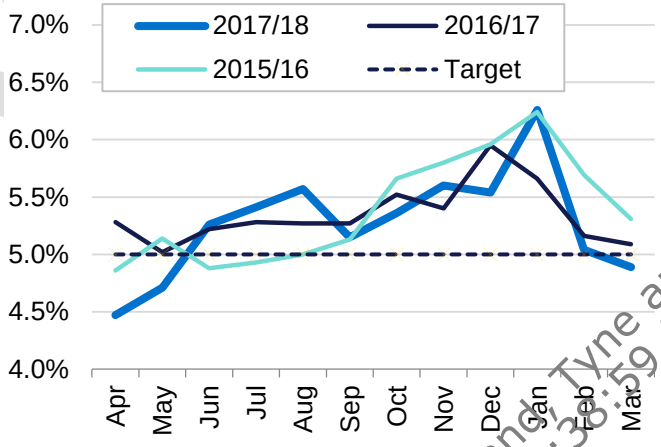


Data source: NHS Digital, Electronic Staff Record. Data includes NTW Solutions, a wholly owned subsidiary company of NTW.
Note: Figures pre-November 2016 have been updated from the 2016/17 Quality Account

The Trust's workforce strategy outlines the corporate approach to the management of absence including a management skills development programme and masterclasses which have a focus on managing absence.

There is also a strong focus on health and wellbeing which is highlighted in the 5 year Health and Wellbeing strategy; this was implemented in 2015 and refreshed in 2017. This strategy not only enables the Trust to support staff but allows us to understand better the health needs of our staff and encourages staff to take responsibility for their own health.

Figure 16: NTW Sickness (in month) 2014/15 to 2017/18



Data source: NTW. Data includes NTW Solutions, a wholly owned subsidiary company of NTW.

We continue to hold the Better Health at Work Award at Maintaining Excellence Level and work in accordance with Investors in People standards. In addition the Trust has signed the Time to Change Pledge to demonstrate our commitment to removing stigma associated with mental health issues.

Staff Survey

Since 2010 the Trust has adopted a census approach to the Staff Survey. Whilst the results listed here are relating to the National Survey, our action planning also takes into account the findings from our census report as well as themes identified from the free text comments. For the last four years, as a direct consequence of staff survey findings, we have been working on improving our approach to staff engagement. We have developed a schedule of listening events called “Speak Easies” where senior managers listen to the views of staff across the Trust, with a focus on empowering people to be able to take action to improve matters at a local level. Staff Survey results are disseminated widely throughout the Trust and views are sought on how we can take action on issues highlighted in the survey results. The Trust wide priorities for action arising from the Staff Survey are agreed by the Trust Board and is monitored through the Trust’s Corporate Decisions Team (Workforce) Group.

Table 29: NHS staff survey responses 2016- to 2017

Response rate	2016	**2017**
Trust	45%	**64%**
National Average	49%	**52%**

Note Trust increase of 19 percentage points

Table 30: Top responses, Staff Survey 2017 Compared to 2016

Top 5 ranking scores	**2017**		2016		**Trust improvement/ deterioration**
	Trust	National Average	Trust	National Average	
KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	**71%**	61%	70%	60%	1% point improvement
KF16. Percentage of staff working extra hours	**66%**	72%	67%	72%	1% point improvement
KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months	**35%**	42%	34%	41%	1% point deterioration
KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	**92%**	85%	93%	87%	1% point deterioration
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	**16%**	21%	17%	22%	1% point improvement

Table 31: Bottom responses, Staff Survey 2017 Compared to 2016

Bottom 5 ranking scores	2017		2016		Trust improvement/ deterioration
	Trust	National Average	Trust	National Average	
KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	**28%**	22%	25%	21%	3% point deterioration
KF23. Percentage of staff experiencing physical violence from staff in last 12 months	**3%**	3%	3%	3%	Result stable
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**33%**	32%	31%	33%	2% point deterioration
KF4. Staff motivation at work	**3.87**	3.91	3.91	3.91	0.04 point deterioration
KF7. Percentage of staff able to contribute towards improvements at work	**73%**	73%	73%	73%	Result stable

Data source (Table 29 to Table 31): Survey Coordination Centre. Data includes NTW Solutions, a wholly owned subsidiary company of NTW.

Actions

Work is taking place at a local level to understand and analyse information with a view to taking early action to address issues that are highlighted

On a Trust-wide basis we are undertaking a fuller analysis of results regarding violence and aggression shown towards staff.

It is recommended that we undertake a full analysis of our bottom five scores and those areas that have deteriorated to seek to understand what those results are telling us and how we might address performance in those areas.

Statements from Clinical Commissioning Groups (CCG), local Healthwatch and Local Authorities

We have invited our partners from all localities covered by Trust Services to comment on our Quality Account.

Corroborative statement from Northumberland, North Tyneside, Newcastle Gateshead, Sunderland and South Tyneside Clinical Commissioning Groups for Northumberland Tyne & Wear NHS Foundation Trust Quality Account 2017/18

The CCGs welcome the opportunity to review and comment on the Trust Quality Account for 2017/18 and would like to offer the following commentary.

Northumberland, North Tyneside, Newcastle Gateshead, Sunderland and South Tyneside Clinical Commissioning Groups (CCGs) are committed to commissioning high quality services from Northumberland Tyne and Wear NHS Foundation Trust (NTWFT) and take seriously their responsibility to ensure that patients' needs are met by the provision of safe, effective services and that the views and expectations of patients and the public are listened to and acted upon.

The CCGs would like to take the opportunity to congratulate the Trust on the numerous national accreditations and awards that it has achieved across the year. These have included the Health Service Journal 'Provider of the Year' award and quality accreditations for older peoples mental health wards, inpatient mental health services, adult forensic and low secure wards and children & young people's wards.

The CCGs commend the Trust for the improvements that are demonstrated in the report in meeting four of their five quality priorities set for 2017/18. Clear progress has been made in the 'Positive & Safe' priority, including reductions in rates of patient restraint through the "Talk 1st" programme to reduce restrictive interventions across the Trust. An increase in total numbers of incidents reported alongside a parallel decrease in patient safety incidents and their severity of harm shows the Trust commitment to the maintenance of a positive patient safety culture across the organisation.

Commissioners would, however, like to see further progress made in 2018/19 in reducing the reported instances of violence and aggression against staff, which have increased by 2% from 2016/17, and the Trust position on which is reported in the 2017 Staff Survey as being both worse than the national average and worse than in the 2016 survey.

It is disappointing to note the ongoing issues that have been experienced by the Trust throughout 2017/18 in attempting to meet the 'Improving waiting times for referrals to multidisciplinary teams'

quality priority. Compared to 2016/17, longer waits are being experienced by patients across all of the CCG areas across adult services, adult autistic spectrum disorder diagnosis services, children & young people's services and community services. The CCGs are pleased to see a continuing focus on improving waiting times in 2018/19 and look forward to working with the Trust to support and develop their initiatives to tackle this crucial work.

The CCGs understand the importance of involving carers in patient treatment and it is encouraging to see the 'Implementing the Triangle of Care' quality priority succeed, with the review of the "Getting to Know You" programme and ongoing carer awareness training for staff and carers at the foundation of its success. This achievement, alongside the success of the 'Co-production & personalisation of care plans' quality priority gives the CCGs assurance that the Trust is putting patients and carers at the heart of their treatment and care plans.

Results of the national Friends & Family Test and the Trust's own 'Points of You' patient survey further support assurance of the excellent work the Trust is conducting to establish whether patients are having a positive experience of care. However, it is noted that complaints are up 25% from 2016/17 and the Trust should ensure that the themes identified from these patient contacts, including waiting times, are addressed systematically as part of the overall Trust improvement plans.

The CCGs have, however, some concerns regarding some of the results of the 2017 staff survey and how this may be related to the Trust staff absence rates which, although improved, are higher than the national average. A reported decrease in 2017 to 68% of staff who agreed or strongly agreed that they would be happy with the standard of care at the Trust if a friend or relative needed treatment is of concern. When coupled with the deterioration in scores in the survey of staff experiencing physical violence and staff experiencing harassment, bullying or abuse from patients, relatives or the public it is clear that the Trust still has some work to do in 2018/19 to resolve these issues. The CCGs are pleased, however, that this is acknowledged in the report and actions are underway to resolve this.

Commissioners are pleased to note that the Trust has successfully implemented the recommendations of the national guidance on 'Learning from Deaths'. CCGs acknowledge that the Trust's work already appears to be proving fruitful, with learning identified in areas including risk assessment, physical health, prescribing, record keeping and carer support. The CCGs would also like the Trust to consider how it will share learning with wider health and social care stakeholders and join up with the Learning Disabilities Mortality Review Programme to provide a system wide picture of potential service improvements.

In 2017/18 an engagement exercise was again undertaken with stakeholders to gather suggestions for the new quality indicators and the CCGs commend the Trust on using this approach and are supportive of the Trust's quality priorities for improvement in 2018/19.

In so far as we have been able to check the factual details, the CCGs' view is that the Quality Account is materially accurate. It is clearly presented in the format required by NHS England and the information it contains accurately represents the Trust's quality profile. Finally, the CCGs would like to offer congratulations to the Trust on the achievements outlined in this report which we believe accurately reflects the Trust's commitment to delivering high quality, patient centred services. The CCGs look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2018/19.

Annie Topping
Director of Nursing, Quality & Patient Safety

NHS Northumberland CCG

Lesley Young Murphy
Exec. Director of Nursing & Chief Operating Officer
NHS North Tyneside CCG

Chris Piercy
Executive Director of Nursing, Patient Safety & Quality
NHS Newcastle Gateshead CCG

Ann Fox
Director of Nursing, Quality & Safety
NHS Sunderland CCG

Jeanette Scott
Director of Nursing, Quality and Safety
NHS South Tyneside CCG

Healthwatch Newcastle, Healthwatch Gateshead and Healthwatch North Tyneside's statement:

We are pleased to read the Northumberland, Tyne and Wear NHS Foundation Trust's (NTW) quality account for 2017/18. It is an interesting and informative read and it is clear the Trust has endeavoured to make improvements against the priorities it set itself, in circumstances that have been challenging at times.

Quality goal 1: Patient Safety

We are pleased to read that last year's quality priority associated with this goal - Embedding the Positive & Safe Strategy – has been met. We are pleased to note that 87.2% of applicable staff have now received 'Risk of Harm to Others' training – meeting the 85% standard, and that instances of prone and mechanical restraint and self-harm have all reduced. We also note the decrease in the number of reported patient safety incidents over the previous year.

We welcome the new goal – Improving the Inpatient Experience. In particular, the aim to reduce the number of out of area placements which we know is very unsettling for both patients and their families; and the aim to reduce bed occupancy rates, which we understand can have a significant impact on patient safety.

Quality goal 2: Service User and Carer experience

It is unfortunate that the target relating to waiting times has not been met. The number of people waiting more than the target 18 weeks has increased by 20% and we note that waiting times for both children and young people services and specialist services have also increased this year. Whilst we appreciate the continuing challenges which have contributed to this situation, we are

concerned about these increases and we feel it is essential that this is kept as a priority goal for 18/19 and we are pleased to see that this is the case. We note that the introduction of the single point of contact for Children and Young People's services, earlier this year, may have impacted on waiting times and we hope that this will continue to be monitored through-out the coming year.

There are particular issues in relation to crisis services. In North Tyneside a number of people have raised concerns around the time it takes to get full support. Most people know which services to access but told us about a number of barriers to actually getting them including the clarity of service provision, waiting times and prior poor experiences. We would reiterate the point we made in our response last year about the need for people to be able to access some support whilst they are waiting for full service provision.

We are happy to see that the priority target related to the implementation of the Triangle of Care – to improve the way we relate, communicate and engage with carers to involve them within care and support planning – has been met. However, we appreciate this is an ongoing piece of work and we are pleased that embedding the principles of the triangle of care remains a quality priority this year, with the focus on rolling out its use in Children's Services.

We are also pleased to note that the priority relating to the co-production and personalisation of care plans, has been met by learning from the actions taken in Older People's Inpatient Services following the CQC Inspection, to embed good practice in all inpatient services.

Quality goal 3: Clinical Effectiveness

We are pleased to read that the priority target relating to clinical effectiveness – Use of the Mental Health Act – Reading of Rights, has been met, through improvements to patient records, the launch of a new form and staff awareness sessions to embed best practise

We welcome the new goal related to Embedding Trust Values of Care and Compassion, Respect and Honesty and Transparency. We feel it makes sense to align feedback and complaints against these values. We would also suggest the trust could employ additional ways of ensuring values are embedded for example in staff supervision and team meetings and in learning from and celebrating positive feedback.

The Trust's new and continuing priorities for 2017/18 are reasonable and comprehensive.

We wish NTW continued success and look forward to receiving updates on progress.

Newcastle City Council Health Scrutiny Committee's statement:

As Chair of Newcastle Health Scrutiny Committee, I welcome the opportunity to comment on your draft Quality Account for 2017/18. The committee discussed the document at their meeting on 23 April 2018 and this letter provides a summary of comments that were raised.

As you know the committee have a particular interest in the commissioning and delivery of mental health services in Newcastle and we will continue to receive updates from Newcastle Gateshead Clinical Commissioning Group as work continues to improve services.

From our discussions we are aware of the unprecedented set of challenges – including high demand, workforce shortages and funding constraints – facing services. Despite this, we acknowledge that NTW is rated as providing outstanding mental health services and has been given the 'provider of the year' award by the Health Service Journal.

In relation to progress against your 2017/18 priorities, we would make the following points:

- We welcome the impact that has been achieved through introduction of the Positive and Safe Strategy, in particular the significant reduction in use of prone restraint and mechanical restraint over the last two years, which had been a concern for us.

- We note the level of reported incidents of violence and aggression, which can be linked to the high bed occupancy levels and hope that in the longer term incidents will fall as the trust is able to reduce bed occupancy.

- Of particular concern to us is the high number of individuals who have difficulty in accessing mental health services within the 18 week NHS target. In particular, we note the 20% increase in demand (285 people) for community services for adults and older people compared to the same period last year.

  We note from our meeting and previous discussions with the CCG that a number of actions are being taken to help address this, which include some changes to services and the adoption of an episodic care model. However, we remain concerned that individuals do not appear to have the same level of access to timely care as they perhaps would for a physical health condition.

  Although this may be a national position, we will continue to monitor the situation in Newcastle and will discuss progress with the CCG. We welcome that this will continue to be a focus for the trust in 2018/19.

- We are surprised at the ethnicity breakdown of service users and wonder if this suggests that a cohort of our BME residents may be disaffected with NHS services. If so, this will be of concern and the committee may wish to discuss this with commissioners and stakeholders during the coming year.

- We note that complaints have increased by 33% from 2015/16, an increase of 182. A significant proportion of these (157) are related to patient care and we would like to explore this further with you in the coming year.

In relation to 2018/19 priorities, we would make the following additional points:

- At our meeting we discussed 'out of area' and 'out of locality' placements and the impact this can have on patients and their families. We acknowledge that this is a national issue, reflecting high demand for services, and although we note that numbers of NTW service users placed out of the area are currently low at two, we welcome a focus on reducing this further.

- Overall, we support the priorities proposed for 2018/19, as being a fair reflection of areas that are of high importance to local residents.

Finally, it is worth noting that we again find the Quality Account document to be clear and informative and we are pleased that the trust has continued in its efforts to be proactive in engaging with stakeholders on the development of priorities, which will lead to a greater understanding.

Finally, I would like to acknowledge the willingness of the trust to engage with the committee whenever requested and I hope that this will continue.

Cllr Wendy Taylor
Chair, Health Scrutiny Committee

Northumberland County Council Health and Wellbeing Overview and Scrutiny Committee's statement:

The Health and Wellbeing Overview and Scrutiny Committee welcomes the opportunity to submit a commentary for inclusion in your Annual Plan and Quality Account for 2017/18 as presented to the committee in draft, and about our ongoing engagement with the Trust over the past year. We have continued to receive information from the Trust with participation of your officers at some of our committee's bimonthly meetings.

At our 20 March 2018 meeting we received a presentation on your draft Quality Account for 2017/18 and your priorities for 2018/19. At that meeting we also received presentations from the Northumbria, North East Ambulance Service and Newcastle Hospitals NHS Foundation Trusts on their own quality accounts; this we believe provides a good joined up picture of the many NHS services in Northumberland. Members responded favourably to the information you presented, with reference to your highly valued staff and clinical support provided. During your presentation, members noted how your three overarching long term goals were refreshed in the 2017-22 NTW Strategy, details of the current Quality Priorities, plus your process of identifying priorities for the next year and why these should be your Quality Priorities for 2018/19. We request you take some of the following issues raised by members into account.

Members welcomed that benchmarking had taken place which included considering patient safety processes, and reductions in restraint requirements, violence and aggression, assisted by the use of other techniques. Members welcomed that the Trust has an open reporting culture. Members did note feedback about the co-production and personalisation of care plans had included comments that some plans included too much or too little detail.

In relation to the reading of patients' rights, members noted how the periodical frequency of being reminded could be subject to interpretation as the guidelines were not clear. It is welcomed that an evaluation of the impact of proposed actions will be carried out during 2018/19. The aspiration that NTW will be able to provide bespoke advice and guidance and respond to GPs within 48 hours of referral is also welcomed.

Members also welcomed how consideration was being given to improving the inpatient experience and to avoid out of area admissions where possible and that if people had to be admitted elsewhere, how work took place to bring them back as soon as possible. Members were very

pleased that a 'getting to know you' tool was used which involved carers when getting to know the service user, enabling the opportunity to arrange any beneficial actions. Carers were essential and NTW's prioritisation of this was strongly welcomed by members.

Reference was made to national pressures and whether this busy year was likely to be a trend. There was a rising acceptance of people with mental health issues, and stopping the deterioration in waiting times was important for the year ahead. NTW should focus on improving rather than continuing current levels. Members were reassured that the Royal College of Psychiatrists recommended the 85% bed occupancy level, which acknowledged that staff also needed time for other development such as training. Members expressed no concerns about levels of nursing staff, but also drew attention to the importance of how the Trust continued to meet the challenge if pressure on services continued to grow. Members welcomed details of collaboration across the North East between Trust and that directors of nursing and finance met up regularly.

From the information you have provided to the committee over the past year, including the presentation about your draft 2017/18 Quality Account and the full version of the document we received on 25 April, we believe the document is a fair and accurate representation of the services provided by the Trust and reflects the priorities of the community. Members also support your priorities for improvement planned for 2018/19, but also request that you note and consider the various points that they have raised in relation to your work going forward.

We also would be very grateful if I could get in contact with you again soon to further discuss possible agenda items for the Health and Wellbeing Overview and Scrutiny Committee to consider about the Trust's services during the next council year beginning in May 2018. If I can be of any further assistance please do not hesitate to contact me.

Mike Bird, Senior Democratic Services Officer, Democratic Services

On behalf of Councillor Jeff Watson, Chair, Northumberland County Council Health and Wellbeing Overview and Scrutiny Committee

Gateshead Council Overview and Scrutiny Committee's statement:

Healthwatch South Tyneside's Statement:

Last year Healthwatch South Tyneside (HWST) appreciated the Quality Goals and Priorities for the coming year, particularly Quality Goal Two around Service User and Carer Experience in terms of waiting times, Triangle of Care and co-production. The main areas of concern for HWST for the 2017/18 Quality Account relate to waiting times.

HWST has noted the 1% improvement in waiting times for adult mental health services with 98% of referrals being contacted within 18 weeks. However HWST is concerned that people in South Tyneside waiting over 18 weeks to be seen by the Adult Attention Deficit Hyperactivity Disorder (Adult ADHD) and the Adult Autistic Spectrum Disorder (Adult ASD) diagnosis service has increased by 8% and 16% respectively. HWST acknowledges that "improving waiting times"

continues to be a quality priority for 2018/19; and would like to see reduced waiting times for South Tyneside residents over the coming year.

HWST is hugely disappointed for the people of South Tyneside that waiting times for children and young people are significantly longer than last year with 56% waiting longer than 18 weeks as at 31st March 2018. This is reflected in intelligence that HWST has heard and the impact on individuals and families cannot be discounted. HWST has noted that this is reflected in the quality priorities for 2018/19 and wants to see improved waiting times for CYP mental health services for local people.

HWST appreciates that the Trust generally performs better than the national average as was reflected in their 2016 Care Quality Commission inspection report.

Jan Pyrke
Operations Manager

South Tyneside Council Overview and Scrutiny Committee's statement:

Thank you for the opportunity to comment on your 17/18 Quality Report.

We have not asked representatives of NTW to attend any of our scrutiny committees this year as our programme has been very much focussed on Primary Care and the "Path to Excellence" consultation.

However, we do intent to include the Learning Disability Transformation Programme in our schedule for next year.

As regards the report itself, we acknowledge what a high performing Trust NTW has become in many areas. However, we have continued concerns over the waiting times for Child and Adolescent Mental Health Services. You will note that a number of years ago we recommended that no child should wait more than 9 weeks for services (when 12 weeks was then the stated target). It is therefore alarming that children and young people waiting to access services have not been maintained and waits have significantly lengthened, with 56% waiting more than 18 weeks.

This is something that we would like to see some progress on and are pleased that it is quite rightly remaining in your priorities for 18/19.

I hope these comments are helpful.

Cllr Rob Dix
Chair
South Tyneside Council Overview and Scrutiny Coordinating and Call-in Committee

Sunderland City Council Overview and Scrutiny Committee's statement:

Sunderland City Council's Health and Wellbeing Scrutiny Committee are pleased to able to comment on this year's Northumberland Tyne and Wear NHS Foundation Trust Quality Report 2017/18. The report provides a detailed overview of the quality of care and key priorities for the year ahead.

The Health and Wellbeing Scrutiny Committee are pleased to acknowledge the high performance rating that the trust has achieved from the Care Quality Commission following inspection in 2016. The committee is particularly pleased to see achievements against the quality priorities set for 2017/18. In particular the progress made in the 'Positive & Safe' priority to actively reduce the violence and aggression across the organisation.

However it is concerning that within community services for adults and older people, the longest waiting times for these services are in Northumberland and Sunderland. The increased demand for community services for adults and older people remains an issue to ensure access to timely care comparable to that of other health services. The Committee would like to see improvements in this particular area and will look to monitor this issue in going forward.

A similar concern remains in terms of Child and Adolescent Mental Health Services where times for children and young people have significantly lengthened, with 42% waiting more than 18 weeks as at 31 March 2018. Again this would be an area where the Committee would like to see improvements and this will be a further issue that will be monitored in 2018/19.

Sunderland City Council's Scrutiny function values its relationship with the NTW NHS Foundation Trust and will continue to challenge and engage with the Trust over key issues and priorities for the city. The Health and Wellbeing Scrutiny Committee are therefore satisfied in endorsing this quality report for 2017/18.

Councillor Darryl Dixon
Chair of the Health and Wellbeing Scrutiny Committee

Appendix 1

CQC Registered locations

The following tables outline the Trust's primary locations for healthcare services as at 31 March 2018.

Table 32: CQC registered locations

Location	Regulated Activities			Service Types							
	Treatment of Disease, Disorder or Injury	Diagnostic and Screening Procedures	Assessment or medical treatment for persons detained under the Mental Health Act 1983	CHC	LDC	LTC	MHC	MLS	PHS	RHS	SMC
Brooke House	●	●	●							●	
Elm House	●	●	●					●			
Ferndene	●	●	●			●		●		●	
Hopewood Park	●	●	●			●		●		●	
Monkwearmouth Hospital	●	●	●			●		●		●	
Campus for Ageing and Vitality	●	●	●					●		●	
Northgate Hospital	●	●	●			●		●		●	
Queen Elizabeth Hospital	●	●	●					●			
Rose Lodge	●	●	●					●			
Royal Victoria Infirmary	●	●	●					●			
St George's Park	●	●	●			●		●		●	
St Nicholas Hospital	●	●	●	●	●	●	●	●	●	●	●
Walkergate Park	●	●	●					●		●	

Service Types:
CHC – Community health care services
LDC – Community based services for people with a learning disability
LTC – Long-term conditions services
MHC – Community based services for people with mental health needs
MLS – Hospital services for people with mental health needs, and/or learning disabilities, and/or problems with substance misuse
PHS – Prison healthcare services
RHS – Rehabilitation services
SMC – Community based services for people who misuse substances

Table 33: CQC Registered Locations for social and residential activities

Registered Home/Service	Regulated Activity	Service Type
	Accommodation for persons who require nursing or personal care	Care home service without nursing
Easterfield Court	●	●

Data source (Table 32 and Table 33): CQC

Appendix 2

Local Clinical Audits undertaken in 2017/18

Board Assurance (6)		
1	CA-16-0023	Clinical Supervision
2	CA-16-0037	Medicines Management: Safe & Secure Medicines Handling
3	CA-16-0088	Learning Disabilities (Transforming Services)
4	CA-17-0001	Medicines Management: Audit of Prescribing Standards, Prescription Accuracy Checking and Drug Administration (Take 5 approach)
5	CA-17-0004	Seclusion 16-17
6	CA-17-0006	Care Co-ordination: Inpatient
Trust Programme (6)		
7	CA-16-0013	Re-audit of S136 suites and acute hospital emergency department psychiatric interview rooms within NTW area against quality and safety standards
8	CA-16-0048	Administration of Electroconvulsive Therapy (ECT)
9	CA-16-0079	Audit of Transition between Inpatient and Community Services
10	CA-17-0010	Domestic Abuse (MARAC) Audit
11	CA-17-0014	Evidencing Person Centred Care through Collaborative Care Planning within Older People's Inpatient Services
12	CA-17-0021	Evidencing Person Centred Care through Collaborative Care Planning within Older People's Inpatient Services
NICE Audits (3)		
13	CA-15-0092	NICE (Implementation) CG103: Audit of Clinical Practice Against Quality Delirium Standards
14	CA-16-0090	NICE (Implementation) GC161: Falls Post Baseline Audit
15	CA-15-0120	NICE (Baseline) CG128: Autism in Children & Young People
Medicines Management Audits (3)		
16	CA-15-0062	Audit of pharmacological therapies policy practice guidance note 17-Melatonin in paediatric sleep disorders
17	CA-16-0062	Controlled Drugs
18	CA-16-0073	Audit on the management of diabetes and hypoglycaemia
North Locality Care Group Audits (26)		
19	CA-14-0136	Advice on driving given to patients on psychotropic medication
20	CA-15-0031	Young person and parental involvement in clinical team meetings
21	CA-15-0032	Young person and parental involvement in Care Co-ordination reviews
22	CA-15-0112	Physical health monitoring in antipsychotic medication according to Trust Guidelines
23	CA-16-0014	Diagnosis and advice on non-pharmacological management of delirium in the acute hospital setting: Audit of adherence to NICE Quality Standards within the Northumberland Psychiatric Liaison Team

24	CA-16-0019	NICE CG72: Audit of transition of young people with ADHD to adult services against NICE Guidelines
25	CA-16-0021	Audit of team meeting documentation on RiO to ensure contemporaneousness of entries, actions following decisions or documented new decisions and changes to risk are recorded in the risk assessment document
26	CA-16-0027	Are patients with Alzheimer's disease in the Tynedale CMHT locality prescribed Memantine according to NICE guidelines?
27	CA-16-0051	Compliance with national agreed standard of completing a comprehensive MDT summary within 5 working days of discharge
28	CA-16-0055	Assessment of capacity in informal admission to WAA Inpatient Wards at St George's Hospital
29	CA-16-0061	An audit looking at benzodiazepine prescribing patterns in Crisis Services within NTW
30	CA-16-0065	An audit of annual physical health monitoring of children and adolescents on antipsychotic medication attending ADHD Clinics in Northumberland
31	CA-16-0066	Clozapine monitoring: are annual plasma tough levels being completed for patients who are prescribed clozapine in the community?
32	CA-16-0075	Are Complex Neurodevelopmental Disorders Service (CNDS) systematically assessing for comorbid mental health disorder as part of ASD second opinion assessments
33	CA-16-0081	Audit of borderline personality disorder: treatment and management, second cycle, Alnwood, St Nicholas Hospital
34	LLCA-99-0014	Audit of Benzodiazepine and Z-drug Prescribing
35	LLCA-99-0015	Do 72-hour meetings really occur within 72-hours of admission?
36	LLCA-99-0018	Re-Audit of physical health monitoring of patients with severe mental illness in a general adult community mental health team
37	LLCA-99-0022	Monitoring requirements for children and young people (<18) years) prescribed antipsychotics (except Clozapine) - an audit on adherence to Trust guidelines in the CYPS/LD population.
38	LLCA-17-0014	Retrospective audit of police disclosure requests and follow-up in acute adult inpatient ward (Embleton)
39	LLCA-17-0017	Vitamin D deficiency – monitoring and treatment in patients within the Medium Secure Unit (NICE PH56)
40	LLCA-17-0020	Re-audit of monitoring of side effects in patients taking depot antipsychotics using GASS or LUNSERS forms
41	LLCA-17-0021	Re-audit of ADHD medication height and weight monitoring on growth charts in CAMHS Inpatients (Ferndene & Alnwood)
42	LLCA-17-0037	The activity of CRHT Northumberland, focusing on facilitated and delayed admissions to acute wards due to bed availability measured against standards within the Crisis Care Concordat
43	LLCA-17-0041	Assessment of the frequency that staff assault is reported to the police in line with promoted Zero Tolerance for staff in the NHS
44	LLCA-17-0053	MDT Seclusion Review in RiO
South Locality Care Group Audits (26)		
45	CA-16-0041	Cardio-metabolic Monitoring of In-patients at Rose Lodge

46	CA-16-0053	Audit of Professional Standards Record Keeping and Consent (2016)
47	CA-16-0076	Audit of Record Keeping 2016
48	CA-14-0100	Prolactin level monitoring in patients receiving antipsychotics
49	CA-16-0042	Physical health monitoring in patients on High Dose Antipsychotic Therapy (HDAT)
50	CA-16-0025	NICE NG10: Are we adhering to NICE Guidance surrounding management violence and aggression in patients in seclusion in PICU at Hopewood Park?
51	CA-16-0052	An audit of the vocational rehabilitation assessment process at Northumberland Head Injuries Service against the British Society of Rehabilitation Medicine recommendations
52	CA-16-0032	Audit of Implementation of Trust's Risk Assessment Record-Keeping Policy within MS Rehabilitation Outpatient Clinics
53	LLCA-99-0003	An audit of timeframe of notifying GPs about patients who present with self-harm
54	LLCA-99-0004	Audit of compliance with NICE and Maudsley guidelines on psychotropic prescribing in delirium
55	LLCA-99-0010	Clozapine related side effects monitoring and management practices audit
56	LLCA-99-0011	Concordance with NICE Guidelines on pharmacologic management of depression and recommended therapeutic monitoring with Liaison Psychiatry
57	LLCA-99-0019	Clinical Record Keeping Standards in patients under 65: referral to Memory Assessment and Management Service (MAMS)
58	LLCA-99-0020	Are we providing a Neuro Rehabilitation MS Service responsive to the needs of people with cognitive impairment?
59	LLCA-99-0024	Physical health monitoring for patients on Clozapine
60	LLCA-99-0025	Audit of cardiovascular monitoring with the use of AChEI's within the Memory Protection Service
61	LLCA-99-0026	Triage documentation audit for the measurement and recording of documentation standards quality and processes
62	LLCA-99-0027	Are 72-hour meetings being completed within the recommended time limit on organic inpatient wards (Mowbray & Roker)?
63	LLCA-99-0028	Family / Carer involvement including Getting to Know You
64	LLCA-17-0006	Re-audit of the use of Psychotropic Medication Patients with Brain Injury
65	LLCA-17-0007	Clinical audit of South Tyneside Old Age Psychiatry Community Consultant telephone case discussions recording in RiO
66	LLCA-17-0010	Long term medicines management – are community depot prescriptions being reviewed?
67	LLCA-17-0011	Audit of discharge summary process and accuracy
68	LLCA-17-0028	Q-Risk scores and statins in secondary (community) and tertiary (in-patient) mental health services
69	LLCA-17-0034	Re-audit of the transition of young people with ADHD to Adult services
70	LLCA-17-0059	Audit of uptake of planned CTERs in the LD CYPS Team, South of Tyne

Central Locality Care Group Audits (35)		
71	CA-15-0042	Antipsychotic Use in Patients with Dementia at Castleside Day Unit
72	CA-16-0063	Evidencing Person Centred Care through collaborative Care Planning within Older People's in-patient services
73	CA-15-0121	NICE NO 205 Clinical Audit on Use of ECT as a Quality Monitoring Tool
74	CA-16-0049	CG 178: ECG monitoring and recording practice on acute admission service
75	CA-16-0054	Assessment of compliance with standards of physical health monitoring: Pregnancy as a crucial aspect of Physical Health Monitoring amongst women of reproductive age group (15-44) in an in-patient psychiatry setting
76	CA-16-0068	Baseline monitoring on initiation of antipsychotics in the elderly (>65 years) in concordance with NICE Guidelines
77	CA-15-0117	Audit of secondary care prescribing through GP letters and Outpatient Recommendation Forms issued by the North Tyneside West CMHT (Longbenton)
78	CA-16-0056	Re-audit of side effect monitoring of patients receiving depot antipsychotics in North Tyneside West CMHT (Longbenton)
79	CA-16-0069	Melatonin Prescribing Practices in Newcastle/Gateshead Tier 3 CYPS Team
80	CA-16-0085	Management of Weight Loss in ADHD Patients in Newcastle CYPS
81	CA-16-0091	Assessment of compliance with standards of physical health monitoring: Pregnancy as a crucial aspect of Physical Health Monitoring amongst women of reproductive age group (15-44) in an in-patient psychiatry setting
82	CA-16-0064	Discharge Summaries for Older People's In-Patient Services
83	CA-16-0074	Re-audit of assessment of the quality of smoking cessation provision and documentation in a forensic inpatient unit
84	LLCA-99-0006	Improving physical healthcare to reduce premature mortality in people with serious mental illness
85	LLCA-99-0008	Documentation of risk management plan in Liaison Psychiatry in accordance with NICE CG16 & 133
86	LLCA-99-0009	Audit of compliance with prescribing guidelines for depot antipsychotics (UHM-PGN-02 Prescribing Medications V01)
87	LLCA-99-0016	The discussion of naloxone provision in the treatment of newly-released prisoners with opiate addiction
88	LLCA-99-0017	Audit of take home naloxone prescribing within Newcastle Addictions Services
89	LLCA-17-0001	To assess the implementation of the Share Care Plan in Children with Learning Disabilities and ADHD and their general practitioner in accordance with NICE Guidance
90	LLCA-17-0002	Re-audit of practice in Adult ADHD patients with comorbid substance use disorder against relevant NICE guidelines and BAP guidelines
91	LLCA-17-0003	High Dose Antipsychotic Therapy Monitoring re-audit
92	LLCA-17-0004	An audit of referral guidelines in the Oswin Unit, Medium Secure Personality Disorder Unit

93	LLCA-17-0016	ECG Monitoring & Recording Practice on Acute Admission Service (Re-audit of CA-16-0049).
94	LLCA-17-0022	Are moderate NE referrals to the Older Persons CTT Single Point Access processed and seen face to face with a clinician within 28 day target
95	LLCA-17-0024	Monitoring of lithium levels at Castleside Day Hospital
96	LLCA-17-0029	Antipsychotic medication for first episode psychosis: an audit of NICE clinical guideline recommendations for psychosis and schizophrenia an children and young people (CG 155)
97	LLCA-17-0030	NICE NO205 Clinical Audit on Use of ECT as a Quality Monitoring Tool
98	LLCA-17-0032	Consultant - Consultant Handover
99	LLCA-17-0033	An Audit against Trust Standards for VTE assessments in Forensic Inpatients
100	LLCA-17-0035	Audit of the database at Plummer Court
101	LLCA-17-0044	Evaluation of NICE Guidance on the Review of Antipsychotic Prescribing in people with Dementia
102	LLCA-17-0050	NICE CG28: Retrospective review of patients who were initiated on medication beginning of August 2017 until end December 2017
103	LLCA-17-0052	Has overestimation of QTc on ECG led to a change in choice of medication?
104	LLCA-17-0056	Driving & Dementia Audit
105	LLCA-17-0058	Completion of FACE Risk Forms on same day as assessment by the Crisis Team

Data source: NTW

Appendix 3

Statement of Directors' Responsibilities in respect of the Quality Report

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 reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017-18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2017 to May 2018
    - papers relating to quality reported to the Board over the period April 2017 to May 2018
    - feedback from Commissioners dated May 2018
    - feedback from governors dated May 2018
    - feedback from Local Healthwatch organisations dated May 2018
    - feedback from Overview and Scrutiny Committees dated May 2018
    - the Trusts Annual review of complaints information which was presented to the Board within the Safer Care (Quarter 4) report published under regulation 18 of the Local Authority, Social Services and NHS Complaints Regulations 2009, dated April 2018
    - the 2017 national patient survey
    - the 2017 national staff survey
    - the Head of Internal Audit's annual opinion over the trust's control environment dated May 2018
    - CQC inspection report dated 1 September 2016

- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality 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 Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Report.

By order of the Board

23rd May 2018	Ken Jarrold	Chair
23rd May 2018	John Lawlor	Chief Executive

Appendix 4

Limited Assurance Report on the content of the Quality Report

Appendix 5

Glossary

ADHD	Attention Deficit Hyperactivity Disorder – a group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness
AIMS	Accreditation for Inpatient Mental health Services
ASD	Autism Spectrum Disorder – a term used to describe a number of symptoms and behaviours which affect the way in which a group of people understand and react to the world around them
CAMHS	Children and Adolescent Mental Health Services
CCG	Clinical Commissioning Group – a type of NHS organisation that commissions primary, community and secondary care from providers
CAS alert	The Central Alerting System is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS.
CCQI	College Centre for Quality Improvement – part of the Royal College of Psychiatrists, working with services to assess and increase the quality of care they provide.
CMHT	Community Mental Health Team – supports people living in the community who have complex or serious mental health problems
Commissioner	Members of Clinical Commissioning Groups (CCGs), regional and national commissioning groups responsible for purchasing health and social care services from NHS Trusts.
Coram Voice	A charity that enables and equips children and young people to hold to account the services that are responsible for their care.
CQUIN	Commissioning for Quality and Innovation – a scheme whereby part of our income is dependent upon improving quality
CMHT	Community Mental Health Team
CRHT	Crisis Resolution Home Treatment – a service provided to service users in crisis.
Clinician	A healthcare professional working directly with service users. Clinicians come from a number of healthcare professions such as psychiatrists, psychologists, nurses and occupational therapists.
Cluster / Clustering	Mental health clusters are used to describe groups of service users with similar types of characteristics.
CQC	Care Quality Commission – the independent regulator of health and adult social care in England. The CQC registers (licenses) providers of care services if they meet essential standards of quality and safety and monitor them to make sure they continue to meet those standards.
CPA	Care Programme Approach – a package of care for some service users, including a care coordinator and a care plan.
CTO	Community Treatment Order

CYPS	Children and Young Peoples Services – also known as CAMHS
Dashboard	An electronic system that presents relevant information to staff, service users and the public
DOLS	Deprivation Of Liberty Safeguards – a set of rules within the Mental Capacity Act for where service users can't make decisions about how they are cared for.
Dual Diagnosis	Service users who have a mental health need combined with alcohol or drug usage
ECT	Electroconvulsive therapy
EIP	Early Intervention in Psychosis
Forensic	Forensic teams provide services to service users who have committed serious offences or who may be at risk of doing so
GP	General Practitioner – a primary care doctor
HMP	Her Majesty's Prison
HoNOS / HoNOS 4-factor model	Health of the Nation Outcome Scales. A clinical outcome measuring tool.
IAPT	Improving Access to Psychological Therapies – a national programme to implement National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders.
LD	Learning Disabilities
LeDeR	The Learning Disabilities Mortality Review Programme aims to make improvements in the quality of health and social care for people with learning disabilities, and to reduce premature deaths in this population.
Lester Tool	The Lester Positive Cardiometabolic Health Resource provides a simple framework for identifying and treating cardiovascular and type 2 diabetes risks in service users with psychosis receiving antipsychotic medication.
MARAC	Multi-Agency Risk Assessment Conference – a risk management meeting for high risk cases of domestic violence and abuse
MDT	Multi-Disciplinary Team – a group of professionals from several disciplines who come together to provide care such as Psychiatrists, Clinical Psychologists, Community Psychiatric Nurses and, Occupational Therapists.
MHA	Mental Health Act
MHCT	Mental Health Clustering Tool – a computerised system used in clustering
NHS Improvement	The independent regulator of NHS Foundation Trusts, ensuring they are well led and financially robust.

Single Oversight Framework	An NHS Improvement framework for assessing the performance of NHS Foundation Trusts (replacing the Monitor Risk Assessment Framework)
NEQOS	North East Quality Observatory System – an organisation that helps NHS Trusts to improve quality through data measurement
NICE	National Institute for Health and Clinical Excellence – a group who produce best practice guidance for clinicians
NIHR	National Institute of Health Research – an NHS organisation undertaking healthcare related research
NRLS	National Reporting and Learning System – a system for recording patient safety incidents, operated by NHS Improvement
NTW	Northumberland, Tyne and Wear NHS Foundation Trust
Out of area placements	Service users admitted inappropriately to an inpatient unit that does not usually receive admissions of people living in the catchment of the person's local community mental health team.
Pathway	A service user journey through the Trust, people may come into contact with many different services
PHSO	The Parliamentary And Health Service Ombudsman
PICU	Psychiatric Intensive Care Unit
Points of You	An NTW service user and carer feedback system that allows us to evaluate the quality of services provided
POMH-UK	Prescribing Observatory for Mental Health – a national organisation that helps mental health trusts to improve their prescribing practice.
PMVA	Prevention and Management of Violence and Aggression
Recovery College	Recovery Colleges take an educational approach to provide a safe space where people can connect, gain knowledge and develop skills.
RiO	NTW's electronic patient record
RTT	Referral To Treatment – used in many waiting times calculations
Serious Incident	An incident resulting in death, serious injury or harm to service users, staff or the public, significant loss or damage to property or the environment, or otherwise likely to be of significant public concern. This includes 'near misses' or low impact incidents which have the potential to cause serious harm.
Transition	When a service user moves from one service to another, for example from an inpatient unit to being cared for at home by a community team.

For other versions telephone 0191 246 6935 or email qualityassurance@ntw.nhs.uk

Copies of this Quality Account can be obtained from our website (www.ntw.nhs.uk) and the NHS Choices website (www.nhs.uk). If you have any feedback or suggestions on how we could improve our quality account, please do let us know by emailing qualityassurance@ntw.nhs.uk or calling 0191 246 6935.

Printed copies can be obtained by contacting:

Commissioning and Quality Assurance Department

St Nicholas Hospital
Jubilee Road, Gosforth
Newcastle upon Tyne
NE3 3XT

Tel: 0191 246 6935

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 23 May 2018

Title and Author of Paper: Annual Governance Statement 2017-2018 Final

Lisa Quinn, Executive Director of Commissioning & Quality Assurance

Executive Lead: John Lawlor, Chief Executive

Paper for Debate, Decision or Information: Decision

Key Points to Note:

The Annual Governance Statement for 2017-2018 is attached for approval. This has been considered by Audit Committee on 16th May 2018 and reviewed by External Audit.

Risks Highlighted to Board : none

Does this affect any Board Assurance Framework/Corporate Risks?
Please state
Yes - A statement of the controls and Governance in place throughout the year

Equal Opportunities, Legal and Other Implications: None

Outcome Required: The Board of Directors is requested to approve the Annual Governance Statement

Link to Policies and Strategies: Corporate Governance Manual

ANNUAL GOVERNANCE STATEMENT 2017 – 2018

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Northumberland, Tyne and Wear NHS Foundation Trust and the group, 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 Northumberland, Tyne and Wear NHS Foundation Trust and the group for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Executive Director of Commissioning and Quality Assurance has overall lead responsibility for performance risk management within the Foundation Trust. While the Executive Director of Commissioning and Quality Assurance has a lead role in terms of reporting arrangements, all directors have responsibility for the effective management of risk within their own area of direct management responsibility, and corporate and joint responsibility for the management of risk across the organisation.

Structures and systems are in place to support the delivery of integrated risk management, across the organisation. Risk management training has continued to take place throughout the Trust this year. This includes training for new staff as well as training which is specific to roles in areas of clinical and corporate risk. Training has been taking place across the Trust to support the implementation of the new Risk Management Strategy and Policy which includes a risk appetite framework. Delivery of training against targets is monitored by the Board of Directors, and managed through the Trust Corporate Decisions Team and devolved management structures. The Foundation Trust has a Board of Directors approved Risk Management Strategy in place.

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

Operations for the Foundation Trust are managed through an organisational structure, with operations divided into three Groups (each of which has four clinical business units), and each has governance committees in place for quality and performance and operational management. Risk registers are maintained and reviewed by each Group and reviewed through the Foundation Trust-wide governance structures.

The Committees of the Board of Directors are required to consider the risks pertaining to their areas of responsibility by reviewing the management of Corporate and Group top risks; reviewing Board Assurance Framework to ensure that effective controls are in place to manage corporate risks and to report any significant risk management and assurance issues to the Board of Directors.

The Corporate Decisions Team and its Risk Management Sub-Group also undertake this review from an operational perspective to ensure that risks are recorded effectively and consistently and that controls in place are appropriate to the level of risk.

The Audit Committee considers the systems and processes in place to maintain and update the Assurance Framework, it considers the effectiveness and completeness of assurances and that documented controls are in place and functioning effectively.

The Mental Health Legislation Committee has delegated powers to ensure that there are systems, structures and processes in place to support the operation of mental health legislation, within both inpatient and community settings and to ensure compliance with associated codes of practice and recognised best practice.

The risk and control framework

The Foundation Trust continually reviews its risk and control framework through its governance and operational structures. It has identified its major strategic risks, and these are monitored, maintained and managed through the Board of Directors Assurance Framework and Corporate Risk Register, supported by Group and Directorate risk registers. The Foundation Trust's principal risks and mechanisms to control them are identified through the Assurance Framework, which is reviewed by the Board of Directors regularly. These risks are reviewed and updated through the Foundation Trust's governance structure. Outcomes are reviewed through consideration of the Assurance Framework to assess for completeness of actions, review of the control mechanisms and on-going assessment and reviews of risk score.

The Foundation Trust's Risk Management Strategy for 2017 – 2022 defines the risk management ambitions for the organisation:-

1. To support greater devolution of decision making and accountability for management of risk throughout the organisation from Trust Board to point of delivery (Board to Ward).
2. To promote a risk culture of monitoring and improvement, which ensures risks to the delivery of the Trust's ambitions are identified and addressed.

3. To define processes, systems and policies throughout the Trust which are in place to support effective risk management and ensure these are integral to activities in the Trust.
4. To support service users, carers and stakeholders through the reduction of risks to service delivery and improved service provision.
5. To support the Trust Board in being able to receive assurance that the Trust is continuously monitoring external compliance targets and legislation responsibilities, including standards of clinical quality, NHSI compliance requirements and Trust's licence.

Risks facing the organisation will be identified from a number of sources, for example:

- Risks arising out of the delivery of day to day work related tasks or activities
- The review of strategic or operational ambitions
- As a result of an incident or the outcome of investigations
- Following a complaint, claim or patient feedback
- As a result of a health and safety inspection/assessment, external review or audit report
- National requirements and guidance

The Foundation Trust Board through its Risk Management Strategy and Policy has adopted a risk appetite statement which shows the amount of risk the Board of Directors is willing to accept in seeking to achieve its Strategic Ambitions. This was agreed following a Trust Board of Directors Development session in February 2017. Risk appetite is the level of risk deemed acceptable or unacceptable based on the specific risk category and circumstances/situation facing the Trust. This allows the Trust to measure, monitor and adjust, as necessary, the actual risk positions against the agreed risk appetite. The Trusts risk appetite statement is shown below:-

Category	**Risk Appetite**
Clinical Innovation	NTW has a **MODERATE** risk appetite for Clinical Innovation that does not compromise quality of care.
Commercial	NTW has a **HIGH** risk appetite for Commercial gain whilst ensuring quality and sustainability for our service users.
Compliance/Regulatory	NTW has a **LOW** risk appetite for Compliance/Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements.
Financial/Value for money	NTW has a **MODERATE** risk appetite for financial/VfM which may grow the size of the organisation whilst ensuring we minimising the possibility of financial loss and comply with statutory requirements.
Partnerships	NTW has a **HIGH** risk appetite for partnerships which may support and benefit the people we serve.
Reputation	NTW has a **MODERATE** risk appetite for actions and decisions taken in the interest of ensuring quality and

	sustainability which may affect the reputation of the organisation.
Quality Effectiveness	NTW has a **LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users.
Quality Experience	NTW has a **LOW** risk appetite for risks that may affect the experience of our service users.
Quality Safety	NTW has a **VERY LOW** risk appetite for risks that may compromise safety.
Workforce	NTW has a **MODERATE** risk appetite for actions and decisions taken in relation to workforce.

All risks which exceed the Trust risk appetite will be reported through the Trust Governance Structures to the Board of Directors. This replaces the system of all risks of 15 and above being reported.

The table below summarises those risks which have exceeded risk appetite, as reported to the Board in the Assurance Framework in March 2018. All risks identified below are considered as in year and future risks relating to the Strategic Ambitions pertinent to 2017-18.

Risk Ref	**Risk description**	**Risk Appetite**	**Risk score**
SA1.3	That there are adverse impacts on clinical care due to potential future changes in clinical pathways through changes in commissioning of services.	Quality Effectiveness (6-10)	12
SA1.4	The risk that high quality, evidence based and safe services will not be provided if there are difficulties in accessing services in a timely manner and that services are subsequently not sufficiently responsive to demands.	Quality Safety (1-5)	8
SA3.1	That we do not further develop integrated information systems across partner organisations	Quality Safety (1-5)	9
SA3.2	That we do not influence the development of integrated new care models (ICS, MCP, STP) affecting the sustainability of MH and LD services.	Quality Effectiveness (6-10)	16
SA4.1	That we have significant loss of income through competition and national policy including the possibility of losing large services and localities.	Finance/VfM (12-16)	20
SA4.2	That we do not manage our resources effectively through failing to deliver the required service change, productivity gains	Finance/VfM (12-16)	20

	and failing to meet the Trust control total of £7.1m		
SA5.2	That we do not meet significant statutory and legal requirements in relation to Mental Health Legislation	Compliance/ Regulatory (6-10)	12
SA5.5	That there are risks to the safety of service users and others if we do not have safe and supportive clinical environments.	Quality Safety (1-5)	10

Action plans are in place to enable any gaps in control to be addressed. This process is managed through the Trust's governance structures described and those supporting and underpinning this are the Audit Committee, Quality and Performance Committee, Resource and Business Assurance Committee, and Mental Health Legislation Committee.

The Trust's governance structures are the subject of periodic review, the last review taking place June 2017 where changes were made to the committee terms of reference to reflect the new arrangements for risk management across the committees.

Each of the committees is chaired by a Non-Executive Director and has Executive Director membership.

Throughout the year the Audit Committee has operated as the key standing Committee of the Trust Board with the responsibility for assuring the Board of Directors that effective processes and systems are in place across the organisation to ensure effective internal control, governance and risk management that support the achievement of the organisations objectives (both clinical and non-clinical).

Each of the sub-committees of the Foundation Trust Board of Directors has responsibility for risks pertaining to their area of focus and ensuring the following takes place:

- Review the management of the Corporate Risk Register and the Groups top risks;
- Review the Board Assurance Framework to ensure that the Board of Directors receive assurances that effective controls are in place to manage corporate risks;
- Report to the Board of Directors on any significant risk management and assurance issues.

The Quality and Performance Committee has responsibility for overseeing the Foundation Trust's performance against fundamental standards for quality and safety as part of this role. The Committee also considers all aspects of quality and performance, in terms of delivery of internal and external standards of care and performance.

The Resource and Business Assurance Committee provides assurance that all matters relating to Finance, Estates, Information Management and Technology and Business and Commercial Development are effectively managed and governed.

The Research and Development Committee, a sub Committee of the Quality and Performance Committee, oversees the implementation and review of the Trust's Research and Development Strategy and ensures that the organisation's research governance responsibilities are met, including the cost effective use of research and development income.

Quality Governance arrangements are through the governance structures outlined above, ensuring there are arrangements in place from ward to Board. Review, monitoring and oversight of these arrangements takes place through the following, among others:

1. Trust Board
2. Quality and Performance Committee
3. Group Quality Standards Meetings
4. Corporate Decisions Team meetings and its Quality Sub-Group

The Trust reviews its performance against NHSI's (*formerly Monitor's*) published Quality Governance Framework on a twice yearly basis through the Quality and Performance Committee.

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 NTW(0)05 and supporting practice Guidance Notes provides the framework for staff for the reporting, management investigation and dissemination of lessons learnt. The Trust has adopted the principles of the National Patient Safety Agency's "Seven Steps to Patient Safety" and embedded them in day to day practice.

The Trust has a data quality improvement plan in place to ensure continuous improvement in performance information and has made continued advances in this area through 2017-18 with continued development of dashboard reporting from patient and staff level to Trust position. The Trust audit plan includes a rolling programme of audit against all performance and quality indicators.

Registration compliance is managed through the above quality governance structures and is supplemented by the Deputy Chief Operating Officer/Group Director being responsible for the oversight of all compliance assessments and management of on-going compliance through the Trust CQC Compliance Group. This Group reports into the Corporate Decisions Team Quality Group. A process is in place through the governance arrangements highlighted above to learn from external assessments and improve our compliance. The CQC Compliance Group undertakes regular reviews of compliance against the CQC Fundamental Standards including undertaking mock visits and identifying Improvement requirements.

This formal governance framework is supplemented by an on-going programme of visits by Executive Directors and members of the Corporate Decisions Team, which are reported through the Corporate Decisions Team, as well as service visits by Non-Executive Directors.

The Foundation Trust is registered with the CQC and has maintained full registration, with no non-routine conditions, from 1st April 2010. The CQC conducted a full comprehensive inspection during 2016 and rated the Trust as 'Outstanding'.

As described above the Trust has robust arrangements for governance across the Trust. Risks to compliance with the requirements of NHS Foundation Trust condition 4 (FT governance) are set out where appropriate within the Assurance Framework and Corporate Risk Register. The Board has reviewed its governance structures and the Board and its Committees undertake an annual self-assessment of effectiveness and annually review their terms of reference.

The Corporate Decisions Team is responsible for the co-ordination and operational management of the system of internal control and for the management of the achievement of the Foundation Trust's objectives agreed by the Board of Directors. Operational management, through the Foundation Trust's directors, is responsible for the delivery of Foundation Trust objectives and national standards and for managing the risks associated with the delivery of these objectives through the implementation of the Foundation Trust's risk and control framework. Governance groups have been in place across all areas throughout this accounting period, with each Group having in place a Locality Management Group, and Quality Standards Group. To fulfil this function the Corporate Decisions Team reviews the Assurance Framework and Corporate Risk Register, as well as reviewing Group top risks. It also receives and considers detailed reports on performance and risk management across the Foundation Trust through its sub groups.

The Risk Management Strategy, the associated Risk Management Policy and the governance structure identified above have been developed in line with nationally identified good practice.

The Trust undertook an external assessment of its governance arrangements using the Well Led Framework through 2015-16, supported by Deloitte, in line with Monitor's recommendations relating to foundation trusts. Deloitte provided feedback to the Board at a Board Development Session in December 2015 and the Board of Directors reviewed the final report, including the recommendations in January 2016. The independent review confirmed that there were no material governance concerns.

As part of CQCs comprehensive inspection during 2016 the trust governance arrangements came under further external scrutiny. The Trust achieved an 'Outstanding' rating for Well-led in addition to its overall rating.

The Foundation Trust involves public stakeholders in identifying and managing risks to its strategic objectives in a number of ways. These include:

- Working with partners in health and social services in considering business and service change. The Foundation Trust has a framework for managing change to services agreed as part of its contracts with its main commissioners across the North East. The Foundation Trust also has good relationships with Overview and Scrutiny Committees, with an excellent record of obtaining agreement to significant service change.

- Active relationships with Healthwatch and user and carer groups, and works with these groups on the management of service risks.

- A Deputy Director, Communications and Corporate Relations reporting directly into the Chief Executive for sustaining effective relationships with the key public stakeholders.

- Active engagement with governors on strategic, service, and quality risks, including active engagement in the preparation of the Annual Plan, Quality Accounts and the setting of Quality Priorities.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Foundation Trust has a Financial Strategy, which was most recently updated as part of the submission of the 2017-19 Operational Plan, and now includes detailed plans for delivery of service and financial objectives to March 2019. A refresh of financial plans for 2018/19 was approved in April 2018. Budgets are agreed based on the overall plan and a full re-basing exercise has taken place to underpin the budgets for 2018/19. All budgets, including Financial Delivery Plans are signed off by budget holders before approval by the Board of Directors. The financial position is reviewed on a monthly basis through, through the Executive Directors meeting and through the Board of Directors and on a quarterly basis by the Resource and Business Assurance Committee.

The Trust Board receives an update on the Financial Delivery Plan at each meeting. On-going plans for financial delivery have been developed through Operational Groups, and reviewed through Business Delivery Group, Group Operational Management Groups, The Executive Directors Meeting, Corporate Decisions Team and the Trust Board, as well as being reviewed through the Resource and Business Assurance Committee. An integrated approach has been taken to financial delivery

with each scheme assessed for its financial workforce and quality impact. Each Group reviews its own performance on its contribution to the Trust Financial Delivery Plan at its Operational Management Group. The Foundation Trust actively benchmarks its performance, through a range of local, consortium based and national groups, and is actively involved in a range of quality, resource and service improvement initiatives with NHS Improvement

Internal Audit provides regular review of financial procedures on a risk based approach, and the outcomes of these reviews are reported through the Audit Committee. The Internal Audit Plan for the year is approved on an annual basis by the Audit Committee, and the Plan is derived through the consideration of key controls and required assurances as laid out in the Trust Assurance Framework. The Audit Committee have received significant assurance on all key financial systems through this process.

Information governance

The Foundation Trust has effective arrangements in place for Information Governance with performance against the Information Governance Toolkit reported through the Caldicott Health Informatics Group, Quality and Performance Committee and the Corporate Decisions Team.

Version 14.1 of the Toolkit was released in May 2017 and the Trust has met the required standard of level 2 across all key standards in the Information Governance Toolkit.

In 2017/2018 the Trust reported one Information Governance incident to the ICO and relevant stakeholders which was classified at level 2 in accordance with the HSCIC Governance Incident Reporting Tool. This incident was brought to the attention of the Trust in May 2017 by NHS Digital CareCert. NHS Digital informed that the Trust's public website www.ntw.nhs.uk had potentially been accessed illegally in July 2016.

The data potentially accessed related to those individuals who have contacted the Trust via the Trust's website. The data potentially accessed includes personal and personal sensitive data for example, name, address (email/contact details) and information relating the nature of the contact made to the Trust.

The Trust took immediate remedial action, investigated the incident and informed the Information Commissioner. It was confirmed that only one record was definitively accessed. The Trust was already in the process of renewing it's website, and a new website has now gone live.

The ICO have concluded their review and have decided that regulatory action is not required in this case.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality

Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

2017-18 is the 9th year of developing Quality Accounts/Report for Northumberland, Tyne and Wear NHS Foundation Trust.

The Trust has drawn upon service user, carer and staff feedback as well as the Council of Governors to inform the Quality Account/Report. We have also listened to partner feedback on areas for improvement and our response to these are incorporated in the 2017-18 Quality Account.

Whilst the national requirement is to set annual priorities the Trust has established 3 overarching Quality Goals which span the life of the Integrated Business Plan, ensuring our annual priorities enable us to continually improve upon the three elements of quality: Patient Safety, Clinical Effectiveness and Patient Experience as shown in the table below.

Goal	**Description**
Safety	Keeping you safe
Experience	Working with you, your carers and your family to support your journey
Effectiveness	Ensure the right services are in the right place at the right time to meet all your health and wellbeing needs

Our Quality Governance arrangements are set out in section 4 of the Annual Governance Statement. The Executive Director of Commissioning and Quality Assurance has overall responsibility to lead the production and development of the Quality Account/Report. A formal review process was established, the Quality Account/Report drafts were formally reviewed through the Trust governance arrangements (Corporate Decisions Team, Quality and Performance Committee, Audit Committee, Council of Governors and Board of Directors) as well as being shared with partners.

The Trust has put controls in place to ensure the accuracy of the data used in the Quality Account/Report. These controls include:

- Trust policies on quality reporting, key policies include:
    - NTW(O)05 Incident Policy (including the management of Serious Untoward Incidents)
    - NTW(O)07 Comments, Compliments and Complaints Policy
    - NTW(O)09 - Management of Records Policy
    - NTW(O)26 - Data Quality Policy

- NTW(O)28 – Information Governance Policy
- NTW(O)34 - 7 Day Follow Up
- NTW(O)62 - Information Sharing Policy
- NTW(O)36 – Data Protection Policy
- NTW(O)08 – Emergency Preparedness, Resilience and Response Policy

- Systems and processes have been further improved across the Trust during 2017-18 with the continued expansion of the near real-time dashboard reporting system, reporting quality indicators at every level in the Trust from patient/staff member to Trust level.

- The Trust has training programmes in place to ensure staff have the appropriate skills to record and report quality indicators. Key training includes:

  - Electronic Patient Record (RiO)
  - Trust Induction
  - Information Governance

- The Trust audit plan includes a rolling programme of audits on quality reporting systems and metrics.

- The Internal Audit Plan is fully aligned to the Trust's Corporate Risk Register and Assurance Framework, and integrates with the work of clinical audit where this can provide more appropriate assurance.

- The Quality and Performance Committee reviews performance against Monitor's published Quality Governance Framework on a twice yearly basis.

- The Foundation Trust has a near real-time reporting system which connects all our business critical systems. The system presents information at varying levels enabling board to patient drill down. It is accessible by all Trust staff.

Through the engagement and governance arrangements outlined above the Trust has been able to ensure the Quality Account/Report provides a balanced view of the Organisation and appropriate controls are in place to ensure the accuracy of data.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other

reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee, and the Foundation Trust governance committees and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Performance and Assurance Framework provide me with evidence that the effectiveness of controls in place to manage the risks associated with achieving key organisational objectives have been systematically reviewed. Internally I receive assurance through the operation of a governance framework as described above, including the Trustwide Governance Structure, Group level governance structures, internal audit reviews and the Audit Committee.

My review is also informed by (i) On-going registration inspections and Mental Health Act reviews by the Care Quality Commission (ii) the National Health Service Litigation Authority Clinical Negligence Scheme for Trusts, (iii) External Audit, (iv) NHS England (v) NHS Improvement's ongoing assessment of the Foundation Trust's performance, (vi) on-going review of performance and quality by our Commissioners and vii) the external assessment of the Trust's governance arrangements using the Well Led Framework through 2015-16, supported by Deloitte.

Throughout the year the Audit Committee has operated as the key standing Committee of the Trust Board with the responsibility for assuring the Board of Directors that effective processes and systems are in place across the organisation to ensure effective internal control, governance and risk management. The Audit Committee is made up of three Non-Executive Directors, and reports directly to the Board of Directors. The Committee achieves its duties through:

- Overseeing the risk management system and obtaining assurances that there is an effective system operating across the Trust. Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the Foundation Trust that supports the achievement of the organisations objectives.

- Consideration of the systems and processes in place to maintain and update the Assurance Framework, and consideration of the effectiveness and completeness of assurances that documented controls are in place and functioning effectively.

- Scrutiny of the corporate governance documentation for the Foundation Trust.

- The agreement of external audit, internal audit and counter fraud plans and detailed scrutiny of progress reports. The Audit Committee pays particular attention to any aspects of limited assurance, any individual areas within reports where particular issues of risk have been highlighted by internal audit, and on follow up actions undertaken. Discussions take place with both sets of auditors and management as the basis for obtaining explanations and clarification.

- Receipt and detailed scrutiny of reports from the Foundation Trust's management concerning the governance and performance management of the organisation, where this is considered appropriate.

- Review of its own effectiveness against national best practice on an annual basis. The terms of reference for the committee were adopted in line with the requirements of the Audit Committee Handbook and Monitor's Code of Governance.

The Trust Board itself has a comprehensive system of performance reporting, which includes analysis against the full range of performance and compliance standards, regular review of the Assurance Framework and Corporate Risk Register, ongoing assessment of clinical risk through review of complaints, SUIs, incidents, and lessons learned. The Quality and Performance Committee receives a regular update on the performance of clinical audit. The Board of Directors also considers periodically a review of unexpected deaths which includes a comparison with national data, when available.

There are a number of processes and assurances that contribute towards the system of internal control as described above. These are subject to continuous review and assessment. The Assurance Framework encapsulates the work that has been undertaken throughout the year in ensuring that the Board of Directors has an appropriate and effective control environment. This has identified no significant gaps in control and where gaps in assurance have been identified, actions are in place to ensure that these gaps are addressed.

Conclusion

My review confirms that Northumberland, Tyne and Wear NHS Foundation Trust and the group has a generally sound system of internal control that supports the achievement of its policies, aims and objectives. No significant internal control issues have been identified.

Signed……..

Chief Executive Date: xx May 2018

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors

Meeting Date: 23rd May 2018

Title and Author of Paper:
Board Self Certification to NHS Improvement
Anna Foster, Deputy Director of Commissioning & Quality Assurance

Executive Lead: Lisa Quinn, Executive Director of Commissioning & Quality Assurance

Paper for Debate, Decision or Information: Decision

Key Points to Note:

To maintain the NHS Provider Licence, NHS Foundation Trusts are required by NHS Improvement to self-certify the following two declarations by 31 May 2018:

- Condition G6(3) – the Trust has complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution),
- Condition CoS7(3) – the Trust has the required resources available to provide services if providing commissioner requested services.

It is recommended that the Board declare compliance with the above statements, and this paper provides the evidence to support this recommendation.

Risks Highlighted: BAF considered

Does this affect any Board Assurance Framework/Corporate Risks: No

Equal Opportunities, Legal and Other Implications: None

Outcome Required / Recommendations: Submission of declaration to NHS improvement by 31st May 2018

Link to Policies and Strategies: 2017-19 Planning Guidance and standard contract, integrated governance arrangements, Operational Plan 2017-19

Northumberland, Tyne and Wear NHS Foundation Trust

NHS FOUNDATION TRUST SELF CERTIFICATION REQUIREMENTS

BACKGROUND

To maintain the NHS Provider Licence, NHS Foundation Trusts are required by NHS Improvement to self-certify on an annual basis the following two declarations:

- Condition G6(3) – the Trust has complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution),

- Condition CoS7(3) – the Trust has the required resources available to provide services if providing commissioner requested services.

The aim of the self-certification is for Trust Boards to carry out assurance that they are in compliance with these conditions, and have taken into account the views of governors. There is no set assurance process prescribed by NHS Improvement, however suggested templates have been provided to facilitate Board sign off.

To comply with the timescales for self-certification prescribed by NHS Improvement, the Board must sign off the declarations no later than 31 May 2018.

NHS Improvement will be conducting an audit of selected Trusts to ask for evidence of self-certification.

General Condition G6 – Systems for Compliance with Licence Conditions

The Board is asked to respond "confirmed" or "not confirmed" to the following statement:

> "Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution."

Note that licence condition G6 is shown in full in Appendix 1. Paragraph 2(b) requires that the systems and processes in place to identify risk to compliance with licence conditions are effective and regularly reviewed.

It is recommended that the Board <u>confirms</u> the above statement, due to the following evidence:

1. **External assurance:**
   - No concerns raised by NHS Improvement
   - CQC registration and "Outstanding" overall and well-led ratings
   - Assurance from External Auditors in relation to:
     - Annual Governance Statements
     - Quality Accounts
     - Annual Accounts

2. **Assurance from the Trust's Internal Audit programme on relevant topics:**

   The Head of Internal Audit Opinion for year ending 31st March 2018 is "from my review of your systems of internal control and reports issued to date, my overall opinion is that substantial assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives."

   The following audits have been received during 2017/2018 (this is reflective of the Head of Internal Audit Opinion report taken at Audit Committee 16th May 2018).

Audit Topic	Substantial	Good	Reasonable	Limited
Board Assurance Framework & Corporate Risk Register				
Financial Reporting & Budgetary Control				
Financial Accounting/General Ledger				
Accounts Payable				
Accounts Receivable				

Audit Topic	Substantial	Good	Reasonable	Limited
Bank and Treasury Management				
Risk Management				
Information Governance Toolkit	At the date of review (January to March 2018) ten out of ten requirements reviewed could be substantiated at the level reviewed.			
Pay Expenditure				
CQC Action Plan Process				
Measurement, Reporting and Acting on Outcomes of Patient Experience				
Performance Management and Reporting				
Staff Engagement with the Staff Survey				
PFI Contract Monitoring				
Patient Care and Non-Patient Care Activities Income				
Estates Process for the delivery of Maintenance, Repairs & Improvements				
Asset Management				
National Alert Systems				
Safeguarding Arrangements – Domestic Abuse				
Management of Asbestos				
Role of the Freedom to Speak Up Guardian				
Implementation of the Smoke-Free Policy				
Compliance with Business Change Process				
Serious Untoward Incident				
TRA1 - Server Configurations and Security				
TRA1 - Data Centre Physical and Environmental Security Controls				
Reference Costs				
Monitoring of Absences				
TRA1 - Wireless Network Security				
SAPP (Safeguarding Adults Public Protection) Referrals				

3. Relevant papers presented to the Board of Directors (a copy of the Trust Governance Structure is attached as appendix 3)

a. Quality, Clinical and Patient Issues

Monthly Reporting
Commissioning and Quality Assurance Report

Quarterly Reporting
Service Visit Feedback – Themes
Service User and Carer Experience
Safer Care Report
Safer Staffing Levels
Guardian of Safe Working

Six Monthly Reporting
Safe Working Hours
Six Monthly Skill Mix Review
Safeguarding Board Updates (Adults and Children)
Learning and Improving from Activity (6 monthly report)
Infection, Prevention and Control Report
Emergency Planning and Resilience Report

Annual Reporting
Safeguarding and Public Protection Annual Report
Fire Response
Seasonal Flu Vaccination Plan
Annual Medicines Management Report
Controlled Drugs Accountable Officer Annual Report
Community Mental Health Survey
Infection, Prevention and Control Annual Report and Plan
Emergency Planning and Resilience Assurance Process
Safer Staffing Annual Report
Research and Development Annual Report

Closed Board
Serious Case Reviews, Safeguarding Adult Reviews etc
Independent Investigations Update
MHL Committee Panel Members Annual Report

b. Workforce Issues

Quarterly Reporting
Workforce Directorate Quarterly Update
Staff Friends and Family report

Six Monthly
Whistle Blowing/Raising Concerns (including Freedom to Speak up Guardian Update)

Annual Reporting
EDS 2/WRES Updates
Focus of Workforce Issues
National Staff Survey Results
Medical Revalidation Annual Report
Annual Deanery Monitoring Report

Closed Board
Employment Tribunal Update
Sickness Absence Update

c. Regulatory

Quarterly Reporting
Quarterly NHSI Report
Board Assurance Framework and Corporate Risk Register

Annual Reporting
Board and Committee Terms of Reference
Board Self Certification to NHS Improvement
Security Management Annual Report
Annual Accounts and Management Rep Letter
Annual Report
Annual Quality Account
Annual Audit Committee Report
Annual Governance Statement
NHS Improvement Self Certification
NHS Improvement Agency Expenditure Board of Directors Self Certification Checklist

d. Strategy and Partnerships

Annual Reporting
State of the Provider Sector Report and MH Infographic
NTW Strategy Annual Update
NTW Supporting Strategies updates
Budget and Financial Plans
2017 – 2019 Contract Update
Voluntary Services Annual Report

Closed Board
Detailed Financial Report
Monthly Finance Report
Finance Plans/Budgets

e. Trust Board Development Sessions

Over the past twelve months the following development sessions have taken place with the Trust Board.

Date	Subject
6 April 2017	Joint engagement session with COG, Learning Disability Transformation update.
24 May 2017	Cyber attack Informatics Strategy Risk management Strategy
28 June 2017	Psychology Strategy AHP Strategy GP Survey Medical workforce strategy
26 July 2017	Services closer to home Physical Health Strategy
28 Sept 2017	NTW Solutions Phase 2 Deciding together New Care Models
24 October 2017	Heads up - Local update (focus on Deciding Together Medical Recruitment Mental Health Legislation Mental health STP workstream
25 October 2017	Nurse Academy Business Case
23 Nov 2017	General Data Protection Regulation CYPS critical service delivery issues Earned Autonomy
12 Dec 2017	Joint session with Governors/Chair focus groups
25 January 2017	Domestic Homicide Review
21 February 2017	Subsidiary Company Trust Branding Ken Tooze
24 May 2017	Cyber Attack Risk Management Strategy
27 June 2017	International Development Head up session including - National Update - Mental Health STP - Locality update - NTW Developments
24 October 2017	Heads up session including - National and STP update - Locality update Medical staff issues and recruitment Mental Health Legislation development session
24th January 2018	Domestic Homicide Review Finance discussion
27 February 2018 Away Day	Finance Operational Plan
28th March 2018	Transforming Care update – over lunch CQC Planning Risk Appetite

Date	Subject
17 April 2018	9.30 – 13.00 Ken Tooze 13.45 – 16.00 CQC Inspection
25 April 2018	9.50 – 11.30 Risk Appetite
23 May 2018	9.30 – 10.30 Cyber security 10.30 – 11.30 Medical training (Jacqui Snaith)

4. Relevant papers presented to Trust Board standing committees for consideration:

a. Quality & Performance Committee

Each Meeting

- Safer Staffing Exception Report
- Safer Staffing Skill Mix Review Report
- Summary Commissioning and Quality Assurance Report
- Sub Group/Quality Standard Group Minutes and Exception Report from Chair to highlight any concerns/risks/mitigations/timescales
  - Quality Standard Groups x3
  - Caldicott and Health Informatics Group
  - Clinical Effectiveness Committee
  - Emergency Preparedness, Resilience and Response Group
  - Health, Safety and Security Group
  - Infection, Prevention and Control Committee
  - Learning and Improvement Practice Group
  - Medicines Management Committee
  - Service user and Carer Involvement and Experience Group
  - Physical Health and Wellbeing Group
  - Positive and Safe Group
  - Council of Governors Quality Group
  - Research and Development Group
  - Safeguarding and Public Protection Group

Quarterly Reporting

- North Locality Care Group Quality & Performance Report
- Central Locality Care Group Quality & Performance Report
- South Locality Care Group Quality & Performance Report
- Quality Governance Framework
- Risk Management Highlight Report
- Safer Care Report
- Service User and Carer Experience
- Patient and Clinician Reported Outcome Measures
- Guardian of Safe Working Hours Report

Three Time Annually

- Medicines Management
- Safeguarding and Public Protection

Six Monthly

- Controlled Drugs-Management and Use
- CQC Compliance, Inspection reports and Intelligent Monitoring
- Workforce Report
- Clinical Audit
- NICE Guidance
- Development of Quality Account and Quality Priorities
- Service User and Carer Experience Group Six Monthly Report

Annual Reporting

- Senior Information and Risk Officer/Caldicott Report
- Director Infection Prevention and Control
- Director Emergency Preparedness, Resilience and Response
- Research and Development
- Eliminating Mixed Sex Accommodation
- Sub Group/Clinical Group annual assessment of effectiveness
- Committee annual assessment of effectiveness and review of terms of reference

Quality Focus Sessions – at each meeting there is a quality focus presentation, over the past year the following sessions have taken place:-

- Positive and Safe
- Bed management
- Waiting Times
- Medical Recruitment
- Positive and Safe analysis of restraint against national picture
- Learning from themes from risk registers

b. Resource & Business Assurance Committee

Each Meeting

- Finance and Business Development - financial position, risks, efficiency plans, capital spend and asset sales, strategic partnerships and tenders
- Income and Commissioning Report - commissioning and income risks
- Capital report - report on risks only - project board highlight reports for information – risks to be highlighted in report
- Workforce and OD - strategy and risks, recruitment and retention, management capacity, skills and knowledge, employment
- Sub Group minutes
  - Capital project boards
  - Integrated Business Development Group
  - Sustainability, Waste and Transport Group

Quarterly Reporting

- Risk exception report - update on risks and how to address
- Informatics Quarterly Report

Six monthly

- Utility and Cost Report

Annual Reporting

- Budget Setting Process
- Operational/Annual Plan
- Sustainability
- Assessment of Committee

c. Mental Health Legislation Committee

Each Meeting

- Panel Member update
- Workforce Report
- Mental Health Legislation Steering Group Report
- Mental Health Legislation Steering Group minutes
- Mental Health Legislation Activity Report – which includes inpatient activity, new sections, Mental Health Tribunals, Hospital Manager hearings, DoLS, Monitoring of mental health act local forms for detained and CTO patients and monitoring of the mental health act.
- MHL Related Policy Report
- CQC MHA Reviewer Visits Summary Report
- Law and Practice – New Reports/Guidance

Quarterly Reporting

- Risk exception reporting

Annual Reporting

- Review of ToR MHLC
- Review of Performance against ToR
- Review of Delegation of Statutory Functions

d. Audit Committee

- Quality Account Preparation 17/18 and Quality Priority setting 18/19
- Quality Account 17/18
- Annual Accounts 17/18
- Annual Governance Statement 17/18
- External Audit review of annual documentation listed above
- Head of Internal Audit Opinion
- A progress update is received from Internal Audit at each meeting
- Board Assurance Framework and Corporate Risk Register is received quarterly.
- Going Concern Report

5. The Risk Management Strategy 2017 – 2022 was approved by Trust Board in May 2017, the Board Assurance Framework and Corporate Risk Register is reviewed on a quarterly basis by Audit Committee and received by Trust Board quarterly.

6. Comprehensive evidence has also been provided to the Trust Board in previous years and there has not been any material events in 2017/18 that have impacted upon the Trust's ability to state compliance with the above requirements.

Continuity of Services Condition 7 – Availability of Resources (Commissioner Requested Services only)

The Board is asked to respond "confirmed" to one of the following three options:
Either (*recommended*):

> "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

Or:

> "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services."

Or:

> "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate."

Note that "required resources to continue to provide commissioner requested services" covers management, financial and staff resources, plus facilities and physical assets. Please see Appendix 2 for the full licence condition.

It is recommended that the Board confirms the first statement above *(After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate)* due to the following evidence**:**

a) Board approval of the 2018-19 budget and operational plans in March 2018
b) External assurance from external auditors in relation to annual accounts, financial systems and processes as shown above
c) Assurance from the Trust's internal audit programme in relation to financial systems and processes as shown above
d) Safer Staffing updates presented regularly to the Trust Board
e) Other relevant papers presented to the Trust Board as shown above
f) Relevant papers presented to the Resource & Business Assurance Committee shown above
g) There has not been any material events in 2017/18 that have impacted upon the Trust's ability to state compliance with the above requirements.

The Board is required to provide a statement of the main factors taken into account when making this declaration. **It is recommended that the evidence shown above be provided to NHS Improvement to meet this purpose.**

Governors' views

It is a requirement that Trust Boards should take the views of Governors into account when agreeing the declarations included within this report. Much of the evidence presented above has been presented to Governors throughout 2016-17 through formal Council of Governors meetings, through engagement sessions and through other Governor meetings such as the Governors Quality Group. Governors have also attended (as observers) Trust Board and standing committees, and also participated in PLACE visits and other visits to Trust services. Through all of these measures, Governors have considered the evidence provided therefore **it is recommended that the Board declare that the above decisions have been made with regard to the views of the Governors.**

Appendix 1

Condition G6 – Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

   the Conditions of this Licence,
   any requirements imposed on it under the NHS Acts, and
   the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

   the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
   regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

Note that Monitor has since been replaced by NHS Improvement

Appendix 2

Condition CoS7 – Availability of resources

The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.

The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.

The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:

> "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."
> "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services".
> "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

The Licensee shall submit to Monitor with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.

The statement submitted to Monitor in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

The Licensee shall inform Monitor immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.

The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition: "distribution"	includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;
"Financial Year"	means the period of twelve months over which the Licensee normally prepares its accounts;

“Required Resources”	means such: management resources, financial resources and financial facilities, personnel, physical and other assets including rights, licences and consents relating to their use, and working capital as reasonably would be regarded as sufficient to enable the Licensee at all times to provide the Commissioner Requested Services.

Note that Monitor has since been replaced by NHS Improvement

Appendix 3