Tees, Esk and Wear Valleys
NHS Foundation Trust

Making a difference together

Annual report and financial statements 2009/2010

Tees, Esk and Wear Valleys NHS Foundation Trust Annual report and financial statements 2009/10

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

Contents

Chief executive's report

Reviewing the past

We have much to be proud of in our first full year as a foundation trust. We have worked hard to bring about the improvements we need to make as we move towards achieving our vision and strategic goals.

We have continued to develop and modernise our services for the benefit of the people who use them and to help our staff build on their skills and expertise so that they can deliver these services.

Improving quality is vital to achieving our goals and we have made good progress over the past year to embed the principles and tools of our quality improvement system into everything we do.

Over the last twelve months we have successfully completed several important projects as we near the end of a long term investment strategy to modernise our facilities (see page 24). In January 2010 we moved into our brand new, purpose-built Lanchester Road Hospital in Durham and as the year came to a close the new Roseberry Park development in Middlesbrough was handed over to the trust.

Our staff are key to our continued success and to achieving our goals. Throughout the year staff from all areas of the trust, at all levels and whatever their job, have continued to show outstanding commitment to improving the quality of our services. We recognised and paid tribute to their dedication, skills and hard work at our third annual staff awards ceremony in January 2010 (see page 42).

The quality of our services and the skills of our staff have also been recognised at a regional and national level and over the last year our teams have been successful in winning a number of prestigious awards including:

- The Primrose Programme at HMP Low Newton won the World Health Organisation's Health in Prison Project award for its work with female offenders who pose a risk of serious harm as a result of severe personality disorder (see page 51).
- The trust's community veteran's mental health service pilot was awarded the Military and Civilian Health Partnership Awards 2009 Care of Veterans award (see page 22).
- Our liaison psychiatry team and Stockton's psychosis team won the regional patient safety summit awards in the preventing suicide category and the drug safety category respectively (see page 34).
- Our quality improvement team were part of the North East team, which won the Lean Healthcare Academy Independent Project of the Year Award.
- Thornton ward (an acute adult mental health ward in Teesside) was a runner up in the Health Service Journal Awards.
- Our acute adult mental health wards in Durham were runners up in the Nursing Times awards for the patient pathway: Making Quality Count Award and Mental Health Nursing Award.
- The randomised Injected Opiate Treatment Trial (RIOTT) was highly commended in the HSJ Health and Safety Awards.

We are committed to providing high quality, safe and effective services. Our success can be measured through the feedback we receive from our external assessors, our service users and carers and our staff. Over the last year I have been very encouraged by the positive reviews we have received.

We were registered (without conditions) under the Care Quality Commission's (CQC) new system for monitoring standards. The new standards cover important issues for patients such as treating people with respect, involving them in decisions about care and ensuring services are safe.

At the end of 2009 we became one of just 11 mental health and learning disability trusts to have achieved the NHS Litigation Authority (NHSLA) level 2. This is an excellent achievement which provides recognition from the NHSLA that the trust is a safer organisation for service users and staff.

We received an excellent first annual report from the CQC on our compliance with the Mental Health Act and the review they undertook of our systems for safeguarding children was also very positive.

The results of two national service user surveys (adult inpatient and community services) placed us in the top twenty percent of trusts in many of the areas covered and above average in all areas. We were particularly pleased with the results of the community services survey where we topped the ratings in two areas, including the overall rating.

We want to be the best employer we can be and we were once again pleased with the results of the national staff survey where we were in the best 20% of trusts in 16 of the key areas. As this report went to print we had also just received confirmation that the trust had been successful in becoming an Investor in People organisation.

I am very pleased with the progress we have made towards achieving our five strategic goals and this report contains some excellent examples of the work we've done over the past year.

Looking to the future

2010/11 will be a transitional year for the NHS. It is the last year when the NHS can expect to receive significant annual growth in levels of funding and we can confidently predict that the reform agenda will continue to have a significant impact on the trust and the health and social care community. In particular:

- an increasing emphasis on health and wellbeing
- the evolving role of commissioners
- plurality of provision in a competitive market environment
- the financial outlook with the need to reduce public sector expenditure

The challenge for the trust will be not only to evolve to reflect these changes in the environment, but also to be a partner in change, both supporting and matching the pace of change as commissioners, statutory health and social care providers, private sector providers and the third sector embrace in full the aspirations of system reform.

You will see as you read this report that much has been achieved. Thousands of people have been helped and supported to minimise the impact that mental ill health or a learning disability has had on their lives. As we enter our third year as a foundation trust, we are now in a position to start making a real difference to the quality of services because of the opportunities that being a foundation trust have given us. One of those key benefits has been the financial regime which has enabled us to save up some cash to invest in improved new facilities. £11m has been set aside for the redevelopment of Cross Lane Hospital in Scarborough and the first phase of that redevelopment should be completed in early 2011, and a further £7m has been set aside for the development of learning disability inpatient facilities in Redcar and Cleveland and building work will start in 2010/11.

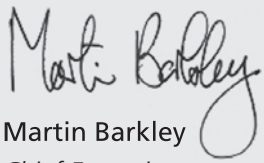
The main focus of the work of the Trust in 2010/11 and beyond will be to continue to improve the quality of what we do, principally using the quality improvement methodologies developed over many years by Toyota. These methodologies will reduce our costs by removing waste and focusing on what adds value. In 2009/10 the Trust developed a compact with our staff (a psychological or cultural relationship) and an important priority in 2010/11 will be embedding the principles of that compact.

One of the main highlights of 2010/11 will be the opening of the new Roseberry Park development in Middlesbrough. Other key priorities for 2010/11 include:

- Further reducing the maximum waiting times for people to access our services. Our aim is that by December 2010 the maximum waiting time for a first appointment will be six weeks.
- Embedding a revised set of values and corresponding behaviours that have been developed in conjunction with hundreds of staff in focus groups.
- Implementing a number of initiatives to improve the health and wellbeing of our staff.
- Implementing key elements of our information strategy including installing a new network. Our IT strategy is a key enabling strategy for us to improve quality and reduce cost.
- Improving the quality of the data we use to inform clinical and business decisions.
- Completing the next phase of modernising our community adult mental health services, by improving access arrangements and further investing in the skills of our staff who now work in either a specialist psychosis team or specialist affective disorders team.
- Improving access to psychological therapy in Durham and Darlington. The new service will start in September 2010 in conjunction with our partners Mental Health Matters and the community health services of Durham and Darlington.
- Developing and implementing a trust-wide framework for the collection of information on patient experience and patient reported outcomes.
- Responding to potential opportunities in North Yorkshire and York to provide specialist mental health services and specialist services for people who have a learning disability
- Through improved working arrangements in inpatient services and between those and the community services, reducing the typical length of stay of inpatients which will lead to reductions in the number of beds the trust needs.
- Continuing to strengthen our partnerships with local authorities as well as other providers and other agencies.

We are grateful for the invaluable support of our staff, our partner organisations, in particular our primary care trusts and local authorities, our service users and their carers, our governors and members and our volunteers.

Our success to date would not have been possible without their help and we appreciate their ongoing commitment to the trust as we tackle the challenges of the coming year.



Martin Barkley
Chief Executive

About the trust

Tees, Esk and Wear Valleys NHS Trust was created in April 2006, following the merger of County Durham and Darlington Priority Services NHS Trust and Tees and North East Yorkshire NHS Trust. In July 2008 we became the North East's first mental health trust to achieve foundation trust status under the NHS Act 2006.

As a foundation trust we are accountable to local people through our council of governors and are regulated by Monitor, the independent regulator of foundation trusts.

We provide a range of mental health, learning disability and substance misuse services for the 1.3 million people living in County Durham, the Tees Valley and North East Yorkshire. With around 5,000 staff (73% female and 27% male) and an annual income of £230 million we deliver our services by working in partnership with seven local authorities and primary care trusts, a wide range of other providers including voluntary organisations and the private sector, as well as service users, their carers and the public. The services are spread over a wide geographical area which includes coastal, rural and industrial areas.

Being a foundation trust is helping us:

- build on and improve positive relationships with service users, carers, staff, partners and local people and give greater accountability to local people
- strengthen our internal process and systems to meet the challenges of modern health services
- develop locally based specialist services (see examples of some of the services we have developed on page 22)
- respond better to market opportunities
- invest in capital developments such as the new hospital in Scarborough (see page 25)

Our mission

To improve peoples lives by minimising the impact of mental ill-health or a learning disability.

Our vision

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

Our values

Commitment to quality

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

Respect

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

Involvement

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

Wellbeing

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

Teamwork

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

Our goals

We have five strategic goals

1. To provide excellent services, working with individual users of our services and their carers to promote recovery and wellbeing.

This means that...

- We deliver high quality and safe services that minimise risk.
- Users of our services and their carers have positive experiences and outcomes.
- Users of our services experience no waiting, no unnecessary transfers and timely access to services and to a choice of personalised care and treatment.
- Our service users and their carers believe we are responsive to their needs and concerns and we advocate for our service users and carers with commissioners where there are perceived gaps in service.
- We deliver services in geographically and physically accessible and high quality environments.
- We actively seek positive and constructive feedback about the services we provide from our service users and carers.
- We have a reputation for excellence amongst the people who currently use our services or who may use them in the future.
- We provide accurate, relevant and timely information on our services, and signposting to the services of our partners, that is valued by the users of our services, their carers and their general practitioners (GPs) and enables informed choices to be made.
- We deliver, where commissioned, service models which are effective, responsive and supportive of the whole care pathway.
- We work at a national and local level to minimise the stigma of mental health and learning disabilities experienced by our service users.
- We continue to reduce the time people are waiting for both internal and external referrals.

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

This means that...

- We are recognised nationally for the high quality service we provide e.g. by Care Quality Commission, Annual Quality Accounts and any other additional benchmarking.
- Quality indicators and outcome measures are a key element of our proactive performance management framework, which uses high quality information at trust, directorate and service levels, to improve quality.
- We have embedded an organisational development approach to quality via the TEWV quality improvement system across the organisation and there is evidence of continuous improvement in the quality and value of our services.

- Our organisational development approach to quality has embedded a culture of continuous improvement with the customer at the heart of our clinical and business decision-making.
- We have an active programme of research and development to deliver better ways of helping our service users.
- We consistently learn and act on the lessons from both positive and negative experiences.
- We have common standards implemented consistently across the trust whilst also recognising the different levels of investment by primary care trust (PCTs) and the sovereignty of PCTs / practice based commissioners (PBCs) and local authority (LA) partners.

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

This means that...

- Our staff feel supported and valued in their role.
- Our staff have well defined job roles which add value.
- The trust and its workforce are committed to working both productively and flexibly.
- We promote and support the wellbeing of our staff.
- Our staff are positively engaged at all levels through effective communication and involvement strategies and practices that enables participation.
- We have embedded an understanding between the trust and our workforce (our compact) that sets out the "gives" and the "gets", the attitudes and behaviours consistent with the trust's values and what it means to work for the trust.
- Our staff access a range of appropriately resourced education, training and development opportunities to support their development and career progression.
- We provide all our staff with opportunities to attain managerial and leadership roles.
- We provide effective placements for students across the organisation.
- We have a workforce that is representative of the communities we serve and we welcome diversity.
- Our managers and leaders are developed to undertake their 'people management' roles effectively.
- Our workforce plans enable high quality service delivery.
- We attract high quality staff and manage succession through the deployment of effective recruitment and selection strategies.

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

This means that...

- The trust will support its commissioners in their ambition to be world class commissioners of mental health, learning disability and substance misuse services.
- We have excellent integrated community teams with our local authority social services partners.
- We are fully engaged in the health and wellbeing agenda via involvement with local strategic partnerships and delivery of the local area agreements (LAAs).
- We actively work with universities and education providers to support delivery of research and workforce plans.
- We have a range of partnerships and joint ventures with other providers and agencies (including acute hospitals, the private and voluntary sectors and the criminal justice system) which add value.
- We articulate and represent the needs and views of the people who use our services to local organisations and local communities.

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

This means that...

- We work with service users and carers to help ensure we are responsive to their views.
- We work together with general practitioners to ensure our services are responsive to them and the needs and views of the people they serve.
- We are the provider of choice with our local commissioners because of our excellent quality and value.
- Our council of governors is fit for purpose, representative of local communities and stakeholders and is actively engaged in our strategic and service development.
- We are accountable to our stakeholders and external regulators through robust governance arrangements.
- Our services are cost effective which can be proved by performance in national benchmarking tests eg national reference costs, Payment by Results.
- Our trust and its services are efficient and demonstrate continuous productivity improvement.
- We can demonstrate that we are an environmentally friendly and socially responsible organisation.
- We continuously develop new business opportunities which are consistent with our vision.
- We continuously deliver our integrated business plan and financial plan which are dynamic, flexible and responsive to the changing environment.
- We ensure our trust is sustainable with effective financial contingency planning.
- We have robust and tested emergency and business continuity plans in place.

"We would like to give you all a very big thank you for all the care and understanding that you have given our mother during her stay. We brought you a very confused and upset lady and in six weeks her life and ours have been completely turned around."

From a service user's daughters

Our services

Adult mental health services

We provide mental health services for adults of working age in partnership with social care and a number of voluntary and independent service providers, including:

- a wide range of community based assessment and treatment services including crisis intervention, assertive outreach, early intervention and eating disorders
- inpatient assessment and treatment services, including acute, intensive care and rehabilitation services

Our main hospitals are Lanchester Road in Durham, West Park Hospital in Darlington, Roseberry Park in Middlesbrough and Cross Lane Hospital in Scarborough.

Children and young people's service

This service includes all child and adolescent mental health services as well as children's learning disability services and also the early intervention in psychosis teams. Most services are provided in the community with inpatient services being located on West Lane Hospital site in Middlesbrough.

Mental health services older people

We provide mental health services for older people working in partnership with social care and a wide range of voluntary and independent service providers. The services we provide include:

- inpatient assessment and treatment services, including acute, intensive care and challenging behaviour
- a wide range of community based services

Our main inpatient services are provided at the Bowes Lyon Unit on the Lanchester Road Hospital site in Durham, West Park Hospital in Darlington, Roseberry Park in Middlesbrough, Auckland Park in Bishop Auckland, Sandwell Park in Hartlepool, Lustrum Vale in Stockton and Cross Lane Hospital in Scarborough.

Learning disabilities

We provide specialist assessment and treatment services to people with learning disabilities and mental health problems, epilepsy and challenging behaviour.

Our main sites include Bankfields Court in Middlesbrough, units within Lanchester Road Hospital in Durham and Hart Lodge in Hartlepool.

Forensic mental health and learning disabilities forensic services

We provide community, inpatient and rehabilitation forensic services for people with mental health problems and learning disabilities. Our inpatient services including medium and low secure environments are based at Roseberry Park in Middlesbrough and Lanchester Road Hospital in Durham.

Substance misuse services

We provide substance misuse services for people aged 18 years and above. These are funded primarily through drug and alcohol action teams across County Durham, Darlington and North East Yorkshire.

Principal risks and uncertainties

Our annual plan, which supports the achievement of our strategic direction, recognises the changing environment and the changing needs of our stakeholders.

The board will continue to focus on assurance and risk management systems as these are recognised as being fundamental to the achievement of our strategic direction.

The principal risks and uncertainties to achieving the trust's objectives are set out below.

We recognise that the nature and scope of risks can change and the board, in accordance with the integrated governance strategy, undertakes regular reviews of the risks facing the trust including key controls to manage and mitigate those risks identified and the assurances that the controls are effective.

The statement on internal control describes the systems and processes through which risks are identified, managed and mitigated. This can be found in chapter 6.

Financial

The trust is in a strong financial position. However, we expect the fiscal position to tighten due to constraints on public sector expenditure.

In addition, financial risks have been identified with regard to the proposed introduction of "Payment by Results". Work is being undertaken to ensure that we are well placed to respond.

Plans are in place through our integrated business plan and long term financial model to reduce costs and increase productivity. These plans will be further developed and refreshed to react to the challenging financial outlook.

Political

Any change in government can be expected to result in significant change to national health policy. The establishment of a coalition government has exacerbated uncertainty about how the National Health Service will develop in the medium term.

The board will continue to focus on ensuring we provide excellent services whilst responding to these changes in the external environment.

Governance and regulatory

The nature of the services we provide exposes us to wide-ranging and complex legal and regulatory risks.

The requirements of our principal regulators, Monitor and the Care Quality Commission have increased.

The trust was registered by the Care Quality Commission without conditions. However, we recognise that the Commission's regulatory systems will evolve.

The failures at Mid Staffordshire Foundation Trust provided lessons to all health care providers. The board has developed an action plan to address the findings of the Independent Inquiry chaired by Robert Francis QC.

Information challenges

The increased emphasis on demonstrating clinical quality requires robust information systems.

In 2008/09 we successfully introduced our new clinical records system (PARIS). Investment in this system will continue to ensure that the benefits of having a single electronic patient record are realised and we can meet the information requirements of our commissioners and regulators.

The board has recognised the need to improve data quality. Action has already been taken to address this issue and further improvements will be made during 2010/11 including:

- completion of the COIN roll out
- roll out of remote access
- procurement of an integrated information centre

Our goal:

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

Developing excellent services

Our aim is to minimise the impact that a person's mental ill health or learning disability has on their lives. Over the past year we have continued to develop and modernise inpatient and community services that promote recovery and wellbeing. These are just a few examples of how we have developed excellent services.

Veterans programme goes from strength to strength

This important service for military veterans gained national recognition in 2009 when it was awarded the Military and Civilian Health Partnership awards Care of Veterans award.

The aim is to make it easier for veterans with concerns about their mental health to seek and access help. It was initiated as part of a national pilot and rather than offering one centre or unit for veterans we chose to train staff across our patch. The trust now has over 150 staff trained in military culture and mental health awareness and veterans are able receive the care and support they need close to home and family.

Physical health in forensic services

We established a new physical healthcare team within our forensic services. It is often difficult for individuals who are being cared for in these services to access and maintain contact with primary healthcare services and this small team offers a wide range of physical health care and screening, including the newly established cervical screening programme.

Early intervention in psychosis

The early treatment of psychosis in young people greatly increases the probability of them enjoying a healthy and productive future. Our early intervention in psychosis (EIP) teams have done some innovative work over the last year in raising awareness of the illness, tackling the stigma that surrounds it and helping young people with psychosis become more involved in their local communities. In Teesside the 'kick it out' football project helped service users to gain confidence and become more involved in their local communities. The team in the north of County Durham worked with service users and pupils from a local school to use graffiti and street art to tackle stigma.

Preparing for the move

Preparing to bring together adult services from St Luke's Hospital and University Hospital of North Tees onto one site has been a key focus for teams in our adult directorate.

This work has been supported by the purposeful inpatient admission service improvement work. This work, which was a result of a quality improvement workshop on one of the adult inpatient wards, ensures that the same consistent approach to assessment, planning and review of care is in place in all areas. Improvements to date have enabled the service to maximise efficient use of resources and develop a clearer focus on recovery for all inpatients. The team has also worked hard to ensure the right mix of skills and competencies of staff working on the new units, with a particular focus on increasing the ratio of registered nurses.

Implementing the national dementia strategy

Since its publication in February 2009, the trust has been working hard to implement the National Dementia Strategy and to continue to improve its dementia services.

Memory clinics in all localities continue to evolve and develop to ensure we are able to quickly assess and diagnose people when they are referred, and to ensure we can support them through their ongoing care. We have been working very closely with colleagues in acute hospitals, building on existing liaison services and exploring opportunities brought about by new projects for example with James Cook University Hospital in Middlesbrough and a large scale change collaborative focusing on dementia care across agencies in Darlington.

The trust has also been working very closely with our primary care colleagues and GPs. We piloted the first part of a dementia care pathway in four areas (Derwentside, Darlington, Redcar and Cleveland and Teesside young onset dementia team). This initiative is intended to support GPs and standardise referral, assessment and diagnostic processes.

A particular success has been the work undertaken in the Durham Dales integrated care pilot to help identify patients within practices who may be struggling with their memory but who have not previously sought help, using a simple screening tool.

Prison pilot

A new trust pilot project got underway in 2009/10 to help friends and family cope with a loved one who is at risk of taking an opioid (e.g. heroin) overdose.

The carers and families overdose and naloxone training project is one of only 16 pilot projects in England and one of only two working with prisoners' families and carers funded by the National Treatment Agency for Substance Misuse.

The initiative is taking place at Her Majesty's Prison Durham and aims to empower families and carers to manage a heroin overdose, thereby reducing drug related deaths.

The two hour training course will help them identify the symptoms and signs of a heroin overdose, learn how to manage the overdose, how to use the heroin antidote (Naloxone) and they will be given Naloxone to take home.

Specialist inpatient unit pilot

In 2009 the trust piloted a specialist service, providing seven inpatient beds for people with complex needs caused by drug or alcohol misuse. As well as receiving treatment for their addiction, people received help and advice on their physical and mental health, personal and social skills, housing, finances, education, employment and training.

This highly quality service received excellent feedback. Unfortunately, there were insufficient referrals for the unit to continue and the tenders for alcohol service that we expected did not go ahead. The scheme closed in January 2010.

Improving the environment

Over the last year we have completed two state-of-the art developments. Both facilities have been specially designed to complement the excellent clinical care we provide and are a key part of our plans to fundamentally modernise the way we provide services.

Lanchester Road Hospital

The trust's new hospital in Durham opened its doors in January 2010. The £17.9 million Lanchester Road Hospital provides modern and spacious accommodation for a range of mental health and learning disability services, replacing the outdated County Hospital in Durham and our adult inpatient unit at Shotley Bridge in Derwentside.

"A well designed building – light, airy with contemplative space, hotel standard"

A trust member about Lanchester Road Hospital

Each of the single, en-suite bedrooms is on the ground floor with a window seat, most of which overlook the surrounding countryside. Each of the wards has its own enclosed garden and there is a beautiful central courtyard with seating areas.

Roseberry Park

Our £75million mental health and learning disability development in Teesside was handed over to the trust at the end of March 2010.

Roseberry Park in Middlesbrough is the penultimate capital development of a long term investment strategy and provides modern and spacious accommodation for mental health services for working age adults and older people, as well as treatment and care for people with learning disabilities.

It has over 300 inpatient beds, with each of the single, en-suite bedrooms on the ground floor. With a floor area of 27,000 sq metres, which incorporates internal courtyard style gardens and outdoor spaces for patients, Roseberry Park is believed to be the largest mental health project recently constructed in the UK.

Both these developments were built under the government's private finance initiative (PFI) scheme. The trust's PFI partners are John Laing (Roseberry Park) and Grosvenor House Group (Lanchester Road Hospital).

Cross Lane Hospital

Work got underway at the end of last year on our £10.4 million redevelopment of the Cross Lane Hospital site in Scarborough. The development, which is due to be completed in 2012 will include a new specialist care unit for older people with 20 assessment and treatment and four day spaces. The adult unit (Ayckbourn) will also be refurbished to provide improved accommodation.

The Cross Lane development is one of a number of projects underway in the area to improve facilities across Scarborough, Whitby and Ryedale.

Bankfields Court

In 2009 we gave the go ahead to build a new assessment and treatment unit in Redcar and Cleveland for adults with learning disabilities.

The £6.2 million development of Bankfields Court, which will open in September 2011, will include a new unit designed to meet the needs of a modern learning disability service. There will be improved living space with single rooms and en-suite facilities as well areas for therapeutic activities. The unit will also include individual self contained living environments for people starting their rehabilitation journey or in need of more complex individual support.

Delivering same sex accommodation

We are proud that the vast majority of patients who are admitted to any of our hospitals will be cared for in a ward where they will have their own bedroom, many with en suite washing and toilet facilities (from May 2010 97% of our inpatient beds are in single rooms of which 73% have en-suite bathrooms). In the small number of wards where there is more than one bed in a bedroom, patients will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed area and clearly signed. This means that any mixed sex accommodation is virtually eliminated.

We received over £170,000 from the Department of Health to further improve more of our accommodation. We have been reviewing all of our facilities and upgrading where necessary, so that we can make sure that everywhere has same sex sleeping accommodation, toilets and bathrooms.

The money has been used to carry out any remedial work needed following the review and to deliver training to our clinical staff to make sure that the care they deliver meets the privacy and dignity needs of each patient.

Improving patient and carer information

It is important that the people who use our services and their carers can easily access appropriate information. Over the past year we have continued to improve the accessibility and quality of the information we provide.

Information prescriptions guide people to relevant and reliable sources of information and advice allowing them to feel more in control and better able to manage their condition. Last year we piloted information prescriptions in two areas. The first of these was in mental health services for older people at Auckland Park in Bishop Auckland. Patients of the memory service and their carers, are now offered a personalised information prescription providing them with information about their health care. Advice and support may be in the form of web addresses, telephone numbers, leaflets and books, and topics covered include condition, treatment, care services, benefits and support groups. Further information is also available for patients and carers to browse in the hospital's memory room. Building on this success, information prescriptions were launched in the acute inpatient units at the former St Luke's hospital.

We have also developed a section on our website to give patients and carers access to information relating to mental health conditions, treatments and support. In addition our clinical staff have access to a database of information leaflets which they can give to patients using our services and their carers.

Patient and public involvement

It is important that we involve service users, their carers, families and the wider community in our work so that they can help us to develop and improve our services. We want to make sure that local people have the opportunity to give us their views and we have continued to promote and strengthen patient and public involvement.

Good two-way communications is essential in facilitating meaningful engagement with our service users, their carers and our local communities. In 2009 we developed a trust communications strategy and plan, which supports our patient and public involvement work.

Service users and carers are represented on a number of groups across the trust. For instance:

- The Mental Health Act management committee, the clinical governance and clinical risk committee, the pharmacy committee and the psychological therapies group have either well established reference groups or direct membership, to ensure that the voices of service users and carers are heard in these important areas of work.
- The directorates of MHSOP, working age adults, forensic services, North East Yorkshire and learning disability services all have local involvement groups. These groups are responsible for developing and maintaining a directorate wide overview of service user involvement and are attended by service users, carers and trust staff.
- The patient environment action teams, who check the cleanliness of the wards, have this year all included service user or carer representatives.
- Service users and carers give presentations about their experiences of the trust to all our new student nurses as part of their induction.
- We have continued to develop the learning disability forensic service user reference group 'ForUs', including providing additional advocacy, giving presentations at regional and national forensic conferences and taking part in our quality improvement workshops.
- Our learning disabilities child and adolescent mental health services worked with young people to produce a short film that is being used in schools to combat bullying of children with learning disabilities. With the support of the team a group of five young people wrote the script, designed the artwork for the DVD and leaflets and worked with the production company to produce and act in the film.
- Service users and carers were involved in helping to develop the trust's communications strategy through a survey and focus groups.

We want to make sure that the people who use our services feel that the experience they had was a positive one. We need to understand what is important to service users so that we can measure it and identify opportunities for improvement. Over the last year we have undertaken three projects to help us do this:

- We worked with service users in the forensic unit and developed a simple scheme to identify their top ten most important issues, measure them and act quickly on the results.
- With the help of an independent consultancy we worked with people under the care of the community teams in Darlington to identify what was important to them, to develop and test ways of getting feedback on these areas and of acting on this feedback quickly.

- We worked with service users in Hartlepool to identify what aspects of community and inpatient care were important to them, to establish mechanisms for getting feedback and of addressing any issues quickly.
- We are trialling the use of electronic feedback systems in an inpatient setting.

Based on these initial pilots we plan to roll out a trust wide system for understanding our patients' and carers' experience of the trust and using this feedback to develop and improve services.

Local involvement networks (LINks)

We have continued to hold the regular quarterly network meeting with the leads from those organisations that host the LINks services across the Trust area. These important networks want to give local people a stronger voice in how their health and social care services are delivered and in February 2010 we hosted an event for LINk members from all the LINks within the trust area. Over 120 people attended this event, which included a number of workshops on topics requested by the LINks and feedback was very positive.

Listening, learning and acting

It is important that we listen to what people have to say about our services, that we learn from what we hear and take action wherever necessary. There are a number of ways in which we do this (see overleaf).

We also receive hundreds of letters of thanks and praise for our services from the people who use them, their carers and families and we have included a selection of their comments in this report.

Patient advice and liaison service (PALS)

PALS have continued to visit wards across the trust area, seeking the views of patients, carers and relatives about their contact with our services. People have contacted PALS using freephone, sent messages via the PALS mobile, sent emails and written letters raising concerns or comments about services. 1006 contacts were recorded and responded to between 1 April 2009 and 31 March 2010.

Formal complaints

In 2009-10 we received 111 written complaints (this was an increase of 7 complaints compared to the 104 complaints received in 2008-9). To date we have responded to 96% of written complaints within agreed timescales with complainants.

Last year the Parliamentary and Health Service Ombudsman was responsible for operating the second stage (independent review) of the NHS complaints regulations process. Although we were contacted seven times by the Ombudsman concerning requests for information relating to trust complaints (two of these contacts related to complaints from previous years), they decided not to investigate any of the complaints further. At the end of the year we had no outstanding cases with the Ombudsman.

Using feedback to improve services

We continue to learn valuable lessons from the complaints and comments we receive from service users and their carers as well as the feedback from surveys and reports. Over the past year we have made a number of improvements because of the comments and feedback we have received including:

- improving communication between services, particularly out of hours, where information may impact on patient care (adult mental health services)
- ensuring there is an explicit, well understood and documented plan for patients prior to discharge (North East Yorkshire)
- strengthening arrangements for breaks or holidays for service users to ensure that support issues are fully addressed and insurance is organised (adult learning disability services)
- improving content and availability of literature to clarify which services are available within substance misuse services
- increasing available activities and meaningful engagement for inpatients including fitness programmes, football tournament, walking group, music group, art group (adult services in north Durham)
- introducing protected meal times (North East Yorkshire)
- improving facilities by creating an environment that is more suited to the young people who spend time there. Staff and patients at the Newberry Centre in Middlesbrough have created themed rooms, including a French bistro (dining room) and an American themed games room
- re-establishing or introducing a number of outreach and satellite clinics to improve access to services (substance misuse services)
- improving choice of food available including the introduction of a healthy eating programme (adult services)

Our goal:

To continuously improve the quality and value of our work

Improving quality

Our aim is to deliver a high quality service. This means that the service:

- is appropriate – is relevant to the needs of the individual or customer and is based on evidence
- is effective – what we do delivers the outcomes that we expect and makes a positive difference to people's lives
- provides a good experience – our service users and customers feel that the service we provided was good and that they had a positive experience
- reduces waste – we should minimise any activity that does not add value or is wasteful

To help us improve the quality of what we do we have developed a quality improvement system, which is based on and supported by Virginia Mason Medical Centre in Seattle. Our quality system is about improving the ways we do things within the trust by identifying and removing wasteful activities and focussing on those that add value to our customers (see priority 3 on page 34).

Our priorities for quality improvement

The board agreed three key priorities for 2009/10 and there is more detailed information about these and the progress we made in our quality report in chapter 9.

Priority 1:

Reduce the number of incidents of violence and aggression

Although most of the incidents of violence and aggression are committed by individuals whose challenging behaviour is a symptom of their illness we were concerned about the number of incidents and agreed that reducing this was a key priority for the trust.

How have we done?

We developed and implemented a new challenging behaviour policy across the trust. We also reviewed and improved training material and the way we deliver training, including enhanced mandatory training in the prevention and competent management of violent incidents. We have also piloted a new process of reviewing serious or recurring incidents and this is now being rolled out across the trust.

We are already seeing a reduction in the number of incidents (34% over the last two years) but this still remains a high priority for us and we will continue to focus on this area over the coming year.

Priority 2:

reduce waiting times for first contact and treatment

Although there are no national waiting time requirements for the services we provide, we still see reducing waiting times as being very important and set ourselves the following targets:

- 80% of people will have been seen for their first appointment within four weeks of a referral from their GP/primary care.
- 95% will have been seen for their first appointment within eight weeks of a referral from their GP/primary care.
- 100% of people will be treated within 18 weeks of a referral from their GP/primary care.

How have we done?

We have made good progress towards achieving our targets and introduced a number of initiatives over the year to help us reduce waiting times such as:

- adult mental health services held Saturday morning clinics
- in children and young people's services we ring fenced 50% of clinicians' time for direct face to face activity
- our child and adolescent mental health services carried out a pilot in Easington with a group of GP practices to improve access
- in substance misuse where there were a high number of alcohol misuse referrals two nurses worked with primary care and the voluntary sector to improve the quality of the referrals
- older people's assessment clinics have been introduced in North East Yorkshire

As a result in March 2010:

- 79% of patients had their first appointment within four weeks of referral (compared to 67% in April 2009)
- 95% of people had their first appointment within eight weeks of referral (compared to 86% in April 2009)
- 98% of people had their first appointment within 18 weeks of referral (compared with 94% in April 2009)

We continue to be committed to improving waiting times in 2010/11.

Priority 3:

Further implementation of the trust's quality improvement system

Last year we agreed the vision for our quality improvement system:

- improved quality and safety – fewer mistakes, accidents and errors, resulting in better patient care
- improved delivery – better work done sooner
- improved throughput – the same people, using the same equipment, find they are capable of achieving much more
- accelerating momentum – a stable working environment with clear, standardised procedures creates the foundations for constant improvement
- increased staff involvement in improvement initiatives – encourage staff involvement and participation in the development of both the change plan and in the actual implementation

We also developed and agreed a 'compact' with our staff. This compact, which is a psychological or cultural agreement, establishes the 'gives' and the 'gets' between staff and the trust and sets the scene for continuous improvement.

Throughout the year we continued to train staff in the tools and techniques of our quality improvement system and increased the number of senior staff who are trained as accredited quality improvement leaders.

Work has continued to embed the system across the trust and dozens of improvement events have been held, driving improvement in key areas and involving more and more staff in using the trust's quality improvement tools and approaches. This has included :

- 31 rapid process improvement workshops (RPIWs) – intensive week long workshops which give teams the opportunity to take time out of their jobs to focus on making improvements to the way they work
- the development of share and spread methods to share lessons learned from improvement activity across speciality areas
- developing clinical pathways for challenging behaviour, trauma in children and young people, epilepsy and personality disorder

Some of the excellent examples of how this work has led to improvements over the last year include:

- Stockton community psychosis team made dramatic improvements to the care of people on high dose antipsychotic therapy (HDAT). They are now able to ensure that all patients on HDAT are monitored appropriately and at the right time. As a result of their work and using the 'share and spread' method these changes have now been implemented across seven community teams.
- Auckland Park Hospital inpatient assessment and treatment services adopted the approach used in adult services and have fundamentally redesigned the way they work to improve

patient care. They have achieved outstanding results – patient satisfaction and staff morale are high, the length of stay on the assessment wards has reduced dramatically, bed occupancy is low and waiting lists are a thing of the past.

- In older people's inpatient services in Middlesbrough the team completely redesigned their assessment systems to improve care. Through the innovative use of information and information technology they speeded up decisions about registered care requirements for patients admitted to the unit. As a result the length of time needed to complete the nursing assessment required by the PCT has reduced from an average of 85 days to a maximum of 16 days.
- The share and spread method has been used on all ten adult inpatient areas to standardise work for assessment and care planning.

Our priorities for 2010/11

We have identified five key priorities for 2010/11 (see below). You will find more detailed information on these in our full quality report (see chapter 9).

Priority 1:

learning lessons from serious untoward incidents (SUIs)

SUIs have a major impact on patients, staff and the organisation as a whole. We therefore recognise that it is vital to work to prevent their occurrence by learning lessons from such events and taking preventative steps.

Priority 2:

reducing violence and aggression

We have continued to identify the reduction in the number of incidents of violence and aggression as a key quality priority for 2010/11 because of the impact it has on our service users and staff.

Priority 3:

implementation of care programme approach (CPA)

This was identified as an area for development in 2009/10. Given the significance of the CPA to the delivery of safe and effective care, we have agreed that we need to build on the work we undertook in 2009/10 in inpatient areas and expand this into our community services.

Priority 4:

transfers of care

A transfer of care is any situation in the patient care journey where the patient moves between services. This can be a change from one therapist to another or a move from one care setting to another. Discharge from an inpatient ward to a community setting is an area of high risk and we have therefore identified improving the discharge from inpatient care to the community as a quality priority.

Priority 5:

development of ways to collect information on patient experience

A key element of our quality definition is whether the users of our services feel that the experience they had whilst using our services was a positive one and we will develop ways of collecting information on patient experience.

Providing high quality services

Our aim is to provide a high quality service and to embed a culture of continuous improvement throughout the organisation. Although we are doing this primarily through our quality improvement system there have been other excellent examples of how we are driving up quality across the trust. For instance:

Giving nurses time to care

In 2009 we launched our participation in the national 'releasing time to care' initiative. This programme is closely aligned with our own quality improvement system and empowers inpatient mental health teams to change the way they work to increase the amount of time they spend on direct patient care.

Led by the trust's modern matrons, the ward teams use tried and tested tools for improving quality to review the way they work and find ways of being more effective.

Full marks

Staff from Lincoln ward at Sandwell Park in Hartlepool were the first in the country to achieve 100% in a nationally recognised quality assessment - the Royal College of Psychiatrists' accreditation for inpatient mental health services (AIMS).

AIMS recognises services which have high standards of organisation and patient care. The rigorous accreditation process lasts between six to nine months. It includes a visit by external assessors, questionnaires which are completed by patients, carers and staff as well as an audit of health records and other key documents.

The standards cover areas such as the ward environment, therapies and activities on the unit, the admission process and patient safety. All our adult inpatient units achieved accreditation in 2009.

"A big thank you for all the help I received from your team while I was feeling so down. I can honestly say that without all your help and assistance I wouldn't be here today."

A service user

Improving our performance

The hard work and dedication of staff throughout the organisation have ensured that we continue to be successful in improving patient care and developing services, whilst ensuring that the organisation remains financially sound.

We achieved our key performance indicators, both financial and non financial in 2009/10 and received green governance rating and planned financial risk ratings throughout the year from Monitor. The table below shows our performance against the non financial Monitor targets.

	2009-10					
	Threshold	2009-10	Q4	Q3	Q2	Q1
100% enhanced CPA patients receiving follow-up contact within seven days of discharge from hospital	95.0%	97.5%	97.3%	98.7%	97.5%	96.6%
Minimising delayed transfers of care	<7.5%	2.9%	2.8%	2.7%	3.1%	2.9%
Admissions to inpatient services had access to crisis resolution home treatment teams	90.0%	97.2%	98.3%	97.0%	96.6%	96.9%
Maintain level of crisis resolution teams set out in 03/06 planning round	Maintain	Maintained				
The trust has full met the HCC Core Standards at year end	Fully met	Fully met				

Our performance against the financial risk rating is shown below

	2009-10				
	2009-10	Q1	Q2	Q3	Q4
Financial Risk Rating - Plan	3	3	3	3	3
Financial Risk Rating - Actual	3	3	3	3	3

In October 2009 the trust was awarded a rating of **Good** for Quality of Services and a rating of **Excellent** for Use of Resources in the Care Quality Commission's (CQC) 2008/2009 Annual Health Check.

Over the last year the trust has also continued to support our local commissioners in achieving their mental health related performance targets:

- CPA 7 day follow up
- early intervention in psychosis new cases
- crisis home treatment episodes

Research and development

Over the last year we have seen a rapidly increasing level of participation in clinical research, with a priority for large multi-site large trials run by the Mental Health Research Network (MHRN). Our research partnership with Durham University has grown further and we have gained funding for important new research which will benefit service users. This is clear evidence of our commitment to improving the quality of care offered, and to contributing to the evidence base for modern mental health care. We are partners in research with major impact on the NHS. In 2009 the results of the national study of intravenous heroin treatment were disseminated, with potentially far-reaching implications for NHS addiction services.

Our clinicians have won research grants for a wide range of studies from funders including the Medical Research Council, Canadian Institute of Health Research, the UK's Knowledge Transfer Partnership scheme, the Guild for Health and the National Institute for Health Research (NIHR). One of the largest personality disorder trials ever conducted was funded in 2009 by NIHR's Health Technology Assessment programme, and is led by the University of Nottingham in full partnership with the trust. The £1.5 million PEPS (psychoeducation with problem solving) trial will run for three years, testing the effectiveness of a therapeutic intervention in this important clinical area of unmet need.

Other research work includes

- A consultant psychologist has won an NIHR Research for Patient Benefit grant with the University of Manchester for the ACTION trial of cognitive behaviour therapy in people with psychosis not taking antipsychotic medication.
- In partnership with Durham University we are conducting a comprehensive evaluation of user and carer experience and clinical outcomes at Roseberry Park in Middlesbrough, funded by the NIHR Physical Environment Programme.
- One of our consultants is leading work at Durham University on the development of improved risk assessment tools in adolescent mental health.
- A trial of behavioural activation therapy was conceived, designed and completed in County Durham by one of our nurse consultants.
- Our clinicians have published articles this year in a range of high quality journals, including Schizophrenia Research, Nature Genetics and the British Medical Journal.
- In partnership with Durham University, we have developed plans for significant expansion of our research capacity in young people's mental health.
- The trust has worked with the MHRN and the Dementia and Neurodegenerative Diseases Research Network to encourage its service users to participate in multicentre studies in a range of clinical areas including bipolar disorder, depression in primary care and dementia.
- One of our service users has developed his role as service user researcher, supporting the active involvement of people with bipolar disorder.

Our goal:

To recruit, develop and retain a skilled and motivated workforce

Being a good employer

We want to be the best employer we can be and this means supporting our staff to

- acquire the skills and expertise they need to do their job well and to develop their career,
- developing our managers to help us successfully lead the organisation and
- making sure all staff have the opportunity to get involved and contribute to decision making within the trust.

In 2009 we decided to seek the **Investors in People** (IIP) standard as part of our commitment to being a good employer. This is a highly regarded national standard which assesses how well we manage and develop our staff. Following a rigorous assessment in March 2010 we were delighted to be awarded this important accreditation.

It is not only what we do that is important but also the way we do things. In 2009/10 we worked with staff from across the organisation to refresh our **values** and to develop a set of associated behaviours. At the end of March the board of directors approved the revised values and behaviours.

Health and wellbeing

The health and wellbeing of our staff is also very important to us and in February 2010 we appointed a new single **occupational health** service provider for the whole trust. Previously there were four separate providers and the new service will mean we are able to offer staff a standardised service across the trust.

Our health at work policy provides a framework for the management of sickness. It includes guidance on good health and wellbeing with practical advice to employees on a range of topics, including lifestyle and health promotion, support available from the trust and self help information.

Reducing the level of sickness absence at the trust remains a challenging target for us and at the end of 2010 our sickness absence rate was 5.8% (against a target of 5.5%).

"I enjoyed it all from start to finish – I thought the speech from the chief executive made all nominees feel special – and being lucky enough to win an award was a highlight for me."

Member of staff about the annual awards ceremony

Valuing our staff

The trust held its third annual staff awards programme in 2009. The Making a Difference Awards have grown in popularity year on year and are recognised across the trust as being a

great way of celebrating the achievements and commitment of staff. Last year we received over 180 nominations for the ten awards and the 40 finalists, made up of teams and individuals, were invited to a special awards ceremony.

Health, safety and security

Throughout the year we have continued to ensure that staff receive advice, support and training on health, safety and security issues. Work to reduce the incidence of violence and aggression was a priority last year (see page 32). We have also seen a 50% reduction (from 82 in 2008/09 to 39 in 2009/10) in the number of incidents which had to be reported under the RIDDOR regulations. We also introduced a new training syllabus covering back care and slips, trips and falls. The Health and Safety Executive visited to the trust to assess us against the HSE stress audit tool and the feedback will be used to improve the management of stress related illness in the trust (see following section on staff survey).

Developing our staff

We have continued to support staff to develop themselves to provide high quality services to the people we serve. Two of the important initiatives which were introduced last year included:

Unionlearn

The trust joined forces with Unionlearn, a national learning based project to encourage staff to increase their skills.

Representatives from both Unison and GMB work with the trust to offer staff (their members) this confidential one to one learning service.

They provide information and advice, arrange provision and encourage take up of learning and training opportunities. The representatives also negotiate between staff and their line managers for appropriate courses and time off work.

New education centre opens

The trust opened a new education centre in Durham in early 2010. The centre, which is on the Lanchester Road Hospital site, has twice the space previously available and brings together multi-professional education and training under one roof.

The light and spacious centre can accommodate over 100 people in five fully equipped training rooms. There is also a specially equipped room for clinical skills training, a fully equipped physical skills training room and facilities for doctors in training.

The new library houses the former County Hospital and Sniperley House libraries in a comfortable, attractive and well lit space. There is a study area as well as seven reader workstations and areas for group work or training sessions.

The trust is committed to supporting staff to develop the skills and knowledge they need to provide high quality services. The learning environment is key to achieving this and these excellent facilities support the trust's commitment to training and development.

Communicating and engaging with staff

Good two-way communications are vital if we are to succeed and we are committed to improving the way we communicate with our staff. During the past year we have continued to strengthen internal communication by improving existing mechanisms, such as the trust magazine, staff intranet and briefing system and developing new ways of engaging with staff.

In 2009 we developed a communications strategy, which sets out our communication aims and objectives and what we have to do to achieve them. It also sets out the responsibilities and expectations of staff in communicating with colleagues, service users and carers.

We have already started work on our implementation plan for 2010/11:

- We have reviewed and revised our team briefing system, providing new guidelines for managers and staff on effective team briefing. We also set up specific training for managers. Our team briefing system aims to make sure that every member of staff has the opportunity to discuss and feed back on local and trust wide issues that concern them.
- We have introduced meeting free Fridays to free up managers so that they can spend more time with their teams
- We have set up a programme of planned, informal visits by directors to services and teams across the trust. Their aim is to help improve communications with staff and increase visibility of directors and around 40 visits are planned for 2010. This is in addition to the monthly structured board visits that take place.
- We have continued to promote the use of the staff intranet (inTouch), using our weekly e-bulletin to signpost people to news and new sections. We have increased the number of content managers, particularly within corporate services, and strengthened the support and training available to them.

We actively seek to consult with staff and their representatives on matters that are likely to affect them. We work closely with staff side representatives and last year developed a revised partnership agreement to improve how we do this. We have monthly meetings with staff side representatives at the joint consultative committee (JCC) and representatives received paid, planned facilities time to participate in the policy sub-group, the workforce and development group and job evaluation panels.

Over the last year we have used many different ways, including focus groups and team meetings, to involve staff in trust-wide projects such as:

- developing the staff compact
- refreshing the trust's values and behaviours
- developing the trust's communications strategy
- reviewing the team briefing system

Staff engagement is also at the heart of our quality improvement system. Last year dozens more managers were trained to support the implementation of this important system and hundreds of staff from all areas of the trust were involved in quality improvement events.

Throughout the year managers have continued to involve and consult with staff on issues that affect them, including planning and implementing the changes that impact on their work (such as planning for the moves into Roseberry Park and Lanchester Road Hospital – see page 24).

Human resource policies

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

- The health at work policy provides a framework for the management of sickness absence including continuing employment of, and arranging the appropriate training for, employees who become disabled. It also includes particular guidance on mental wellbeing in the workplace and provides a framework for addressing issues concerning disability.
- The recruitment and selection policy aims to ensure full and fair consideration to applications for employment including those made by people with a disability.
- The learning and development policy provides guidance about the trust's inclusive approach towards ensuring all employees, including employees with a disability, have access to appropriate training, career development and promotion.
- The equality and diversity policy aims to eliminate discrimination and encourage diversity amongst our workforce and to ensure equality and fairness for all applicants and employees in their employment regardless of age, disability, gender, marital status, domestic circumstances, race, ethnic origin, colour, nationality, national origin, sexual orientation, religion, social or educational background or trade union membership.

"Thank you so much for showing me what good practice and nursing is all about. I've learned so much from you all and I was always made to feel part of the team."

A student

Staff survey

The results of the national staff survey were announced in March 2010. They placed our trust in the top 20% of mental health and learning disability trusts in the country in 16 of the key areas. Our response rate was 60% (an increase of 2% over the previous year).

Details of our top and bottom ranking scores are included in the table opposite (see KF reference below).

Our top ranking areas, compared to other mental health and learning disability trusts, included:

- percentage of staff receiving job-relevant training, learning or development in the last 12 months (86% compared to 81% nationally) **KF12**
- percentage of staff feeling there are good opportunities to develop their potential at work (57% compared to 48% nationally) **KF11**
- percentage of staff believing the trust provides equal opportunities for career progression or promotion (94% compared to 90% nationally) **KF39**
- work pressure felt by staff (2.89 compared to a national average of 3.02 – a lower score is better) **KF6**

The four areas where we were below average compared to other mental health and learning disability trusts were:

- percentage of staff experiencing physical violence from patients / relatives in last 12 months (21% compared to 18% nationally). Our figure was broadly the same as last year but the national average improved which meant we were placed in the bottom 20% of trusts in this area **KF24**
- percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month (31% compared to 29% nationally) **KF21**
- percentage of staff suffering work-related injury in the last twelve months (9% compared to 8% nationally) **KF18**
- Percentage of staff receiving health and safety training in the last 12 months (74% compared to 75% nationally) **KF17**

Over the last year we have done a lot of work to address issues highlighted in the staff survey, particularly around reducing the level of violence and aggression against staff. Recent figures show a reduction in the level of incidents although we have yet to see this reflected in the staff survey. We were, however, pleased to see that the perceptions of staff on how effectively we deal with incidents put us in the top 20% of trusts.

We have also adopted a number of different training methods aimed at increasing the take up of equality and diversity training. We use both e-learning and face-to-face training and also deliver sessions at team meetings and away days. We were pleased to see a significant increase in the number of staff who had received this important part of their mandatory training.

It is important that we use the feedback we receive from the staff survey, the IIP assessment and the Health and Safety Executive stress survey to improve the working lives of our staff. In early 2010/11 we will pull together a development plan to incorporate feedback from these three sources and progress against this plan will be reported to the executive management team, JCC and the workforce development group.

Summary of staff survey results

	2008/09		2009/10		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Response Rate					
	58%	54%	60%	55%	Increase in % points
Top 4 Ranking Scores					
KF12	88%	81%	86%	81%	Increase in % points
KF11	55%	47%	57%	48%	Increase in % points
KF39	91%	88%	94%	90%	Increase in % points
KF6	2.94	3.03	2.89	3.02	Improvement in % points
Bottom 4 Ranking Scores					
KF24	20%	19%	21%	18%	Increase in % points
KF21	27%	31%	31%	29%	Increase in % points
KF18	7%	8%	9%	8%	Increase in % points
KF17	81%	75%	74%	75%	Decrease in % points

Our goal:

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

Building strong relationships

It is important that we build strong relationships with the organisations who commission our services, those we work with to provide services and the GPs who refer people to them.

These organisations and individuals are essential to our continued success and effective two-way communication is vital in helping us build and sustain positive relationships with them. Over the last year we have continued to strengthen and improve communication with our key stakeholders. This work has included the introduction of a quarterly email bulletin for GPs and improvements to the website such as the development of a specific section for GPs and other professionals.

Senior managers across the trust are continuing to strengthen their links with our stakeholders at a strategic level. We also have 17 appointed governors on our council of governors (see page 80) who are helping us develop alliances and partnerships to promote better understanding between the trust and the wider health community.

Throughout the year we have continued to work closely with colleagues in the overview and scrutiny committees (OSCs) of our local authorities and with the primary care trust links to the OSCs. Formal public consultations are carried out by the primary care trusts although we work closely with them on any proposals for change.

Working with our partners

Throughout the year we have continued to work with our partners to develop services and introduce new initiatives. Some examples of this include:

Primrose programme

Last year this important programme, which is hosted by HMP Low Newton in Durham, won the World Health Organisation Health in Prison Project award - 'Best practice regarding health care services provided to prisoners' category - for its work with female offenders who pose a risk of serious harm because of a severe personality disorder.

The programme incorporates a range of treatments to address violent behaviour, unresolved psychological trauma, personality disorders and self-harming behaviour. It also helps offenders' rehabilitation by empowering them with skills for life.

The Primrose Programme is the only female programme like this in the country and trust and prison healthcare staff work together to ensure offenders receive the full range of treatments that they need.

Improving access to psychological therapies

In 2009 the trust joined forces with the statutory and independent sectors to provide talking therapies on Teesside.

A local consortium led by the national charity Mental Health Matters, working closely with the trust, was awarded the contract to improve access to psychological therapies. The consortium also includes Alliance Psychological Services Limited, Hartlepool Mind and Middlesbrough Mind.

The impact of depression and anxiety on the sufferer's home and working life is huge, affecting not only the individual but their family and loved ones too. Many people want an alternative to anti-depressants and this initiative is giving that choice to thousands more people.

People have the choice of contacting the service directly or through their general practitioners and in most cases are able to see their therapists in or near their own homes in places such as doctors' surgeries.

New pharmacy partnership

A new partnership with high street pharmacy, Lloyds, is helping us improve services across the trust.

The five year contract, which came into force in November 2009, is for supplying medication to service users across all our sites in County Durham and Teesside. The move to a single supplier is helping us standardise our procedures, reduce drug wastage, minimise errors and improve patient safety.

Lloyds now run on-site pharmacies at three of our main sites - Lanchester Road Hospital, West Park Hospital and Roseberry Park. They provide greater access to medicines from these hub pharmacies as well as an extended hours service from designated Lloyds community pharmacies.

The changes to the way pharmacy services are provided has also released trust pharmacy staff from the dispensary and given them more to time to take on clinical pharmacy work on the wards.

The new service does not include North East Yorkshire.

National pilot

The trust was one of six sites nationally and the only one in the North East region to be chosen to pilot a children and young people's diversion and criminal justice liaison service. The project aims to help children at risk of emotional and mental health problems who are picked up by the police.

The youth custody diversion team works closely with South Tees youth offending service, the police, youth court and Crown Prosecution Service to identify young people, aged 10-18 years, in the Middlesbrough and Redcar and Cleveland area who need additional help.

The teams provide individual assessments and interventions for both risk and mental health needs and referrals to appropriate services which may include education, housing, social care, substance misuse and mental health services.

The project will run over a two year period and is helping us to build upon existing good partnership working arrangements, ensuring that young people with mental health and emotional difficulties are identified early and receive the services they need.

The scheme is supported by the Department of Health, the Youth Justice Board, the Department for Children, Schools and Families, the Ministry of Justice and the Sainsbury Centre for Mental Health.

Integrated community teams

During 2009/10 the trust worked towards finalising partnership agreements with our seven local authorities and reached final agreement with our largest authority. These agreements set out what is expected of the trust and social services in the integrated community teams that operate in adult mental health and learning disabilities services.

It is recognised that people with mental health problems and/or learning disabilities usually need support from a wide range of professionals and that by bringing these staff together in one team we are able to provide more effective and efficient care.

In adult mental health services the trust manages the integrated teams, which consist of trust staff and local authority employed social workers, on a day to day basis. The integrated community teams in learning disabilities are managed by social services.

"The crisis team were excellent. They listened to him carefully as he explained his situation and they managed to get medication for him straight away. My brother is recovering slowly thanks to their care and concern"

A relative of a service user.


HUGHES
Dynamic psychother
What W
Therapy

Our goal:

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

Caring for the environment

The trust recognises that every element of our delivery of mental health care services has an impact on both the local and worldwide environment. The board of directors is committed to ensuring that we take measurable steps to reduce our carbon footprint in line with the Climate Change Act 2008 and work closely with partner organisations, staff, patients and local community groups to make best use of finite resources.

Following consultation the trust's environmental strategy was approved by the board of directors in April 2010. Action against an annual implementation plan will be measured against an agreed set of performance targets, which will be reported through the environmental steering group to both the executive management team and board of directors.

Trust's carbon footprint

Over the past three years, the trust has worked closely with the Carbon Trust to develop baseline figures against which we will measure our future progress in reducing our carbon emissions and overall carbon footprint.

Governance arrangements

The board of directors agreed to establish governance arrangements which include:

- **Board leadership**: A non executive director has been charged with acting as an environmental management champion. An executive director has been charged with developing, directing and delivering the environmental management action plan and establishing an environmental strategy steering group.
- **Audit**: We will use the Carbon Trust carbon footprint assessment and the Good Corporate Citizenship assessment model to monitor performance.
- **Performance trajectories**: In line with the NHS Sustainable Development Unit and the Carbon Trust, we need to develop an agreed set of targets and trajectories against which to measure progress.
- **Embedding sustainable change**: Sustainability needs to be an integral part of the quality improvement system agenda at all stages of our business, from induction of new staff to reporting to the board of directors.
- **Assurance**: The board requires assurance that the environmental management strategy action plan is being delivered; that evidence is available to support strategic goal five, the CQC standards declarations, the annual report to Monitor as a foundation trust and that regular reporting of progress against agreed performance targets is given to the environmental strategy steering group. By March 2011 we will have achieved ISO 14001 accreditation which will give further assurance to the board.

During 2009/10 we also committed to work with our primary care trusts and local authority climate change action groups.

Performance 2009/2010

Although this has been a development year to ensure we have a measurable environmental strategy, we have continued to implement a wide range of actions which have had a beneficial impact on our sustainability agenda, including:

- **Construction and refurbishment**: Over the past three years we have seen unprecedented changes in the built environment. By mid 2010, 80% of our inpatient facilities will be delivered from three new sites (West Park Hospital (WP), Darlington; Lanchester Road Hospital (LRH), Durham and Roseberry Park (RP), Middlesbrough). This will increase to 90% on four sites in 2011 when Cross Lane Hospital, Scarborough is commissioned. Each development has undergone a BREEAM assessment at the design stage to mitigate the environmental impacts of the development, and these have included:
    - energy efficient materials, glazing and finishes
    - ground source heat pumps (LRH)
    - under-floor high pressure heating (LRH and RP)
    - rainwater recycling for gardens (LRH)
    - low energy lighting (all)
    - multi-fuel boilers (LRH and RP)
    - development of green, multi-access spaces (all)
    - public transport access (WPH)
    - efficient air handling and exchange (all)
    - recycling waste building materials (RP)
    - minimising waste in construction (all)

- **Energy management**: In 2007, the trust applied for and was awarded a £1.3m investment grant to replace ageing boiler / heating plant in a range of locations. In particular, the Lanchester Road Hospital site in Durham replaced older oil fired boilers with modern gas fired units for each of the main buildings on the site. At the same time, we established an energy management system to monitor and predict energy consumption at the majority of our sites.

- **Waste reduction**: Work has been underway to minimise the amount of waste we send to landfill. Waste compactors; glass, metal, paper collection and recycling; electrical equipment recovery for recycling and the re-use of furniture and fittings as facilities close or are refurbished are limited examples of work to date.

Summary performance

Area		Non-financial data (applicable metric)			Financial data (£k)	
		2008/09	2008/09		2008/09	2008/09
Waste minimisation and management	Absolute values for total amount of waste produced by the trust	279T (LRH+WP+SL)	256T (LRH+WP+SL)	Expenditure on waste disposal	£240,468 (Trustwide)	£242,524 (Trustwide)
	Methods of disposal (Optional)					
Finite Resources	Water	124,489	108,841	Water	344,836	319,718
	Electricity	10,114,112	9,912,387	Electricity	1,112,552	923,371
	Gas	31,673,629	30,382,030	Gas	1,045,230	1,019,102
	Other energy consumption Oil (08/09) Wood pellets (09/10)	363,232	60,000	Other Energy consumption	34,507	2,742

Future priorities and targets

Our priorities and targets will be developed in early 2010/2011 using the NHS Good Corporate Citizenship Assessment audit tool and will include:

Travel:

- policy and performance framework
- local travel policy engagement
- site access plans
- encouraging active travel to improve health
- business travel policy and plans to minimise impact

Procurement:

- policy and performance framework
- sustainable procurement awareness
- sustainable procurement process and procedures
- engaging suppliers of goods and services
- waste minimisation and recycling planning
- ethical procurement plans and local supplier development

Facilities management:

- policy and performance framework
- carbon reduction plan
- application of a waste minimisation plan
- water management and efficiency plan

- hazardous substances management of use plan
- positive use of trust green space

Workforce:
- development of a sustainable workforce agenda
- positive approach to equality and diversity
- workforce is demonstrably valued
- development of a healthy workplace environment
- support for local childcare and career activity
- a well maintained learning and personal development approach

Community engagement:
- policy and performance framework to support local communities
- engagement with local strategic partnerships
- engaging local community participation in our sustainability agenda
- commitment to healthy and sustainable food choices awareness
- positive approach to share assets and resources with local communities
- well developed communications plan

Buildings:
- policy and performance approach to sustainable buildings
- early engagement of partners in design development
- demonstration of low impact design approach to future developments
- sustainable development and construction procedures
- minimising the carbon impact of energy and building management
- commitment to the development and management of green space within all future projects

Equality and diversity

We are committed to embedding equality, diversity and human rights into everything we do and our single equality scheme (SES) describes the significant targets and challenges we have set ourselves. It is a long-term commitment driven by our aim to provide excellent services to anyone who requires them, and by the needs and wishes of our local population, stakeholders and staff. For that reason, much of the work will develop over time and the board of directors and council of governors are committed to monitoring progress and reporting regularly and openly on the developments in this scheme.

We also recognise that much of this scheme's ideals and promises will rely on the significant contributions made each and every day by our staff. We acknowledge that it is our duty to promote these ideals as much with our staff as it is with service users and their carers.

Our executive director of nursing and governance leads on equality, diversity and human rights in the trust, together with a non-executive director. The director of nursing and governance has particular responsibility for ensuring our services are fair and equally accessible whilst our director for human resources has responsibility for the human resource aspect of equality, diversity and human rights.

The single equality scheme implementation plan and performance is monitored through the equality and diversity steering group. This group is chaired by a non-executive director and reports to the clinical governance and clinical risk committee, a sub committee of the board of directors. The single equality scheme and equality impact assessments are published on the trust's website.

Action plans

We have developed an implementation plan with timescales for delivering equality, diversity and human rights within the trust. The trust has also established a dedicated team to lead on this work.

For 2010/11 our particular priorities are:

- to increase the number of equality impact assessments carried out on services by carrying out one to one coaching sessions on equality and diversity with all senior managers and delivering equality impact assessment training to all clinical services managers
- to improve access to services for black and minority ethnic and other minority groups. To help us with this work we have employed a temporary equality and diversity facilitator for three months to improve links between the trust and the community development workers
- to carry out a cultural audit to determine the perception communities and service users have of the trust. The audit will be used to inform both strategic and local management issues, future equality, inclusion and consultation strategies, training needs and a range of personnel issues linked to developing and sustaining the equality agenda. The results of the audit will also be used to identify future priorities.

There is further information about our ten key priority areas in relation to equality and diversity and the SES implementation plan which is on the trust's website.

Workforce analysis

	Staff *(as at 30/09/08)*		Staff *(as at 31/08/09)*	
	Number	%	Number	%
Age				
16-25	248	4.92%	202	4.0%
26-35	1009	20.04%	978	19.36%
36-45	1660	32.96%	1565	31.0%
46-55	1529	30.36%	1667	33.0%
56-65	558	11.08%	605	11.98%
65+	32	0.64%	34	0.67%
Ethnicity				
White	4723	93.79	4814	95.29%
Mixed	15	0.3%	23	0.46%
Asian or Asian British	93	1.85%	103	2.05%
Black or black British	32	0.64%	35	0.69%
Chinese or other ethnic group	19	0.38%	19	0.38%
Not declared	154	3.06%	58	1.15%
Gender				
Male	1335	27%	1290	25.53
Female	3701	73%	3762	74.47%

Membership analysis

	Members *(as at 31/03/09)*		Members *(as at 31/03/10)*	
	Number	%	Number	%
Age				
14 - 16	24	0.56%	91	1.87%
17 - 21	461	10.84%	635	13.04%
+21	3770	88.6%	3971	81.54%
Ethnicity				
White	3924	92.22%	4587	94.19%
Mixed	9	0.21%	11	0.23%
Asian or Asian British	77	1.81%	87	1.79%
Black or black British	26	0.61%	34	0.70%
Other (includes not declared)	219	5.15%	151	3.10%
Gender				
Male	1632	38.35%	1869	38.38%
Female	2623	61.65%	2996	61.52

Serious untoward incidents involving data loss or confidentiality breach

Summary of personal data related incidents 2009/10

Category	Nature of Incident	Total
i	Loss of inadequately protected equipment, devices or paper documents from secured NHS premises	0
ii	Loss of inadequately protected electronic equipment devices or paper documents from outside secured NHS premises	2
iii	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
iv	Unauthorised disclosure	3
v	Other *	7

** includes items such as access control problems, password violations*

Compliance framework and risk ratings

Monitor, the independent regulator of foundation trusts, has developed a compliance framework which sets out its approach to assessing compliance by foundation trusts with the terms of their authorisations.

There are three main components to the *compliance framework*:
- Annual risk assessment based on an evaluation of the annual plan.
- In-year monitoring usually through quarterly submissions.
- Intervention.

Monitor assigns risk ratings in three areas based on the following criteria:
- Finance – *achievement of plan, underlying performance, financial efficiency and liquidity.*
- Governance – *legality of the constitution, growing a representative membership, appropriate board roles and structures, service performance (targets and national standards), clinical quality and patient safety, effective risk and performance management, co-operation with NHS bodies and local authorities.*
- Mandatory services – *changes to mandatory service provision and disposal of protected assets.*

The risk ratings are expressed as:
- **Green** – low risk
- **Amber** – medium risk or emerging concerns
- **Red** – high risk

Risk rating performance 2008/09 and 2009/10

	2008/09			
	Q1	Q2	Q3	Q4
Financial risk rating			4	4
Governance risk rating			Green	Green
Mandatory services			Green	Green

As we were authorised as a foundation trust on 1 July 2008 we were not required to produce an annual plan for 2008/09 nor provide quarterly compliance framework submissions for the first two quarters of that year. Our financial risk rating for 2008/09 was capped at four as this was our first year as a foundation trust.

	Annual Plan 2009/10	2009/10			
		Q1	Q2	Q3	Q4
Financial risk rating	3	3	3	3	3
Governance risk rating	Green	Green	Green	Green	Green
Mandatory services	Green	Green	Green	Green	Green

The reduction in the financial risk rating from 4 in 2008/09 to 3 in 2009/10 was due to the impact of accelerated depreciation on properties which have been replaced by the PFI schemes at Lanchester Road, Durham and Roseberry Park, Middlesbrough. This resulted in a planned income and expenditure deficit which reduced the financial efficiency element of the risk rating. This was a temporary position and will not be repeated from 2010/11 onwards. Further information on this matter is set out in the annual accounts (see chapter 7).

Regulatory interventions

Monitor did not use its formal powers of intervention against the trust in 2008/09 and 2009/10.

Further information

Further details of Monitor's Compliance Framework for 2009/10 can be found at www.monitor-nhsft.gov.uk

Governance review

The Foundation Trust Code of Governance

The "NHS Foundation Trust Code of Governance" was published by Monitor, the independent regulator of foundation trusts, to bring together best practice from the private and public sectors. It provides an overarching framework for corporate governance and complements the statutory and regulatory obligations placed on foundation trusts.

Our constitution requires our board of directors and council of governors to seek to comply with the code of governance, including both its main and supporting principles, at all times.

For 2009/10 we complied with all the provisions of the code of governance with the following exceptions:

- Code provision A.3.5: Mr P Briggs is both a non-executive director of this trust and a governor of Newcastle Upon Tyne Hospitals NHS Foundation Trust.
- Code provision C.2.1: The appointments of our chief executive and executive directors are not time limited. We consider time limited executive appointments to be contrary to more recent best practice. (Note: This provision has been removed from the revised version of the Code which came into effect on 1st April 2010).
- Code provision C.2.2: Mr J Tucker has been appointed as a non-executive director for a period of 4 years in view of the commercial and marketing expertise he has brought to the trust and to ensure the retirement dates of non-executive directors are spread out.

The code of governance is available on Monitor's website: www.monitor-nhsft.gov.uk

Overview of governance arrangements

Our governance arrangements are led by the chairman of the trust being both the chairman of our board of directors and council of governors.

Our council of governors contributes to the development of the trust by representing the views of our members and the wider community and ensures that we comply with the terms of our authorisation.

Our council of governors has the following specific roles:

- to develop our membership and represent their interests
- to assist with the development of the trust's strategy
- to provide its views on any matter when consulted by the board of directors
- to appoint or remove the chairman and the non-executive directors
- to determine the remuneration and allowances, and the other terms and conditions of office, of the chairman and non-executive directors
- to approve the appointment of the chief executive
- to consider the annual accounts and annual report
- to appoint or remove the trust's external auditor

A number of committees including the nomination and remuneration committee support this work (see page 85).

Our board of directors provides overall leadership and vision to the trust and is ultimately and collectively responsible for all aspects of performance, including clinical and service quality, financial performance and governance.

Our board of directors has retained certain decisions to itself including the definition of the trust's strategic goals and objectives, the approval of the annual plan (following consultation with our council of governors); the acquisition, disposal or change of use of land or buildings with a value in excess of £500,000; and the introduction or discontinuance of any significant activity or operation. Further details are provided in the "Scheme of decisions reserved to the board" which is available on our website as part of the constitution.

Any powers which the board has not reserved to itself or delegated to sub-committees are exercised on behalf of the board by our chief executive.

Under the leadership of our chief executive, the executive management team (which comprises the executive, corporate and service directors) is accountable for the ratification of trust-wide policies for implementation and for ensuring:

- performance against our objectives and key targets is reviewed
- the effective operation of our integrated assurance systems
- the provision of appropriate and accurate information to our board of directors

In our decision making we have complied with the pledges of the National Health Service Constitution.

The board of directors

Our board of directors comprises:

- a non-executive chairman
- seven non-executive directors
- five executive directors

In accordance with the constitution the executive directors must include the chief executive (as the accounting officer), the finance director, a registered medical practitioner and a registered nurse.

The trust's three corporate directors (directors of human resources and organisational development, performance and planning, estates and facilities management) also attend board meetings in a non-voting capacity.

All members of the board are equally responsible for scrutinising the performance of the trust's executive management team in meeting agreed goals and objectives and, in doing so, satisfying themselves as to the integrity of financial, clinical and other information and that

financial and clinical quality controls and systems of risk management are robust and defensible. However the non-executive directors have a special responsibility to ensure that scrutiny takes place.

The board considers that the chairman and all the non-executive directors are independent in accordance with the criteria set out in the foundation trust code of governance. The board has also agreed a clear division of responsibilities between the chairman and the chief executive which ensures a balance of power and authority such that no one individual has unfettered powers of decision.

The board reviewed the balance, completeness and appropriateness of its membership prior to authorisation as a foundation trust and as part of recruitment activities for non-executive directors.

Since 1 April 2009 there has been only one change to the membership of the board with the appointment of Dr. Nick Land who succeeded Dr. Chris Fisher as medical director on his retirement on 31 December 2009.

The chairman has no other significant commitments than shown below.

The membership of the board as at 31 March 2010 was as follows:

Mrs Jo Turnbull*, chairman*

Jo is a former chairman of County Durham and Darlington Priority Services NHS Trust and a former non-executive director of County Durham and Darlington Health Authority. She is a non-practicing solicitor and a Justice of the Peace.
Qualifications: LLB Newcastle University
Term of office: April 2010 to 31 March 2013

Mr John Robinson*, deputy chairman and chairman of the clinical governance and clinical risk committee*

John is a former non-executive director for County Durham and Darlington Priority Services NHS Trust. A former head of nursing in Hartlepool, he is now a councillor for Durham County Council, a Justice of the Peace for south Durham, board member for Sedgefield Housing and member of Durham and Darlington Fire Authority.
Qualifications: RMN and RGN, CPN Certificate, Further Education Teaching Certificate, Diploma in Management Studies
Term of office: July 2006 – 30 June 2010
(On 13 May 2010 the council of governors re-appointed Mr Robinson as a non-executive director until 31 August 2012)

Left to right:
John Robinson, Sharon Pickering, Chris Parsons, Mike Newell, David Levy, Graham Neave, Douglas Taylor, Paul Briggs, Martin Barkley, Colin Martin, Jo Turnbull, Jim Tucker, Andrew Lombard, Les Morgan, Chris Stanbury and Nick Land.

Mr Andrew Lombard*, non-executive director, senior independent director and chairman of the Mental Health Act management committee*

Andrew is a former non-executive director for Tees and North East Yorkshire NHS Trust. He was previously head of information and communications technology with Cleveland Police and was for many years chairman of a charity for people with disabilities.

Qualifications: HNC maths, stats, computing and a post graduate diploma in numerical analysis

Term of office: July 2006 – 30 June 2010

(On 13 May 2010 the council of governors re-appointed Mr Lombard as a non-executive director until 31 August 2013)

Mr Douglas Taylor*, non-executive director and chairman of the audit committee*

Douglas is a former director of finance in a development corporation and a major NHS teaching hospital trust. He was also most recently chief executive of a Newcastle based regional housing association and is a consultant to the housing sector.

Qualifications: Qualified accountant, CIPFA

Term of office: March 2008 to 28 February 2011

Mr Paul Briggs*, non-executive director and chairman of the investment committee*

Paul was previously a managing director of a number of North East companies with 20 years main board experience. He was previously chair of the regional CBI, vice-chair of the Regional Assembly and is currently a member of the ANEC North East Planning Board. Paul is a former non-executive director of Durham and Chester-le-Street Primary Care Trust and currently an appointed governor of the Newcastle Hospitals Foundation Trust.

Qualifications: MA Economics / Law

Term of office: July 2006 to 30 June 2010

Mr Mike Newell, *OBE, non-executive director*

Mike is a former governor of Durham Prison and former president of the Prison Governors Association. He is an executive advisor to the board of an educational charity and research consultant with Kings College.

Qualifications: BA Engineering, post graduate diploma in management studies

Term of office: July 2006 to 30 June 2010

(On 13 May 2010 the council of governors re-appointed Mr Newell as a non-executive director until 31 August 2012)

Mr Graham Neave, *non-executive director*

Graham has worked for Northumbrian Water since graduating from Sheffield University. He currently holds the position of operations director and is a Northumbrian Water Limited executive director with overall responsibility for the customer, technical and operations directorates.

Qualifications: B.Eng Civil and Structural Engineering, MBA, C Eng.

Term of office: September 2008 to 31 August 2011

Mr Jim Tucker, *non-executive director*

Jim is a former operations director and general manager with Nike. He spent over 20 years working for Nike in a number of roles and most recently as general manager for the developing markets in Eastern Europe, Middle East and Africa.

Qualifications: BSc Chemical Engineering

Term of Office: September 2008 to 31 August 2012

Mr Martin Barkley, *chief executive*

Martin joined the NHS in 1972 as a trainee hospital administrator and has been a senior manager in mental health and learning disability services since 1986. He has served as chief executive at three trusts since 1996 (East Surrey, Nottingham and Hampshire) before joining this trust in April 2008.

Qualifications: Dip IHM, DMS, MBA (Henley/Brunel)

Appointed: April 2008

Dr Nick Land, *medical director*

Nick has been a consultant psychiatrist for people with learning disabilities for 16 years. Prior to becoming the medical director he was clinical director for learning disabilities and forensic services at the trust. Interests include service development and medical education. He is on the executive of the NHS Confederation mental health network.

Qualifications: MA, MBBS, MRCPsych

Appointed: January 2010

Mr Colin Martin, *director of finance*

Colin has worked in local government and the NHS and was previously the director of finance for Tees and North East Yorkshire NHS Trust. He is a member of the Department of Health expert working group for the development of PBR for mental health services, a member of the

national costing development group and the HFMA mental health special interest group.
Qualifications: Qualified accountant, FCCA
Appointed: April 2006

Mr Les Morgan*, chief operating officer*
Les is a qualified registered mental health nurse who moved into general management in 1990. He has held director of nursing posts in North Tyneside Healthcare NHS Trust and Northumbrian Healthcare, where he was also deputy chief executive. Before moving to this trust he was director of service delivery and nursing at Bradford District Care Trust.
Qualifications: Enrolled nurse (MH), registered mental health nurse (RMN), Diploma in Management Studies
Appointed: September 2006

Mrs Chris Stanbury*, director of nursing and governance*
Chris joined the NHS in 1980 as a psychology graduate and registered as an RMN in 1985. She has held a variety of both clinical and educational roles, gaining further registration in both psychotherapy and as a nurse tutor, together with a masters degree in education. She was deputy director of nursing in mental health and learning disabilities at County Durham and Darlington Priority Services NHS Trust and then associate director of nursing at the trust prior to appointment.
Qualifications: BSc, RMN, RNT, PGDip Psych, M.Ed.
Appointed: February 2009

Details of company directorships or other material interests in companies held by directors which might conflict with their management responsibilities are included in the "Register of Interests of the Board of Directors". This is available for inspection on our website www.tewv.nhs.uk.

"How do I start to say thank you for all the care and kindness you have shown my husband. The respect you show your patients is in my opinion quite unique".
From a service user's husband.

Attendance at board meetings

Name	Title	Date of Board Meeting											
		28/4/09	26/5/09	4/6/09 (Special)	30/6/09	28/7/09	29/9/09	27/10/09	24/11/09	22/12/09 (Special)	26/1/10	2/3/10	30/3/10
Mrs Jo Turnbull	chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr John Robinson	deputy chairman	✓	✓	✓	-	✓	✓	✓	-	✓	✓	✓	✓
Mr Andrew Lombard	senior independent director	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Paul Briggs	non-executive director	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓
Mr Graham Neave	non-executive director	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	-
Mr Mike Newell	non-executive director	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓
Mr Douglas Taylor	non-executive director	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓
Mr Jim Tucker	non-executive director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Martin Barkley	chief executive	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	✓	✓
Dr Chris Fisher	medical director *(to 31/12/09)*	✓	✓	✓	✓	✓	-	✓	✓	✓			
Dr Nick Land	medical director *(from 1/1/10)*										✓	-	✓
Mr Colin Martin	director of finance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Les Morgan	chief operating officer	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	✓
Mrs Chris Stanbury	director of nursing and governance	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Denotes that the board member was not in office at the time of the meeting

The trust secretary attended every board meeting in accordance with the requirements of the constitution.

Keeping informed of the views of governors and members

Our board of directors ensures it is kept informed of the views of governors and members in a number of ways, including:

- attendance at council of governors meetings
- receiving reports on the outcome of consultations with governors, for example on the annual plan and the trust's strategic objectives
- non-executive directors and executive directors have been aligned to each of the public constituencies and attend both formal and informal meetings and training events
- updates by the chairman at board meetings

Andrew Lombard, as the senior independent director is also available to governors if they have concerns regarding any issues which have not been addressed by the chairman, chief executive or director of finance.

With regard to attendance at the five meetings of the council of governors held during 2009/10:

- The chairman and chief executive attended all meetings.
- Attendance at meetings by non-executive directors is not compulsory; however, there is a standing invitation for them to attend as observers. Attendance at meetings by the non-executive directors has been as follows:

Name	Meeting Date				
	23/6/09	30/7/09 (AGM)	22/9/09	10/11/09	18/2/10
Paul Briggs	-	✓	✓	✓	✓
Andrew Lombard	✓	-	✓	✓	✓
Graham Neave	-	✓	-	-	✓
Mike Newell	-	✓	✓	✓	✓
John Robinson	-	✓	✓	-	-
Douglas Taylor	-	✓	✓	✓	-
Jim Tucker	✓	✓	✓	✓	✓

- Executive and corporate directors attended meetings if required, for example Mr. Martin attends meetings to deliver the finance report, or as observers.

Name	Meeting Date				
	23/6/09	30/7/09 (AGM)	22/9/09	10/11/09	18/2/10
Colin Martin	✓	✓	✓	✓	✓
Les Morgan	-	✓	✓	✓	-
Chris Stanbury	✓	✓	✓	-	-
Dr. Chris Fisher	-	✓	-	-	-
David Levy	✓	✓	-	-	-
Chris Parsons	✓	✓	-	✓	-
Sharon Pickering	✓	✓	✓	✓	✓
Nick Land					-

Evaluating board performance

In 2008, following consultation with the council of governors, the board put in place arrangements to evaluate its own performance and that of its committees, the chairman and individual non-executive directors.

The overall scheme and the assessment tools were developed by Deloitte LLP based on best practice, including 360° techniques.

Under the scheme:

- The collective performance of the board is evaluated by each board member, the staff governors and a selection of senior managers and clinicians. The board agrees a development plan based on the outcome of the evaluation.
- The performance of the chairman is evaluated by self assessment, assessments by each board member and by a governor focus group facilitated by the senior independent director.
- The performance of each non-executive director is evaluated by self assessment and assessments by the chairman and a sample of both non-executive and executive directors.
- Detailed consideration of the results of the performance evaluation of the chairman and non-executive directors is undertaken by the nomination and remuneration committee of the council of governors. A report from the committee is made to a general meeting of the council of governors.
- The appraisal of the performance of executive directors was carried out by the chief executive, whose performance was appraised by the chairman. The outcomes of the appraisals are reported to the Remuneration Committee of the board.
- Personal development plans are completed by the chairman and board members and monitored during the year.
- The performance of the board's committees is by self assessment. The results are considered by each committee and the board.

At its meeting held on 13 May 2010 the council of governors considered the outcomes of the appraisals of the chairman and non-executive directors for 2009/10.

The council of governors considered that a rigorous evaluation of the performance of the chairman and non-executive directors had been undertaken in accordance with the process adopted by the trust.

The council of governors was entirely satisfied that the chairman continues to perform in accordance with her role. It also considered that no major concerns had been identified with regard to the performance of the non-executive directors.

The chairman and all the non-executive directors continued to demonstrate commitment to their roles.

Committees of the board

The audit committee

The board has established a formally constituted audit committee comprising five non-executive directors with a quorum of three. There is also a standing invitation for all other non-executive directors to attend meetings of the committee and participate in discussions but not to vote.

The committee is supported by officers of the trust and internal and external auditors.

The audit committee has an overarching responsibility for providing assurance to the board on the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

The responsibilities of the audit committee also include:

- reviewing the adequacy of all risk and control disclosure statements (eg the statement on internal control) prior to endorsement by the board
- ensuring the internal audit function is effective, meets mandatory NHS internal audit standards and provides appropriate independent assurance
- making recommendations to the council of governors on the appointment, re-appointment or removal of the external auditor
- approving the remuneration and terms of engagement of the external auditor and reviewing and monitoring the independence and objectivity of the external auditor
- reviewing the work and findings of the external auditor and considering the implications and management responses to their work
- reviewing the findings of other assurance functions, both internal and external to the organisations (eg the Care Quality Commission, Monitor, etc) and considering the implications to the governance of the trust
- reviewing and monitoring the integrity of any financial statements including any financial judgements contained in them and ensuring the completeness and accuracy of information provided to the board
- reviewing arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters (the whistle blowing policy)

The committee provides an annual report to the board on compliance with its terms of reference including:

- its work in support of the statement of internal control specifically commenting on the fitness for purpose of the assurance framework
- the completeness and embeddedness of risk management in the organisation
- the integration of governance arrangements

Five meetings of the audit committee were held between 1 April 2009 and 31 March 2010.

Attendance by members of the committee at these meetings was as follows:

Name	Meeting Date				
	2/6/09	1/9/09	1/12/09	25/1/10	23/3/10
Douglas Taylor *(Chairman of the Audit Committee)*	✓	✓	✓	✓	✓
Paul Briggs	✓	✓	✓	✓	✓
Andrew Lombard	✓	✓	✓	✓	✓
Mike Newell	✓	✓	✓	✓	✓
Jim Tucker	✓	✓	✓	✓	✓

The audit committee has agreed a policy to ensure that auditor objectivity and independence is safeguarded if the firm providing external audit services is commissioned to provide services outside of the external auditor's responsibilities. This policy stipulates that only the chief executive, finance director and trust secretary may commission the external audit firm for non-audit services and the appointment must be approved by the chairman of the audit committee. Safeguards are required that:

- external audit does not audit its own firm's work
- external audit does not make management decisions for the trust
- no joint interest between the trust and external audit is created
- the external auditor is not put in the role of advocate for the trust
- the external audit firm does not undertake certain functions including: preparation of accounting records and financial statements, advising on the selection, implementation or running of IS/IT systems, staff secondments, employee remuneration or selection and recruitment and finance or transaction services work within the trust
- the external auditor must ensure that the provision of non-audit services meets its own ethical standards and internal operational policies

The external audit firm has not been commissioned to provide non-audit services during 2009/10.

The council of governors appointed Deloitte LLP as the trust's external auditor on 5 November 2008 until after the audit of the 2010/11 accounts; with a view to renew after that time. Deloitte LLP had previously been appointed by the Audit Commission as the external auditor in January 2008 prior to authorisation as a foundation trust.

The cost of providing external audit services during 2009/10 was £171,000. This included the two special reviews commissioned by the Audit Committee on the following matters:

- the IT strategy
- adult services modernisation

Clinical governance and clinical risk committee

The clinical governance and clinical risk committee has a standing agenda that covers:

- quarterly service governance reports
- regular reports from working groups that report to the committee
- items relating to the patient experience, patient safety and clinical effectiveness agendas within the scope of the quality agenda and relating to the quality account
- regular reports on complaints received, serious untoward data and serious untoward report outcomes and recommendations, incidents and other patient safety data
- issues related to the implementation of NICE guidance, other national guidance, clinical audit and referred items to the audit committee

Issues that arise from national reports, inquiries and reviews in relation to clinical governance and the quality agenda are reviewed and debated. Other project development, particularly in relation to the trust's quality improvement programmes and national improvement programmes, e.g. DSSA, are presented and debated by the committee.

The committee has an annual review process and this year has undertaken both self assessment and a rigorous structural and analytical review of the function and process of the committee.

A monthly report is made to the board of directors on the activity and outcomes of the committee supplemented by additional annual reports as required by the regulators for patient safety issues, eg infection prevention control, safeguarding adults and children.

The committee has also been responsible for the co-ordination of the compliance returns for Standards for Better Health and has co-ordinated the application for the trust registration with the Care Quality Commission to commence April 2010.

Clinical governance and clinical risk committee attendance

Name	Date of Meeting											
	April 09	May 09	June 09	July 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10
Mr John Robinson, *non-executive director (Chair)*	✓	✓	✓	-	-	✓	✓	✓	✓	✓	✓	✓
Mr Mike Newell, *non-executive director*	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓	✓
Mr Graeme Neave, *non-executive director*	-	-	✓	✓	✓	-	✓	✓	✓	✓	✓	✓
Mrs Chris Stanbury, *director of nursing and governance*	✓	✓	✓	✓	✓	*	✓	✓	✓	✓	✓	✓
Dr Chris Fisher, *medical director*	✓	-	✓	✓	✓	✓	✓	✓	✓			
Mr Les Morgan, *chief operating officer*	✓	-	✓	✓	-	✓	✓	✓	✓	✓	✓	✓
Mrs Sharon Pickering, *director of planning and performance*	-	✓	-	✓	✓	-	✓	✓	✓	-	✓	✓
Mrs Lesley Crawford, *service director*	✓	*	✓	✓	✓	-	-	✓	✓	✓	✓	-
Mr Paul Newton, *service director*	✓	-	-	✓	-	-	✓	-	-	-	✓	✓
Mr David Brown, *service director*	*	✓	*	✓	✓	✓	✓	-	-	✓	✓	✓
Dr Angus Bell, *clinical director*	*	✓	✓	-	✓	-	✓	-	✓	-	✓	-
Dr Nick Land, *medical director*[1]	-	✓	✓	-	-	✓	-	✓	✓	✓	✓	✓
Dr Wolfgang Kuster, *clinical director*	✓	✓	-	✓	✓	✓	✓	✓	✓	✓	-	-
Dr Kasi Prasad, *clinical director*	✓	✓	-	✓	-	✓	✓	✓	✓	-	✓	-
Prof Joe Reilly, *clinical director*	✓	✓	✓	✓	-	✓	-	-	✓	✓	✓	✓
Wendy Broderick, *associate director of pharmacy*	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓	✓
Dr Ingrid Whitton, *clinical director*	*	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓
Mrs Diane Lee, *associate director of clinical governance*	✓	✓	✓	✓	✓	✓	✓	✓	✓	*	✓	*
Dr Paul Walker, *associate clinical director*			✓	✓	-	✓	-	-	-	✓	✓	✓
Dr Marcus Missen, *clinical director*					-	✓	✓	-	✓	-	✓	✓
Dr Ahmad Khouja, *clinical director*										-	✓	✓

[1] *Attended as clinical director 1/04/09 - 31/12/09*

* *Not in attendance but represented*

Denotes not a member at time of meeting

Denotes member retired

Investment committee

The investment committee has been established by the board to review and provide assurance on financial and investment policy issues. Its duties include:

- establishing the overall methodology, processes and controls which govern investments
- reviewing the trust's investment strategy and policy
- evaluating and maintaining an oversight of the trust's investments, ensuring compliance with the trust's policies, Monitor's requirements and the FT terms of authorisation
- considering the trust's medium-term financial strategy, in relation to both revenue and capital
- reviewing proposals (including evaluating risks) for major business cases and their respective funding sources prior to submission to the board
- reviewing the management and administration of charitable funds held by the trust

During 2009/10 the committee reviewed and recommended the following major business cases to the board:

- CAMHS LD short break services for challenging behaviour (Durham)
- Bankfields Court site redevelopment

The committee also assisted the board in the review of the trust's long term financial model in response to a request from Monitor for all foundation trusts to examine potential implications of a slow down in the growth of health funding from 2011.

Attendance at meetings by members of the investment committee was as follows:

	Meeting Date				
Name	**4/6/09**	**14/7/09**	**3/9/09**	**3/12/09**	**5/3/10**
Mr Paul Briggs, *non executive director (chairman of the investment committee)*	✓	✓	✓	✓	✓
Mr Douglas Taylor, *non-executive director*	✓	✓	✓	✓	✓
Mr Jim Tucker, *non-executive director*	✓	✓	✓	✓	✓
Mr Martin Barkley, *chief executive*	✓	✓	✓	✓	✓
Mr Colin Martin, *director of finance*	✓	✓	✓	✓	✓
Mr Les Morgan, *director of finance*	-	-	✓	✓	✓
Mrs Sharon Pickering, *director of planning and performance*	-	✓	-	✓	✓

Mental Health Act management committee

This committee's responsibilities are:

- to appoint associate managers and oversee manager's hearings
- to receive information and review, if necessary, the number of patients detained under each section of the Mental Health Act for the previous quarter
- to consider matters of good practice, and in particular, the implication of the Code of Practice (Revised): Mental Health Act 1983 and make proposals for change to the board; receive regular reports from the mental health policy groups
- to receive the Mental Health Act Commission visit report/s and the management response including the implementation of an action plan
- to review regularly the trust's compliance with statutory requirements of the Mental Health Act 1983
- to consider other topics as defined by the board

In the course of fulfilling its functions and duties if the committee becomes aware of any risk which could impact on the trust's ability to deliver its strategic goals it shall seek assurances from the appropriate director that the risk is being managed effectively. On considering the director's report it shall:

- assure itself that appropriate controls are in place to manage the risk or specify the controls it considers should be established to mitigate the risk
- report to the audit committee if the risk raises concerns regarding the effectiveness of the trust's governance arrangements; risk management and assurance arrangements or system of internal control
- make a recommendation to the board that the risk be included in the board's chapter of the integrated assurance framework and risk register if it believes the risk could have a significant impact on the sustainability/viability of the trust or on its ability to deliver the strategic direction

Attendance at the committee was as follows:

Name	Meeting Date			
	April 09	July 09	Oct 09	Jan 10
Mr Andrew Lombard, *non executive director (chair)*	✓	✓	✓	✓
Mr Douglas Taylor, *non-executive director*	✓	✓	✓	✓
Mr John Robinson, *non-executive director*	✓	✓	-	-
Mr Paul Briggs, *non-executive director*	-	✓	✓	✓
Mrs Chris Stanbury, *director of nursing and governance*	✓	✓	✓	✓
Dr Chris Fisher, *medical director*	✓	-	-	
Dr Nick Land, *medical director*				✓
Mr Paul Newton, *service director*	✓	-	✓	✓
Mr Chris Parson, *director of estates and facilities management*	✓	-	-	-
Mr Rob Cowell, *deputy EFM director*	-	✓	✓	-
Service user and carer reps.	✓	✓	✓	✓
Mrs Lesley Mawson, *associate director of nursing and governance*	✓	✓	✓	✓
Ms Pam Griffin, *MHA advisor*	✓	✓	✓	✓
G Millward, *MHAC*	✓	✓	✓	✓
Ms Mel Wilkinson, *MHA project manager*	✓		✓	✓
Ms Leigh Roberts, *MHA advisor*	✓	✓	✓	✓
Mr Simon Marriott, *training and policy manager*	-	-	-	✓

Remuneration committee

The remuneration committee membership comprises all the non-executive directors including the chairman.

Three remuneration committees were held during 2009/10:

Name	Meeting Date		
	22/5/09	22/1/10	2/3/10
Mrs Jo Turnbull	✓	✓	✓
Mr Martin Barkley *(by invitation)*	✓	✓	✓
Mr Jim Tucker	✓	✓	✓
Mr John Robinson	✓	✓	✓
Mr Douglas Taylor	✓	✓	✓
Mr Mike Newell	✓	✓	✓
Mr Andrew Lombard	-	✓	✓
Mr Paul Briggs	-	✓	-
Mr Graham Neave	✓	-	-

David Levy, director of human resources and organisational development attended all three meetings to provide secretarial support and advice to the remuneration committee.

Members of the council of governers

The council of governors

Our council of governors comprises:

- The chairman of the trust as chairman of the council of governors
- 28 governors elected by the public members of the following constituencies:-
    - Darlington (two governors)
    - Durham (ten governors)
    - Hartlepool (two governors)
    - Middlesbrough (three governors)
    - North East Yorkshire (four governors)
    - Redcar & Cleveland (three governors)
    - Stockton (four governors)
- Eight governors elected by staff members, one for each of the following classes:
    - adult services
    - allied health professionals
    - children and young people's services, older people's mental health services, substance misuse and North East Yorkshire
    - corporate
    - learning disability and forensic directorate
    - nursing
    - medical
    - psychology
- 17 Governors appointed by the following stakeholder and partner organisations :
    - County Durham Primary Care Trust, Darlington Primary Care Trust (one governor)
    - Middlesbrough Primary Care Trust, Redcar and Cleveland Primary Care Trust, Hartlepool Primary Care Trust, Stockton-on-Tees Teaching Primary Care Trust (one governor)
    - North Yorkshire and York Primary Care Trust (one governor)

- North East Mental Health and Learning Disability Commissioning Directorate (one governor)
- Durham County Council (one governor)
- Darlington Borough Council (one governor)
- Hartlepool Borough Council (one governor)
- Stockton-on-Tees Borough Council (one governor)
- Middlesbrough Borough Council (one governor)
- Redcar & Cleveland Borough Council (one governor)
- North Yorkshire County Council (one governor)
- University of Teesside (one governor)
- Durham University (one governor)
- North Tees and Hartlepool NHS Foundation Trust, South Tees Hospitals NHS Foundation Trust, County Durham and Darlington NHS Foundation Trust, Scarborough and North East Yorkshire Healthcare NHS Trust (one governor)
- North East Prisons Directorate (one governor)
- Voluntary Organisations Network North East and Ryedale Voluntary Action (two governors)

Monitor requires that a "lead governor" is nominated to facilitate direct communication between Monitor and the council of governors in a limited number of circumstances where it may not be appropriate to communicate through the normal channels, which in most cases will be via the chairman or the trust secretary. The council of governors has nominated Cllr Ann McCoy (Appointed Governor for Stockton Borough Council) as its lead governor.

Our council of governors met five times during 2009/10. During the year the council of governors has:

- held our Annual General Meeting including the launch of our involvement in the national anti stigma campaign "Time to Change"
- held constituency meetings in each of the trust's public constituencies in partnership with local voluntary organisations focussing on crisis services, the implementation of the national dementia strategy and the trust's capital developments
- approved the membership strategy and plan for 2010/11
- assured itself of the our financial and operational performance.
- assisted with the development of the trust's strategic goals and objectives and the annual plan
- assisted with the development of our quality report (see chapter 9)
- contributed to the development to our values
- re-appointed Jo Turnbull as the chairman of the Trust until 31 March 2013
- considered and been assured on the performance of the board, the chairman and the non-executive directors
- approved the remuneration of the chairman and non-executive directors
- reviewed our constitution
- approved the training and development plan for governors
- reviewed its own performance and established its development plan
- received briefings on the outcomes of the national patients survey and our approach to quality innovation productivity and prevention (QIPP)

Membership of the council of governors and attendance at meetings

Name	Constituency	Term of Office		Attendance at Meetings				
		From	To	23/6/09	30/7/09	22/9/09	10/11/09	18/2/10
Public Governers (Elected)								
David Hall	Darlington	1/7/08	30/6/11	✓	-	✓	✓	✓
Dennis Haithwaite	Darlington	15/12/08	14/12/11	-	✓	✓	✓	✓
Betty Gibson	Durham	1/7/08	30/6/11	✓	✓	✓	✓	✓
Christopher Wheeler	Durham	1/7/08	30/6/11	✓	✓	-	✓	✓
Roger Humphries	Durham	1/7/08	30/6/10	-	-	-	✓	✓
Mary Thompson	Durham	1/7/08	30/7/09	-	-			
Susan Jennings	Durham	8/7/09	23/11/09		-	✓	✓	
Maggie Bosanquet	Durham	29/10/09	30/6/11				-	✓
Andrew Everett	Durham	29/10/09	30/6/10				✓	✓
Vince Crosby	Durham	29/10/09	30/6/10				✓	-
Rachel Mitchell	Durham	1/7/08	30/6/11	✓	-	✓	✓	✓
John Hayton	Durham	1/7/08	29/6/09	-				
Emma Carter	Durham	1/7/08	21/5/09					
John Doyle	Durham	1/7/08	30/6/10	✓	✓	✓	✓	✓
Simon Carey	Durham	15/12/08	14/12/11	✓	-	✓	✓	✓
Christine Jeffreys	Hartlepool	8/4/09	7/4/12	-	-	-	-	✓
Paul Williams	Hartlepool	16/7/08	15/7/11	✓	✓	-	✓	✓
Ann Tucker	Middlesbrough	29/10/09	30/6/11				✓	✓
Catherine Haigh	Middlesbrough	29/10/09	30/6/11				✓	✓
Michael Taylor	Middlesbrough	1/7/08	30/6/10	✓	✓	✓	✓	✓
Raymond Skipp	Middlesbrough	1/7/08	23/07/09	-				
Paul Hyde	North East Yorkshire	1/7/08	30/6/10	✓	✓	-	-	✓
Richard Thompson	North East Yorkshire	1/7/08	30/6/11	✓	✓	✓	✓	✓
Kenneth Dale	North East Yorkshire	1/7/08	20/10/09	✓	✓	✓		
Keith Marsden	North East Yorkshire	25/1/10	30/6/10					✓
Andrea Darrington	North East Yorkshire	17/2/09	16/2/12	✓	✓	✓	-	✓
Vivienne Trenchard	Redcar and Cleveland	1/7/08	30/6/10	✓	✓	✓	-	✓
Jayne Mitchell	Redcar and Cleveland	1/7/08	30/6/11	✓	✓	✓	✓	✓
Caroline Parnell	Redcar and Cleveland	15/12/08	14/12/11	✓	✓	✓	-	✓
Susan Keith	Stockton	1/7/08	30/6/10	-	-	-	-	-
Gareth Rees	Stockton	1/7/08	30/6/11	✓	✓	-	✓	-
Rita Clark	Stockton	1/7/08	30/6/11	✓	✓	✓	✓	✓
Ray McCall	Stockton	15/12/08	14/12/11	✓	✓	✓	✓	✓
Staff Governers (Elected)								
Richard Pyatt	Medical	1/7/08	30/6/11	-	✓	-	✓	✓
Simon Hughes	Allied Health Professionals	1/7/08	30/6/11	✓	✓	-	✓	✓
Tim Cate	Psychology	1/7/08	9/7/09	-				
Giles Hallam	Nursing	1/7/08	30/6/11	✓	✓	✓	-	✓
Judith Hurst	Corporate	25/1/10	3/6/11					✓
Nigel Cooke	LD & Forensic	1/7/08	30/6/11	✓	✓	✓	✓	-
Jill Jefferson	MHSOP, C&YP, SM, NEY	1/7/08	30/6/11	✓	✓	-	✓	-
Clare Beighton	Adult Mental Health	16/7/08	15/7/11	✓	✓	✓	✓	-

Name	Constituency	Term of Office		Attendance at Meetings				
		From	To	23/6/09	30/7/09	22/9/09	10/11/09	18/2/10
Appointed Governors								
Cath Siddle	North Tees and Hartlepool NHS FT / South Tees Hospitals NHS FT / County Durham and Darlington NHS FT / Scarborough and North East Yorkshire Healthcare NHS Trust	1/7/08	30/6/11	-	-	-	-	✓
Alan Tallentire	North East Prisons Directorate	1/7/08	30/6/11	-	-	-	-	-
Jane Robinson	Darlington Borough Council	1/7/08	18/5/09					
Pauline Mitchell	Darlington Borough Council	8/1/10	30/6/11					-
Lesley Tickell	Durham County Council	1/7/08	30/6/11	-	-	✓	✓	✓
Nicola Bailey	Hartlepool Borough Council	1/7/08	23/7/09	-				
Jill Harrison	Hartlepool Borough Council	23/7/09	30/6/11		-	-	✓	-
Ruth Hicks	Middlesbrough Borough Council	1/7/08	30/6/11	✓	✓	-	✓	-
Caroline Seymour	North Yorkshire County Council	1/7/08	23/7/09	-				
Herbert Tindall	North Yorkshire County Council	14/1/10	30/6/11					✓
Mike Dillon	Redcar and Cleveland Borough Council	1/7/08	30/6/11	-	-	-	-	✓
Ann McCoy	Stockton Borough Council	1/7/08	30/6/11	✓	✓	✓	✓	✓
Yasmin Chaudhry	County Durham PCT/ Darlington PCT	1/7/08	15/4/09					
Malcolm Cook	County Durham PCT/ Darlington PCT	15/4/09	30/6/11	-	✓	-	✓	-
Brian Key	North East Mental Health & Learning Disability Commissioning Directorate	1/3/09	30/6/11	✓	-	-	✓	✓
Paddy Pearce	North Yorkshire and York PCT	1/7/08	30/6/11	-	✓	✓	-	-
Clare Hunter	Middlesbrough PCT/Redcar & Cleveland PCT/ Stockton-on-Tees Teaching PCT	1/7/08	30/6/11	✓	✓	✓	✓	✓
Pali Hungin	University of Durham	1/7/08	30/6/11	✓	-	✓	-	✓
Cliff Allan	University of Teesside	1/7/08	21/9/09	-	✓			
Cliff Hardcastle	University of Teesside	26/11/09	25/11/12					-
Mike Hill	Voluntary Organisations Network North East	1/7/08	30/6/11	✓	✓	-	-	✓
Robert Salkeld	Ryedale Voluntary Action	1/7/08	30/6/11	✓	-	✓	✓	✓

Denotes that the Governor was not in office at the time of the meeting

Details of company directorships or other material interests in companies held by governors where those companies or related parties are likely to do business of are possibility seeking to do business with the trust are included in the "Register of Interests of the Council of Governors". This is available for inspection on our website, www.tewv.nhs.uk.

Elections held during 2009/10

Date of Election	Constituency	Number of Members in the Constituency	Number of seats	Number of Contestants	Turnout %
8/4/09	Hartlepool	653	1	2	10.7%
6/7/09	Durham	1014	1	7	15.8%
28/10/09	Middlesbrough	761	2	4	13%
28/10/09	Durham	1002	3	9	15.4%
25/1/10	North East Yorkshire	224	1	6	17%
25/1/10	Staff Corporate	1002	1	3	15.5%

All elections to the council of governors have been administered and overseen by either the Electoral Reform Services or the Association of Electoral Administrators to ensure independence and compliance with the election rules contained within the trust's constitution.

Committees of the council of governors

Our council of governors has established five committees to support its work:

Thematic committees

In their work so far the thematic committees of the council of governors have progressed the following issues:

Improving the experience of carers committee

- reviewed how the trust identifies carers
- reviewed the information the trust makes available to carers, identifying and recommending best practice
- reviewed and developed draft carer standards for the trust
- reviewed the training and practical help available from the trust to carers
- reviewed support and information available to young carers

Improving the experience of service users

- reviewed the outcome of the GP survey and monitored progress on the subsequent action plan for the trust to improve communication and liaison with GPs
- reviewed how the trust collates and acts on service user feedback with the aim of developing a standard for the trust
- reviewed the trust's responsibilities where delayed discharges occur, especially within learning disability and older people's services, and how it can work more effectively with partner organisations

Promoting social inclusion

- delivered a conference to look at the national perspective and best practice of social inclusion
- developed a definition of social inclusion for the trust
- reviewed how the trust currently ensures that patients' social needs are met
- considered and monitored the involvement of the trust in the national anti stigma

campaign, "Time to Change"
- considered the development of a social inclusion strategy

Making the most of membership
- monitored the membership strategy and plan for 2009 and developed a revised strategy and plan for 2010
- monitored recruitment and engagement activities
- reviewed information available on trust membership to ensure that it is fit for purpose
- ensured that all governors have the opportunity to be briefed on membership recruitment

The nomination and remuneration committee

The nomination and remuneration committee has been established to support the council of governors regarding the appointment of the chairman and non-executive directors and on their remuneration and terms of service.

During 2009/10 the committee has:
- considered the outcomes of the performance evaluation of the board of directors and the appraisals of the chairman and non-executive directors for 2008/09 and provided assurance to the council of governors that:
    - rigorous evaluations of the performance of the chairman and non-executive directors were undertaken in accordance with the process adopted by the trust.
    - the chairman and non-executive directors performed in accordance with, and demonstrated commitment, to their roles
- reviewed the remuneration and terms of service for the chairman and non-executive directors for 2009/10
- developed the detailed procedure for the appointment/re-appointment of the chairman and non-executive directors
- reviewed the performance evaluation of Jo Turnbull as chairman during 2009/10 and recommended her re-appointment to council of governors
- reviewed the performance of those non-executive directors whose present terms of office are due to come to an end in 2010
- commenced the recruitment of a non-executive director

The membership of the committee and attendance at meetings was as follows:

	Meeting Date				
Name	**4/6/09**	**30/11/09**	**27/1/10**	**18/2/10**	**10/3/10**
Jo Turnbull, *Chairman of the Trust*	✓	✓	✓	✓	✓
Martin Barkley, *chief executive*	✓	✓	✓	✓	-
Clare Hunter, *Appointed Governor*	✓	-	✓	✓	✓
Mike Hill, *Appointed Governor*		✓	✓	✓	-
Roger Humphries, *Public Governor*	✓	✓	✓	✓	✓
Paddy Pearce, *Appointed Governor*	-	✓	✓	-	✓

Denotes that the Governor was not in office at the time of the meeting

Mr Lombard also attended the meetings held on 6 June 2009, 30 November 2009 and 27 January 2010 in his capacity as the senior independent director for the discussions on the board performance evaluation scheme as this included arrangements for the appraisal and re-appointment of the chairman of the trust.

Meetings of the committee are chaired by the chairman of the trust except that the senior independent director becomes a member of and chairs the committee for the matters relating to the appraisal and appointment of the chairman.

The appointments of the chairman and the non-executive directors can be terminated for the following reasons:

- by resignation
- by ceasing to be a public member of the trust
- upon becoming a governor of the trust
- upon being disqualified by the Independent Regulator
- upon being disqualified from holding the position of a director of a company
- upon being adjudged bankrupt
- upon making a composition or arrangement with, or granting a trust deed for, his/her creditors
- upon being convicted of any offence and a sentence of imprisonment being imposed (whether suspended or not) for a period of not less than three months (without the option of a fine).
- upon removal by the council of governors at a general meeting

Other governor groups and meetings

Quality task group
This task group of governors has assisted with the development of the quality report (see chapter 9).

Annual plan workshops
Workshops were held to enable governors to assist with the development of the annual plan.

Annual accounts and annual report workshops
Workshops are held to enable governors to scrutinise the annual accounts and annual report prior to submission to the annual general meeting.

Training and development

Each year the council of governors reviews its operation based on the best practice outlined in the code of governance. The review is based on self assessment and focus group discussions. A development plan is produced based on the review and agreed by the council of governors.

Individually governors are required to attend training to ensure they are skilled in undertaking their role.

A training and development plan has been approved based on a needs assessment and issues arising from the annual review of the operation of the council of governors undertaken in 2009.

All governors must undertake the following mandatory training:

- induction
- financial management
- business planning and performance
- constitution
- risk management
- equality and diversity
- quality improvement system

The training and development plan also provides opportunities for governors to undertake self development with a range of optional training courses available.

Various other ad hoc briefing and training events are held for governors throughout the year to ensure they have an understanding of initiatives undertaken by the trust.

Governors have also participated in a number of national development opportunities, including the national programme provided by the Foundation Trust Network/FT Governors Association.

Membership

Membership is important in helping to make us more accountable to the people we serve, to raise awareness of mental health and learning disability issues and assists us to work in partnership with our local communities.

Public membership

Anyone (unless eligible to join the staff constituency) aged 14 or over who lives in the area covered by the public constituencies may become a public member of the trust.

During 2009/10 the size and movements in public membership were as follows:

Movement in pulic membership	
Public members as at 1/4/09	4255
New members during 2009/10	823
Members leaving during 2009/10	208
Public members as at 31/3/10	**4870**

The number of members for each of the public constituencies was as follows:

Staff Constituencies Total	4870
Darlington	515
Durham	1249
Hartlepool	702
Middlesbrough	833
North East Yorkshire	264
Redcar & Cleveland	401
Stockton	906

At present our public membership is broadly representative in terms of age, gender and ethnicity.

We aim to have a growing, engaged and representative membership and we will be seeking to recruit an additional 500 members (net) each year. If you would like to become a member please contact the trust secretary's department on 01325 552314, email ft.membership@tewv.nhs.uk or visit our website www.tewv.nhs.uk.

Staff membership

All staff employed by the trust (including those on a temporary or fixed term contract of 12 months or more) are eligible to become members of the staff constituency.

Members of staff are opted in upon commencement of employment and given the choice to opt out of membership in writing.

Our staff membership as at 31 March 2009 was as follows:

Staff Constituencies Total	4979
Corporate	1004
Nursing	1581
Learning disability and forensic services	650
Psychology	134
Medical	176
Adult mental health	604
Allied health professionals	167
MHSOP, CYP, NEY *	663

*mental health services for older people, children and young people's services, North East Yorkshire

Six members of staff have currently opted out of membership

Membership strategy and plan 2010

Our membership strategy and plan has been developed by the "making the most of membership" committee and was approved by the council of governors following consultation with the board.

Overall the strategy recognises that our membership is reasonably representative; however as well as seeking the continued growth in the number of members throughout our catchment area, we will be focussing particularly on the following key areas of under-representation:

- males
- North East Yorkshire
- Durham
- Redcar and Cleveland

During 2009/10 recruitment has been undertaken using:

- direct mailing
- trust website
- attendance at public meetings and events held by the trust
- attendance at events held by other organisations
- advertising in a range of public venues and in the local press
- promotional stands in organisations, shopping centres, leisure centres, libraries, trust premises etc
- activities promoting the "Time to Change" anti-stigma campaign
- involvement of governors in activities outside of the trust

Our plans for recruiting members during 2010/11 are based on the following activities:

- continuing to build on links with stakeholders to promote membership
- direct targeting of key groups
    - carers / patients

    - community and support groups
    - voluntary sector organisations
    - public sector organisations
    - young people
    - students in the mental health, learning disability field
- website activity
- promotional stands
    - shopping centres
    - large employer organisations
    - trust events
    - awareness weeks
    - large events/conferences within the region
- greater visibility of the trust membership in premises
- encouraging patient membership through staff involvement
- greater involvement of governors in recruitment activity

We acknowledge that achieving the recruitment targets will still be a challenge and progress will be monitored by the 'making the most of membership' committee.

Engagement

As well as growing a representative membership we are committed to ensuring accountability through developing member engagement.

In 2009/10 engagement with members was undertaken via the following:

- annual general meeting including a national guest speaker
- receipt of bi-monthly publication 'Insight' which includes a members page
- personal invitation to public meetings held in constituencies
- personal invitation to opening of new premises
- communication to relevant constituencies to promote awareness of elections
- meeting members at promotional stands at a variety of events
- website forum for members' information

Over the coming year these methods of engagement will be enhanced by:

- further promotion at local events and conferences held by the trust
- developing the public constituency meetings and the involvement of partner organisations
- consulting with members on proposed changes to services by the trust

All engagement activity is monitored through the "making the most of membership" committee.

Financial review 2009/2010

Financial review 2009/2010

Summary of financial performance

2009/10 was the first full 12 month reporting year as a foundation trust and built on the strong underlying financial position which has existed since the trust was formed in April 2006. This position allowed new investments in services and improvements in quality to take place against a background of low levels of financial risk.

These are the trust's first financial statements prepared in accordance with International Financial Reporting Standards (IFRS). The 2008-09 UK GAAP accounts were restated to IFRS in line with Monitor and HM Treasury requirements. The transition date of IFRS for the trust was 1 July 2008.

The 2009/10 financial strategy was agreed by the board of directors as part of the trust's integrated business plan and underpinned the achievement of the trust's strategic objectives.

The following objectives were set:

Objectives	Outcomes
Delivering a £3.5m operating deficit	Operating deficit of £1.8m achieved (£60.4m deficit outturn)
Achieving a Monitor risk rating of 3	Calculated risk rating of 3 achieved
Delivery of £6.2m cost reductions	£6.4m saving
EBITDA margin of 9.0%	EBITDA margin of 8.4% achieved

The trust planned an operating deficit of £3.5m for the financial year and achieved £1.8m. This was mainly due to reduced depreciation and PDC dividend payable.

In line with Department of Health guidance the trust has undertaken a full revaluation of land and buildings completed by external property consultants in 2009/10. From a modern equivalent asset (MEA) perspective property, plant and equipment have been valued down by £58million net in March 2010. This was made up of an impairment charge of £58.6million and an increase in revaluation reserve of £0.6million.

This resulted in a £60.4m deficit outturn position in 2009/10.

Income and surplus growth

The trust experienced a further year of income growth which has enhanced the underlying position and provided a firm base for revenue and capital investment in clinical services.

Underlying performance against Monitor's compliance regime – financial metrics

The trust's performance against Monitor's compliance regime is shown in the table below:

Financial metrics

	Performance	Rating
EBITDA margin	8.4%	3
EBIDTA % achieved	94.2%	4
Return on assets	1.3%	2
I & E surplus margin	-0.80%	2
Liquid rate	68.4 days	5
Overall rating		3

Improving efficiency and ensuring value for money

The trust is continuously striving to improve efficiency in its use of resources by reviewing systems and pressures, evaluating skill mix, optimising the use of capacity and ensuring best value through robust procurement practices. In year, £6.4m or 2.8% of our cost base was saved through a variety of ongoing and one off schemes. Internal efficiency is independently reviewed by internal audit and reported to the audit committee and board of directors.

Capital investment

The trust has utilised its freedoms as a foundation trust to improve the infrastructure and ensure the most modern equipment and technology is available for patient care. Over the last twelve months we have reinvested surpluses with the aim of providing the best possible environment. As a foundation trust during 2009/10, £8.1m was invested in capital assets.

The trust's investment and disposal strategy is summarised as follows:

	2009/10 £
Investment in fixed assets	8.1m
Disposal of unprotected asset	0.1m

The trust has a borrowing limit of £107.1m which is agreed with Monitor to cover PFI finance lease obligations. The trust was not required to raise borrowings to finance the capital investment strategy which was funded in full from the trust's internally generated resources.

Working capital

Throughout the year the trust had access to a £17m committed working capital facility. This was not required during the year as the Trust had strong liquidity which improved further in year linked to robust treasury management and debt management policies.

Accounting policies

The trust prepares the financial statements in accordance with the NHS Foundation Trust Annual Reporting Manual (2009/10) and fully complies with International Financial Reporting Standards accounting practices (IFRS).

The trust's accounting policies are set out in the annual accounts and have been consistently applied over the comparative period. Fixed assets are reflected in the statement of financial position based on a modern equivalent asset (MEA) valuation undertaken as at 31 March 2010. Full details can be found at note 1.6 of the accounts.

Going concern

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

The 2010/11 annual plan provides for a surplus of £4.5m (1.9% of turnover).The financial plans for 2011/12 and 2012/13 indicate that this level of surplus will be maintained. The directors' view is that the trust is a going concern and can make the disclosure as recommended by the accounting standards board that:

"After making enquiries the directors have a reasonable expectation that the Tees, Esk and Wear Valleys NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt the going concern basis in preparing the accounts".

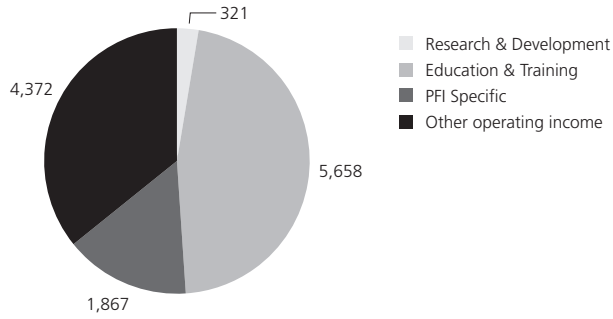
Income generation

During 2009/10 as a foundation trust, income generated was £232.3m from a range of activities; 94.7% from direct patient care. Patient care income came from the following areas:

Patient care income 2009/10

There is a further £12.2m from education and other non-patient care services.

Other income 2009/10



Accounting information

The accounts are prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

The accounts are independently audited by Deloitte LLP as external auditors in accordance with the National Health Service Act 2006 and Monitors Code of Audit Practice. As far as the directors are aware, all relevant audit information has been fully disclosed to the auditor and no relevant audit information has been withheld or made unavailable. Nor have any undisclosed post balance sheet events occurred.

No political or charitable donations were made by the trust during 2009/10.

Accounting policies for pensions and other retirement benefits are set out in page 115 in the accounts and details of senior employees' remuneration can be found in page 144.

The trust has complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector Information guidance.

Better payment practice code

The better payment practice code requires the trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. Performance for the financial year 2009/10 is as follows:

	Year to date	
	Number of Invoices	**Value of invoices £000s**
NHS creditors		
Total bills paid	1,173	13,909
Total bills paid within target	777	9,835
Percentage of bills paid within target	66.24%	70.71%
Non-NHS creditors		
Total bills paid	54,784	47,682
Total bills paid within target	52,804	45,818
Percentage of bills paid within target	96.39%	96.09%

In line with best practice the trust continues to monitor expenditure on management costs in accordance with Department of Health definitions. In 2009/10 4.65% of our total income was incurred on management costs.

Martin Barkley
Chief Executive

Date: 3 June 2010

Statement of the chief executive's responsibilities as the accounting officer of Tees, Esk and Wear Valleys NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the accounting officers' memorandum issued by the independent regulator of NHS foundation trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed the Tees, Esk and Wear Valleys NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the accounts direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Tees, Esk and Wear Valleys NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the accounting officer is required to comply with the requirements of the NHS Foundation Trust Financial Reporting Manual and in particular to:

- observe the accounts direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Martin Barkley
Chief Executive

Date: 3 June 2010

Responsibilities of directors for preparing the accounts

The directors are required under the National Health Service Act 2006, and as directed by Monitor, the independent regulator for NHS foundation trusts, to prepare accounts for each financial year.

Monitor, with the approval of HM Treasury, directs that these accounts shall show, and give a true and fair view of the NHS foundation trust's gains and losses, cash flow and financial state at the end of the financial year. Monitor further directs that the accounts shall meet the accounting requirements of the NHS Foundation Trust Financial Reporting Manual that is in force for the relevant financial year, which shall be agreed with HM Treasury.

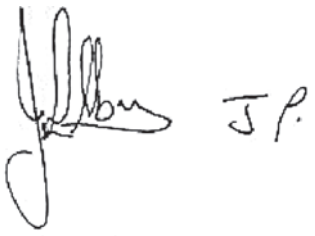
In preparing these accounts, the directors are required to:

- apply on a consistent basis, for all items considered material in relation to the accounts, accounting policies contained in the NHS Foundation Trust Financial Reporting Manual issued by Monitor
- make judgements and estimates which are reasonable and prudent; and ensure the application of all relevant accounting standards, and adherence to UK generally accepted accounting practice for companies, to the extent that they are meaningful and appropriate to the NHS, subject to any material departures being disclosed and explained in the accounts

The directors are responsible for keeping proper accounting records which disclose, with reasonable accuracy, at any time the financial position of the trust. This is to ensure proper financial procedures are followed, and that accounting records are maintained in a form suited to the requirements of effective management, as well as in the form prescribed for the published accounts.

The directors are also responsible for safeguarding all the assets of the trust, including taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief, they have complied with the above requirements in preparing the accounts.



John Robinson Date: 3 June 2010

Deputy Chairman

On behalf of the Chairman and Board of Directors

Statement on internal control 2009-10

Scope of responsibility

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Tees, Esk and Wear Valleys NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Tees, Esk and Wear Valleys NHS Foundation Trust for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts.

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.

Capacity to handle risk

The chief executive is the trust's accounting officer responsible for ensuring that the principles of risk management are embedded throughout the organisation.

The trust's clinical governance and clinical risk committee (a sub-committee of the board) has delegated authority to oversee and manage the risk management programme as it relates to clinical risk. The audit committee has delegated authority to oversee and manage the risk management programme as it relates to non-clinical risk.

Guidance and training in the risk assessment process is aimed at all levels of staff. This is achieved through the inclusion of risk assessment techniques and processes in the trust mandatory training programme.

The risk and control framework

The trust's risk management strategy contained in the integrated governance strategy is subject to regular review.

Key elements of the risk management strategy are:

- to provide clear management structures and responsibilities throughout the organisation leading to the board of directors
- lead executive responsibility for each risk
- to outline the trust's approach to risk management and identifying risks
- to outline and implement a system for assessing risk
- to select the approach for dealing with the risk
- monitoring and reporting of risk
- use of an integrated risk register for prioritising and reviewing risks
- decision making on acceptability of risk
- training and awareness of risk management
- assurance framework mapping objectives to risks, controls and assurances

Risk is identified using a number of mechanisms including; external assessments such as NHSLA and Care Quality Commission, complaints management, litigation, staff surveys, task groups, clinical audit and internal and external audit. As a result of the Francis inquiry into the Mid Staffordshire NHS Foundation Trust the board reviewed the findings and recommendations contained within the report and has taken steps to ensure the trust is able to build on the lessons learnt.

Risk management can be demonstrated to be embedded in the trust by:

- clear structures and responsibilities with clear reporting arrangements to trust board
- a system for risk assessment in place to identify and minimise risk as appropriate
- consideration of acceptability of risk
- development of risk registers at strategic and operational level
- awareness training for all staff.

Public stakeholders are also involved in managing risks which impact upon the organisation in a variety of ways:

- foundation trust membership and council of governors
- patient satisfaction surveys
- complaints, claims and patient advice and liaison(PALS) concerns
- the trust involves patients and the public in the development of services
- the trust maintains close links with social services departments to ensure the delivery of integrated care and treatment

The trust has been formally assessed against standards prescribed by CNST Level 2. In addition an assurance framework was in place at 31 March 2010 and remains in place up to the date of approval of the annual report and accounts. Principal risks to the trust meeting its principal objectives have been identified within the framework together with the key controls in place to manage these risks. The trust had no significant gaps in control identified during the year

but has recognised that there were gaps in controls in managing some risks. These included the development of a robust workforce performance management framework, the further development of the trust's IT systems to support the organisation's objectives including data quality, the lack of agreed currencies, quality and outcome measures for the trust's patient care contracts, and the evaluation of training and approach to project management. In all cases plans are in place to mitigate this situation and to ensure that these gaps are removed as soon as is practicable. This process is managed by the trust board's sub committees and reported to the board. The trust has identified that it needs to improve the level of reliance it can place on assurances it gains that controls are operating effectively. This will be achieved by an increasing reliance on validated 3rd party assurances through the development of a system which records and validates the form and frequency of assurances received. This system will allow the trust to assess the level of assurance that can be taken and what actions are necessary to improve the benefit of all 3rd party assurances. This will ensure that governance processes continue to become more dynamic in the pursuit of effectiveness and efficiency.

The trust has confirmed its compliance with the requirements of the Department of Health information governance assurance programme. The trust has achieved a green rating in the information governance toolkit and this position was confirmed by a review undertaken by internal audit. The director of nursing and governance is the senior information risk owner at board level. The trust has, through the senior information risk owner, introduced an information governance campaign, which in turn has increased information governance awareness, training and understanding through delegation of responsibility to information asset owners and information asset administrators.

The trust is fully compliant with the core Standards for Better Health.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The 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 the obligations of Tees, Esk and Wear Valleys NHS Foundation Trust under the Climate Change Act and the adaptation reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The trust has agreed a process to ensure that resources are used economically, efficiently and effectively that involves:

- agreeing a rolling three year annual financial strategy and plan
- a rigorous process of setting annual budgets and a detailed cost improvement programme
- annual review of standing financial instructions and schemes of delegation
- the formalisation of a treasury management policy
- robust performance management arrangements

- a programme of supporting directorates to better understand and manage their relative profitability
- breaking the trusts overall reference cost indicator down to specialty/directorate
- levering efficiencies through internal and collaborative procurement initiatives
- using benchmarking and nationally published performance metrics to inform plans for improved bed and community service efficiency
- rationalising the estate
- improving workforce productivity
- benchmarking management costs
- commissioning external consultancy where the trust believes economy and efficiency can be improved

The board plays an active role by:
- determining the level of financial performance it requires and the consequent implications
- reviewing in detail each month financial performance, financial risk and delivery against the detailed CIP
- agreeing the IBP, annual plan and self certification submitted to Monitor.
- Considering plans for all major capital investment and disinvestment

The trust audit committee has a key role on behalf of the board in reviewing the effectiveness of our use of resources. The trust has also gained assurance from:
- internal audit reports, including review of CIP
- external audit reports on specific areas of interest
- the Care Quality Commission annual health check

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare quality accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The following steps have been put in place to ensure that the quality accounts present a balanced and accurate view:
- The clinical governance and clinical risk committee is responsible for producing the quality accounts with the director of nursing and governance and the director of planning and performance being lead directors. The clinical governance and clinical risk committee has received reports throughout the year regarding the development of the quality accounts, including an early draft of the accounts.
- Priorities for improvement have been identified from an analysis of serious untoward incidents, complaints, as well as feedback from users and other stakeholders. These priorities have been shared with wider stakeholders for comment and were approved by the clinical governance and clinical risk committee before final sign off by the board of directors.

- The director of finance and information is the corporate lead for data quality and chairs an internal group which has the responsibility for ensuring data quality within the trust. The executive management team considers data quality on a monthly basis as part of a dedicated meeting concerned with performance. Furthermore data quality is also discussed at monthly performance meetings between the director of finance and information, director of planning and performance and the chief operating officer with each clinical directorate.
- Data quality is included within the corporate risk register which is used by the board of directors to monitor the risk of incomplete and inaccurate data.
- Significant assurance was provided by internal audit on the processes in place to accurately report the three performance indicators mandated by Monitor to be contained within the quality accounts.
- The trust has the following policies linked to data quality:
    - data quality policy
    - minimum standards for record keeping
    - policy and procedure for PARIS (electronic patient record/information system)
    - care programme approach (CPA) policy
    - information governance policy
    - information systems business continuity policy
    - data protection policy

  The policies incorporate national standards where available and are regularly reviewed. All the policies are held on the intranet and are available to staff at all times. When policies have been reviewed (or new ones published) there is a mechanism to inform staff through team brief.
- A significant amount of training was undertaken in terms of data entry as part of the implementation of the new electronic patient record (PARIS) and the implementation of the national changes to CPA. Training has continued where issues around data quality have been identified.
- As part of performance reporting to the board actual data is used to forecast future positions thus improving the decision making process.
- All data returns are submitted in line with agreed timescales.

Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of the review of the effectiveness of the system of internal control by the trust board, audit committee, clinical governance and clinical risk committee and Mental Health Act committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by:

- the Care Quality Commission
- NHSLA Clinical Negligence Scheme for Trusts (CNST)
- internal audit
- external audit
- Health and Safety Executive
- internal clinical audit team

The following groups and committees have been involved in maintaining and reviewing the effectiveness of the system of internal control:

- The trust board is responsible for setting the strategic direction of the organisation and monitoring the progress of the organisation against targets. The board also receives minutes and reports from its sub committees.
- The audit committee provides an independent view of internal control by reviewing financial systems, overseeing audit services and providing assurance to the board on non financial governance issues.
- The clinical governance and clinical risk committee oversees on behalf of the trust board all clinical governance activity including a review of the clinical audit processes and programme.
- Internal audit provides an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the trust's objectives.
- The external auditor provides progress reports to the audit committee.
- The annual report and accounts are presented to the board of directors for approval.

Conclusion

In summary, the trust has a sound system of internal control in place which is designed to manage the key organisational objectives and minimise the trust's exposure to risk. The board of directors is committed to continuous improvement and enhancement of the systems of internal control.

Martin Barkley

Chief Executive

Date: 3 June 2010

Independent auditors' report

to the board of governors and board of directors of Tees, Esk and Wear Valleys NHS Foundation Trust

We have audited the financial statements of Tees, Esk and Wear Valleys NHS Foundation Trust for the year ended 31 March 2010 under the National Health Service Act 2006 ("the Act") which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 34. These financial statements have been prepared in accordance with the accounting policies set out therein. We have also audited the information in the Directors' Remuneration Report that is described as having been audited.

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Tees, Esk and Wear Valleys NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditors' report and for no other purpose. To the fullest extent permitted by law, we do not, in giving our opinion, accept or assume responsibility to anyone other than the Trust and the Boards, as a body, for this report, or for the opinions we have formed.

Respective Responsibilities of the Accounting Officer and Auditors

The Accounting Officer's responsibilities for preparing the Annual Report, the Directors' Remuneration Report and the financial statements in accordance with directions issued by Monitor – Independent Regulator of NHS Foundation Trusts are set out in the Statement of Accounting Officer's Responsibilities.

Our responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements (including statute and the Audit Code of NHS Foundation Trusts) and International Standards on Auditing (UK and Ireland).

We report to you our opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts and whether the financial statements and the part of the Directors' Remuneration report to be audited have been properly prepared in accordance with the National Health Service Act 2006 and the directions made thereunder by Monitor – Independent Regulator of NHS Foundation Trusts. We also report to you whether in our opinion the information given in the directors' report is consistent with the financial statements.

In addition, we report to you if, in our opinion, the financial statements have not been prepared in accordance with directions made under paragraph 25 of Schedule 7 of the Act, the financial statements do not comply with the requirements of all other provisions contained

in, or having effect under, any enactment applicable to the financial statements, or proper practices have not been observed in the compilation of the financial statements.

We review whether the statement on internal control reflects compliance with the requirements of Monitor contained in the NHS Foundation Trust Annual Reporting Manual. We report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the statement on internal control covers all risks and controls. We are also not required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

We read the other information contained in the Annual Report as described in the contents section and consider whether it is consistent with the audited financial statements. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the financial statements. Our responsibilities do not extend to any further information outside the Annual Report.

Basis of audit opinion

We conducted our audit in accordance with the Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with International Standards on Auditing (UK & Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements and the part of the Directors' Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgements made by the Directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Directors' Remuneration Report to be audited.

Independent auditors' report

to the board of governors and board of directors of Tees, Esk and Wear Valleys NHS Foundation Trust

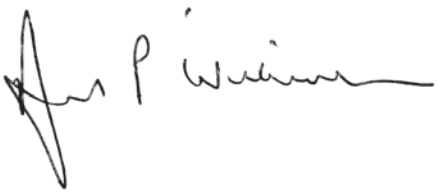
Opinion

In our opinion:

- the financial statements give a true and fair view of the state of affairs of Tees, Esk and Wear Valleys NHS Foundation Trust as at 31 March 2010 and of its comprehensive income for the year then ended in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts;
- the financial statements and the part of the Directors' Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 2006 and the directions made thereunder by Monitor – Independent Regulator of NHS Foundation Trusts; and
- the information given in the directors' report is consistent with the financial statements.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.



David Wilkinson FCA, CF (Senior Statutory Auditor)
For and on behalf of Deloitte LLP
Chartered Accountants
Newcastle-upon-Tyne, UK
7 June 2010

Financial statements

Statement of Comprehensive Income for 12 months ended 31 March 2010

		12 months ended 31 March 2010 Including impairments	12 months ended 31 March 2010 impairments	12 months ended 31 March 2010 Excluding impairments	9 months ended 31 March 2009
Revenue	**NOTE**	**£000**	**£000**	**£000**	**£000**
Income from activities					
Other operating income	**2**	221,845	0	221,845	167,182
Total operating income	**2**	10,460	0	10,460	9,415
		232,305	**0**	**232,305**	**176,597**
Operating expenses					
Operating (deficit)/surplus	**3**	(287,927)	(58,681)	(229,246)	(170,382)
		(55,622)	**(58,681)**	**3,059**	**6,215**
Finance costs:					
Finance income					
Finance expense - financial liabilities	**5**	208	0	208	577
Finance expense - unwinding of	**6.1**	(1,408)	0	(1,408)	(812)
discount on provisions		(21)	0	(21)	(17)
PDC dividends payable					
Net Finance Costs		(3,546)	0	(3,546)	(4,530)
		(4,767)	**0**	**(4,767)**	**(4,782)**
(Deficit)/surplus for the year					
		(60,389)	**(58,681)**	**(1,708)**	**1,433**
Other comprehensive income					
Revaluation gains less impairment losses property, plant and equipment		383	383	0	958
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets		(218)	(201)	(17)	(15)
Total comprehensive (expense)/income for the year		**(60,224)**	**(58,499)**	**(1,725)**	**2,376**

Statement of Financial Position as at 31 March 2010

	NOTE	31 March 2010 £000	31 March 2009 £000	1 July 2008 £000
Non-current assets				
Property, plant and equipment	**8.1**	179,151	160,228	176,361
Trade and other receivables	**14**	369	1,414	1,529
Total non-current assets		**179,520**	**161,642**	**177,890**
Current assets				
Inventories	**13**	223	203	225
Trade and other receivables	**14**	5,670	7,802	5,311
Non current assets for sale and assets in disposal groups	**10.1**	5,055	1,395	1,760
Cash and cash equivalents	**23**	41,594	26,660	20,359
Total current assets		**52,542**	**36,060**	**27,655**
Current liabilities				
Trade and other payables	**16**	(14,744)	(9,172)	(12,744)
Tax payable	**16**	(3,388)	(3,279)	(3,250)
Borrowings	**18**	(1,992)	(285)	(924)
Provisions	**22**	(667)	(1,246)	(560)
Other liabilities	**17**	(2,348)	(1,926)	(4,325)
Total current liabilities		**(23,139)**	**(15,908)**	**(21,803)**
Total assets less current liabilities		**208,923**	**181,794**	**183,742**
Non-current liabilities				
Borrowings	**18**	(102,309)	(15,038)	(14,613)
Provisions	**22**	(1,020)	(938)	(1,236)
Total non-current liabilities		**(103,329)**	**(15,976)**	**(15,849)**
Total assets employed		**105,594**	**165,818**	**167,893**
Financed by taxpayers' equity				
Public dividend capital		143,821	143,821	143,821
Revaluation reserve		12,382	15,023	20,983
Donated asset reserve		282	500	491
Income and expenditure reserve		(50,891)	6,474	2,598
Total Taxpayers' Equity		**105,594**	**165,818**	**167,893**

The financial statements on pages 110 to 143 were approved by the Board and signed on its behalf by:

Martin Barkley
Chief Executive

Date: 4 June 2010

Statement of Changes in Taxpayers' Equity

	Total	Public Dividend Capital (PDC)	Revaluation Reserve	Donated Assets Reserve	Income & Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers Equity at 1 April 2009	**165,818**	**143,821**	**15,023**	**500**	**6,474**
Deficit for the year	**(60,389)**	0	0	0	(60,389)
Revaluation gains and impairment losses property, plant and equipment	**383**	0	383	0	0
Reduction in the donated asset reserve in respect of depreciation, impairment and/or disposal of on donated assets	**(218)**	0	0	(218)	0
Other transfers between reserves	**0**	0	(3,024)	0	3,024
Taxpayers' Equity at 31 March 2010	**105,594**	**143,821**	**12,382**	**282**	**(50,891)**
Taxpayers Equity at 1 July 2008	**167,893**	143,821	20,983	491	2,598
Surplus for the year	**1,433**	0	0	0	1,433
Revaluation gains and impairment losses property, plant and equipment	**958**	0	958	0	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets	**(15)**	0	0	(15)	0
Transfer of the excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve	**0**	0	(2,439)	0	2,439
Other transfers between reserves	**0**	0	(7)	3	4
Movements on other reserves	**(4451)**	0	(4,472)	21	0
Taxpayers' Equity at 31 March 2009	**165,818**	**143,821**	**15,023**	**500**	**6,474**

Statement of Cash Flows for 12 months ended 31 March 2010

	12 months ended 31 March 2010	9 months ended 31 March 2009
	£000	£000
Cash flows from operating activities		
Operating (deficit)/surplus from continuing operations	(55,622)	6,215
Operating surplus	**(55,622)**	**6,215**
Non-cash income and expense:		
Depreciation and amortisation	16,411	14,173
Impairments	58,681	2,549
Reversal of impairments	(30)	0
Transfer from donated asset reserve	(17)	(15)
Decrease/(increase) in trade and other receivables	3,259	(2,150)
(Increase)/decrease in inventories	(20)	22
Increase/(decrease) in trade and other payables	4,765	(3,742)
Increase/(decrease) in other liabilities	531	(2,399)
Decrease/(increase) in provisions	(497)	364
Net cash generated from operations	**(27,461)**	**(15,017)**
Cash flows from investing activities		
Interest received	208	662
Purchase of financial assets	0	(173)
Purchase of property, plant and equipment	(7,255)	(3,782)
Sales of property, plant and equipment	68	133
Net cash generated used in investing activities	**(6,979)**	**(3,160)**
Cash flows from financing activities		
Capital element of Private Finance Initiative obligations	(510)	(214)
Interest element of Private Finance Initiative obligations	(1,408)	(812)
PDC dividend paid	(3,645)	(4,530)
Net cash generated used in financing activities	**(5,563)**	**(5,556)**
Increase in cash and cash equivalents	**14,919**	**6,301**
Cash and cash equivalents at 1 April 2009	**26,660**	**20,359**
Cash and cash equivalents at 31 March 2010	**41,579**	**26,660**

Notes to Accounts

Note 1 Accounting Policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual and has been agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2009/10 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

As the trust was authorised for Foundation Trust status on 1 July 2008 any prior year comparatives can only refer back to this date.

Transition to IFRS
These are the trust's first financial statements prepared in accordance with International Financial Reporting Standards (IFRS). The trust restated the 2008-09 UK GAAP Accounts in line with Monitor and HM Treasury requirements. The transition date of IFRS for Tees Esk and Wear Valleys NHS Foundation Trust was 1 July 2008.

The adjustments at the date of transition to IFRS from that previously reported under UK GAAP are highlighted below:

	Retained earnings £000
Taxpayers' equity at 31 March 2009 under UK GAAP	7,919
Adjustments for IFRS changes:	
Private finance initiative	(808)
Others - employee benefits	(637)
Taxpayers' equity at 1 April 2009 under IFRS	**6,474**
Taxpayers' equity at 30 June 2008 under UK GAAP	3,747
Adjustments for IFRS changes:	
Private finance initiative	(681)
Others - employee benefits	(468)
Taxpayers' equity at 1 July 2008 under IFRS	**2,598**
.	
Surplus for 9 Months ended 31 March 2008 under UK GAAP	
Adjustments for IFRS changes:	1,979
Private finance initiative	(296)
Others - employee benefits	0
Surplus for 9 Months ended 31 March 2008 under IFRS	**1,683**

Private Finance Initiative : due to the adoption of IFRS, under IFRIC 17 PFI schemes are now recognised. Consequently property, plant and equipment has increased by £14,515k, whilst borrowings have increased by £15,323k.

Other employee benefits: under IAS19 the trust is required to recognise its employees holiday accruals in the Accounts. This was not required under UK GAAP.

There were no implications of the transition to IFRS on the cash flow statement.

Accounting convention
The financial statements have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Accounting standards that have been issued but have not yet been adopted
The following standards and interpretations have been adopted by the European Union but are not required to be followed until 2010/11. The expected impact on the trust's financial statements has not yet been considered :

- IAS 27 (Revised): Consolidated and separate financial statements.
- Amendment to IAS 32 Financial instruments: Presentation on classification or rights issues.
- Amendment to IAS 39: Eligible hedged items.
- IFRS 3 (Revised): Business combinations.
- IFRIC 17: Distributions of Non-cash Assets to Owners.
- IFRIC 18: Transfer of assets from customers.

Critical accounting judgements and key sources of estimation uncertainty
These are methods adopted by the trust to arrive at monetary amounts, corresponding to the measurement basis selected for assets, liabilities, gains, losses and charges to the reserves. Where the basis of measurement for the amount to be recognised under accounting policies is uncertain, an estimation technique is applied.

Income recognition
Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. Main source of income for the trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Interest Income from cash balances held on deposit is recognised only when the revenue is received.

Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the trust commits itself to the retirement, regardless of the method of payment.

Other expenses
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:
- an item has a cost of at least £5,000; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost;
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably.

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

Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Depreciated replacement cost has been applied for assets with a short life and/or low values.

Each piece of new equipment has its useful economic life assessed prior to capitalisation; however, the range of useful lives is shown below :
- IT equipment is depreciated over 5 years
- furniture and equipment and other equipment are depreciated between 5 and 10 years
- plant aligned to buildings is depreciated between 15 and 30 years

Land and buildings used for the trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being fair value at the date of revaluation less subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
- land and non-specialised buildings – market value for existing use
- specialised buildings – depreciated replacement cost

Until 31 March 2008, the depreciated replacement cost of specialised buildings had been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. HM Treasury has agreed that NHS foundation trusts must apply these new valuation requirements by 1 April 2010 at the latest. The trust appointed valuers to undertake a full valuation in 2009/10. These valuations are effective from 31 March 2010 and are based on Modern Equivalent Asset Valuations (MEAVs).

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures

and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Susequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Intangible assets
Intangible assets are capitalised when they are capable of being used in a Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis, except capitalised research and development which is revalued using an appropriate index figure. The carrying value of the intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

The Trust does not recognise any intangible assets.

Depreciation, amortisation and impairments
Freehold land and properties under construction are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the trust expects to obtain economic benefits or service potential from the asset. This is specific to the trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Donated assets
Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to the donated asset reserve. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to offset the expenditure. On sale of donated assets, the net book value is transferred from the donated asset reserve to retained earnings.

Government grants
Government grants are grants from government bodies other than revenue from NHS bodies for the provision of services. Revenue grants are treated as deferred income initially and credited to income to match the expenditure to which they relate. Capital grants are credited to the government grant reserve and released to operating revenue over the life of the asset in a manner consistent with the depreciation and impairment charges for that asset. Assets purchased from government grants are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the government grant reserve and, each year, an amount equal to the depreciation charge on the asset is released from the government grant reserve to offset the expenditure.

Non-current assets held for sale
Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

Private Finance Initiative (PFI) transactions
HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- payment for the fair value of services received;
- payment for the PFI asset, including finance costs; and
- payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the

same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement
Components of the asset replaced by the operator during the contract (lifecycle replacement) are capitalised where they meet the trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.
The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the trust to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the trust's Statement of Financial Position.

Inventories
Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the trust's cash management.

Provisions
Provisions are recognised when the trust has a present legal or constructive obligation as a result of a past event, it is probable that the trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 22.

Non-clinical risk pooling
The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

Contingencies
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

The trust has no contingent assets

Where the time value of money is material, contingencies are disclosed at their present value.

Financial assets
Financial assets are recognised when the trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly/through a provision for impairment of receivables.

Financial liabilities
Financial liabilities are recognised on the statement of financial position when the trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Value Added Tax
Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Foreign currencies
The trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March 2010. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 32 to the accounts.

Public Dividend Capital (PDC) and PDC dividend
Public Dividend Capital represents taxpayers' equity in the NHS foundation trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as PDC dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. Prior to 2009/10 the PDC dividend was determined using forecast average relevant net assets and a note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year. From 1 April 2009, the dividend payable is based on the actual average relevant net assets for the year instead of forecast amounts.

Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not

arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

Joint operations
Joint operations are activities undertaken by the trust in conjunction with one or more other parties but which are not performed through a separate entity. The trust records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

The trust has not entered into any joint operations with another party.

Pension costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2010, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2010 with summary global member and accounting data.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

Scheme provisions
In 2008-09 the NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

Annual Pensions
The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Pensions Indexation
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Lump Sum Allowance
A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill-Health Retirement
Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

Death Benefits
A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Additional Voluntary Contributions (AVCs)
Members can purchase additional service in the NHS Scheme and contribute to money purchase AVCs run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Transfer between Funds
Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits
Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Compensation for Early Retirement
Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

Operating segments
The Trust has no elements that require segmental analysis for the period ended 31 March 2010. The chief operating decision maker has been identified as the executive director chief operating officer post within the Trust; and on this basis the trust has identified healthcare as the single operating segment.

The Trust does not undertake any material income generation activities with an aim of achieving profit.

Note 2.1 Operating Income (by classification)

	12 months ended 31 March 2010	9 months ended 31 March 2009
	£000	£000
Income from activities		
Cost and Volume Contract income	27,091	18,730
Block Contract income	184,489	138,312
Clinical Partnerships providing mandatory services (including S31 agreements)	3,579	6,940
Clinical income for the Secondary Commissioning of mandatory services	2,356	1,590
Other clinical income from mandatory services	4,330	1,610
Total income from activities	**221,845**	**167,182**
Other operating income		
Research and development	321	250
Education and training	5,658	4,372
Transfers from Donated Asset Reserve in respect of depreciation on donated assets	17	15
Non patient care services to other bodies	3,278	4,176
Other revenue	1,156	584
profit on disposal of land and buildings	0	18
Reversal of impairments of assets held for sale	30	0
Total other operating income	**10,460**	**9,415**
Total operating income	**232,305**	**176,597**

Note 2.2 Private patient income
The trust has no private patient income

Note 2.3 Operating lease income
The trust has no operating lease income

Note 2.4 Operating Income (by type)

	12 months ended 31 March 2010	9 months ended 31 March 2009
	£000	£000
Income from Activities		
NHS Foundation Trusts	780	560
NHS Trusts	4	51
Strategic Health Authorities	46	162
Primary Care Trusts	215,836	159,205
Local Authorities	3,567	6,999
Department of Health - Other	0	205
Non NHS Other	1,612	0
Total income from activities	**221,845**	**167,182**
Other operating income		
Research & Development	321	250
Education and training	5,658	4,372
Transfers from Donated Asset Reserve	17	15
Non-patient care services to other bodies	3,278	4,176
Profit on disposal of land & buildings	0	18
Reversal of impairments of assets held for sale	30	0
Other	1,156	584
Total other operating income	**10,460**	**9,415**
Total operating income	**232,305**	**176,597**
Analysis of income from activities - non NHS other		
Other government departments and agencies	1,472	0
Other	140	0
	1,612	**176,597**
Analysis of other operating income - other		
Estates recharges	692	257
Staff accommodation rentals	0	10
Creche services	0	15
Catering	366	249
Rental income	7	8
Other	91	45
	1,156	**584**

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

Note 3.1 Operating expenses (by type)

	12 months ended 31 March 2010	9 months ended 31 March 2009
	£000	£000
Services from NHS Foundation Trusts	1,485	1,095
Services from NHS Trusts	602	1,109
Services from other NHS Bodies	499	469
Purchase of healthcare from non NHS bodies	1,770	1,779
Executive directors costs	1,422	1,053
Non-executive directors costs	152	127
Staff costs	168,358	120,821
Drug costs	3,599	3,009
Supplies and services - clinical (excluding drug costs)	1,668	1,409
Supplies and services - general	5,252	4,150
Establishment	5,348	6,411
Transport	3,469	2,315
Premises	14,836	8,658
Increase / (decrease) in bad debt provision	149	(28)
Depreciation on property, plant and equipment	16,411	14,174
Impairments of property, plant and equipment	58,479	2,299
Audit fees		
audit services - statutory audit	83	149
audit services - regulatory reporting	89	0
Other auditors remuneration		
further assurance services	218	185
Clinical negligence	502	253
Impairments of assets held for sale	202	250
legal fees	165	0
Consultancy costs	614	463
Training courses and conferences	1,413	0
Patient travel	60	40
Redundancy	89	0
Hospitality	186	0
Insurance	56	0
Other services e.g.: external payroll	0	92
Losses, ex-gratia & special payments	5	(142)
Other	746	242
Total operating expenses	**287,927**	**170,382**

Impairments on property plant & equipment
Until 31 March 2008, the depreciated replacement cost of specialised buildings had been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. HM Treasury has agreed that NHS foundation trusts must apply these new valuation requirements by 1 April 2010 at the latest. The trust appointed valuers to undertake a full valuation in 2009/10. These valuations are effective from 31 March 2010 and are based on modern equivalent asset valuations (MEAVs).

Other Audit Remuneration
Other audit remuneration in 2009-10 for £218k (9 months end 31 March 2009; £185k) is for internal audit services.

Note 3.2 Arrangements containing an operating lease

	12 months ended 31 March 2010	9 months ended 31 March 2009
	£000	£000
Minimum lease payments	3,934	2,048
Total	**3,934**	**2,048**

Note 3.3 Arrangements containing an operating expenses

	12 months ended 31 March 2010	9 months ended 31 March 2009
	£000	£000
Future minimum lease payments due:		
not later than one year	870	297
later than one year and not later than five years	2,086	1,699
later than five years	790	379
Total	**3,746**	**2,375**

The trust operating leases includes leased vehicles for staff and property rental.

Note 4.1 Employee expenses

	12 months ended 31 March 2010			9 months ended 31 March 2009
	Total £000	Permanently Employed £000	Other £000	Total £000
Salaries and wages	137,573	134,344	3,229	99,655
Social Security Costs	9,740	9,135	605	7,217
Employer contributions to NHS Pension scheme	16,632	15,784	848	12,142
Agency / Contract staff	5,924	0	5,924	2,987
Employee benefits expense	**169,869**	**159,263**	**10,606**	**122,001**

Note 4.2 Average number of employees (WTE Basis)

	12 months ended 31 March 2010			9 months ended 31 March 2009
	Total Number	Permanently Employed Number	Other Number	Total Number
Medical and dental	237	233	4	235
Administration and estates	842	822	20	826
Healthcare assistants and other support staff	320	315	5	298
Nursing, midwifery and health visiting staff	2,739	2,719	20	2,765
Scientific, therapeutic and technical staff	417	388	29	399
Social care staff	37	0	37	39
Bank and agency staff	238	0	238	200
Total	**4,830**	**4,477**	**353**	**4,762**

Note 4.3 Employee benefits

There were no employee benefits paid in the twelve months ended 31 March 2010 (nine months to 31 March 2009, nil).

Note 4.4 Early retirements due to ill health

During the period to 31 March 2010 there were 6 (2008-09, 5) early retirements from the trust on the grounds of ill-health. The estimated additional pension liabilities of the ill-health retirement will be £444,547 (2008-09, £256,232.) The cost of this ill-health retirement will be borne by the NHS Business Services Authority - Pension Division.

Note 5 Finance Income

	12 months ended 31 March 2010	9 months ended 31 March 2009
	£000	£000
Bank deposits	208	577
Total	**208**	**577**

Note 6.1 Finance Costs - interest expense

	12 months ended 31 March 2010	9 months ended 31 March 2009
	£000	£000
Finance costs in PFI obligations		
main finance cost	1,230	678
contingent finance cost	178	134
Total	**1,408**	**812**

Note 7.1 Intangible Assets

The Trust has no intangible assets as at 31 March 2010 (31 March 2009, nil).

Note 8.1 - Property, plant and equipment 2009/10

	Total £000	Land £000	Buildings excluding dwellings MEA valuation £000	Buildings excluding dwellings Non MEA valuation £000	Dwellings £000	Assets under Construction £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & fittings £000
Cost or valuation at 1 April 2009	190,617	57,726	107,376	13,438	196	518	2,532	243	6,291	2,297
Additions purchased	97,531	0	94,294	0	0	3,016	82	50	89	0
Impairments charged to revaluation reserve	(8,423)	(5,105)	(3,318)	0	0	0	0	0	0	0
Impairments charged to donated asset reserve	(201)	0	(201)	0	0	0	0	0	0	0
Reclassifications	0	0	382	0	0	(382)	0	0	0	0
Revaluation surpluses	8,806	716	8,090	0	0	0	0	0	0	0
Transferred to disposal group as asset held for sale	(9,566)	(3,510)	(6,056)	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0	0
Cost or valuation at 31 March 2010	**278,764**	**49,827**	**200,567**	**13,438**	**196**	**3,152**	**2,614**	**293**	**6,380**	**2,297**
Accumulated depreciation at 1 April 2009	30,389	910	10,949	9,018	3	0	2,275	241	5,560	1,433
Provided during year	16,411	0	13,463	2,209	193	0	73	2	288	183
Acquisition through business combination	0	0	0	0	0	0	0	0	0	0
Impairments recognised in operating expenses	58,479	34,547	23,932	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0	0
Revaluation surpluses	0	0	0	0	0	0	0	0	0	0
Transferred to disposal group as asset held for sale	(5,666)	0	(5,666)	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0	0
Accumulated depreciation at 31 March 2010	**99,613**	**35,457**	**42,678**	**11,227**	**196**	**0**	**2,348**	**243**	**5,848**	**1,616**
NBV - Purchased at 1 April 2009	159,728	56,816	95,935	4,420	193	518	249	2	731	864
NBV - Donated at 1 April 2009	500	0	492	0	0	0	8	0	0	0
NBV total at 1 April 2009	**160,228**	**56,816**	**96,427**	**4,420**	**193**	**518**	**257**	**2**	**731**	**864**
NBV - Purchased at 31 March 2010	178,869	14,370	157,613	2,211	0	3,152	260	50	532	681
NBV - Donated at 31 March 2010	282	0	276	0	0	0	6	0	0	0
NBV total at 31 March 2010	**179,151**	**14,370**	**157,889**	**2,211**	**0**	**3,152**	**266**	**50**	**532**	**681**

Within buildings excluding dwellings St Luke's Hospital and Cross Lane Hospital (excluding Ayckbourne) are not held at Modern Equivalent Asset values (MEA). These assets are subject to previously agreed accelerated depreciation, as per approved business case capital developments and demolition programmes.

Note 8.2 - Property, plant and equipment 2008/09

	Total £000	Land £000	Buildings excluding dwellings MEA valuation £000	Buildings excluding dwellings Non MEA valuation £000	Assets under Construction £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & fittings £000
Cost or valuation at 1 July 2008	190,278	58,055	119,874	196	975	2,476	243	6,162	2,297
Additions purchased	3,833	0	3,289	0	457	56	0	31	0
Additions donated	0	0	0	0	0	0	0	0	0
Acquisition through business combination	0	0	0	0	0	0	0	0	0
Impairments charged to revaluation reserve	(4,521)	(1,116)	(3,405)	0	0	0	0	0	0
Reclassifications	0	0	816	0	(914)	0	0	98	0
Revaluation surpluses	1,028	788	240	0	0	0	0	0	0
Transferred to disposal group as asset held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0
Cost or valuation at 31 March 2009	**190,618**	**57,727**	**120,814**	**196**	**518**	**2,532**	**243**	**6,291**	**2,297**
Accumulated depreciation at 1 July 2008	13,917	0	4,918	1	0	2,222	240	5,242	1,294
Provided during year	14,173	0	13,660	2	0	53	1	318	139
Acquisition through business combination	0	0	0	0	0	0	0	0	0
Impairments recognised in operating expenses	2,299	910	1,389	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation surpluses	0	0	0	0	0	0	0	0	0
Transferred to disposal group as asset held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0
Accumulated depreciation at 31 March 2009	**30,389**	**910**	**19,967**	**3**	**0**	**2,275**	**241**	**5,560**	**1,433**
NBV - Purchased at 1 July 2008	175,844	58,055	114,448	195	975	245	3	920	1,003
NBV - Finance Lease at 1 July 2008	0	0	0	0	0	0	0	0	0
NBV - Donated at 1 July 2008	517	0	508	0	0	9	0	0	0
NBV total at 1 July 2008	**176,361**	**58,055**	**114,956**	**195**	**975**	**254**	**3**	**920**	**1,003**
NBV - Purchased at 31 March 2009	159,728	56,816	100,355	193	518	249	2	731	864
NBV - Finance Lease at 31 March 2009	0	0	0	0	0	0	0	0	0
NBV - Donated at 31 March 2009	500	0	492	0	0	8	0	0	0
NBV total at 31 March 2009	**160,228**	**56,816**	**100,847**	**193**	**518**	**257**	**2**	**731**	**864**

Note 8.3 Property, plant and equipment - protected assets

	Total £000	Land £000	Buildings excluding dwellings MEA valuation £000	Buildings excluding dwellings Non MEA valuation £000	Dwellings £000	Assets under Construction £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & fittings £000
NBV - Protected assets at 31 March 2010	165,681	14,230	149,240	2,211	0	0	0	0	0	0
NBV - Unprotected assets at 31 March 2010	13,470	140	8,649	0	0	3,152	266	50	532	681
Total at 31 March 2010	**179,151**	**14,370**	**157,889**	**2,211**	**0**	**3,152**	**266**	**50**	**532**	**681**
NBV - Protected assets at 31 March 2009										
NBV - Unprotected assets at 31 March 2009	135,955	50,127	81,408	4,420	0	0	0	0	0	0
Total at 31 March 2009	24,273	6,689	15,019	0	193	518	257	2	731	864
	160,228	**56,816**	**96,427**	**4,420**	**193**	**518**	**257**	**2**	**731**	**864**

Note 8.4 Economic life of property, plant and equipment

	Min Life Years	Max Life Years
Land	n/a	n/a
Buildings excluding dwellings	1	90
Assets under Construction & POA	10	90
Plant & Machinery	1	10
Transport Equipment	1	7
Information Technology	1	5
Furniture & Fittings	1	7

Note 8.5 - Property, plant & equipment valuations

	Land	Buildings exc.dwellings	Dwellings	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
Year of revaluation	2009-10	2009-10	n/a	n/a	n/a	n/a	n/a
Method of accounting for revaluation	In year revaluation	In year revaluation	n/a	n/a	n/a	n/a	n/a
Alternative Site method used	Yes	Yes	n/a	n/a	n/a	n/a	n/a

NBV of assets covered by valuation method	**Land**	**Buildings exc.dwellings**	**Dwellings**	**Plant and machinery**	**Transport equipment**	**Information technology**	**Furniture & fittings**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Modern Equivalent Asset (no Alternative Site)	0	0	0	0	0	0	0
Modern Equivalent Asset (Alternative Site)	14,370	152,481	0	0	0	0	0
Other historical costs	0	7,619	0	266	50	532	681
Total	**14,370**	**160,100**	**0**	**266**	**50**	**532**	**681**

	Land	**Buildings exc.dwellings**	**Dwellings**
MEA transactions	**£000**	**£000**	**£000**
Revaluation surplus	716	8,090	0
Impairment to Revaluation Reserve	(5,105)	(3,318)	0
Impairment to SoCI	(34,547)	(23,932)	0
Total	**(38,936)**	**(19,160)**	**0**

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The trust appointed valuers to undertake a full valuation in 2009/10. These valuations are effective from 31 March 2010 and are based on Modern Equivalent Asset Valuations (MEAVs).

Note 9 Net book value of assets held under finance leases

	Total £000	Buildings exc. dwellings £000	Assets under construction £000
Cost or valuation at 1 April 2009	16,797	16,532	265
Additions - purchased	90,721	90,721	0
Reclassifications	0	265	(265)
Revaluation surpluses	5,033	5,033	0
Cost or valuation at 31 March 2010	**112,551**	**112,551**	**0**
Accumulated depreciation at 1 April 2009	1,581	1,581	0
Provided during the year	255	255	0
Impairments recognised in operating expenses	8,782	8,782	0
Accumulated depreciation at 31 March 2010	**10,618**	**10,618**	**0**
NBV - Purchased at 1 April 2009	15,216	14,951	265
NBV total at 1 April 2009	15,216	14,951	265
NBV - Purchased at 1 April 2010	101,933	101,933	0
NBV total at 31 March 2010	**101,933**	**101,933**	**0**

Opening balance includes IFRS restatement exercise (West Park Hospital). 2009-10 includes the additions of Lanchester Road and Roseberry Park. All assets have had MEA valuations applied as at 31 March 2010.

Note 10.1 - Non current assets for sale and assets in disposal groups 2009-10

	Total £000	Property, Plant & Equipment £000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2009	1,395	1,395
Plus assets classified as available for sale in the year	3,900	3,900
Less assets sold in year	(68)	(68)
Less impairment of assets held for sale	(202)	(202)
Plus reversal of impairment of assets held for sale	30	30
NBV of non-current assets for sale and assets in disposal groups at 31 March 2010	**5,055**	**5,055**

Assets Held for Sale
The trust has the following five properties which are currently held for sale and have a combined open market value of £5,055k. These properties are non-operational that are surplus to requirements. At the end of the accounting period there is no planned reclassifications of these properties.
52-54 Belle Vue Grove
County Hospital
Dawson House
Greenbank
North End Flatts

Note 10.2 - Non current assets for sale and assets in disposal groups 2008/09

	Total £000	Property, Plant & Equipment £000
NBV of non-current assets for sale and assets in disposal groups at 1 July 2008	1,760	1,760
Less assets sold in year	(115)	(115)
Less impairment of assets held for sale	(250)	(250)
NBV of non-current assets for sale and assets in disposal groups at 31 March 2009	**1,395**	**1,395**

Note 10.3 - Liabilities in disposal groups

There were no liabilities in disposal group up to 31 March 2010 (nil, 31 March 2009).

Note 11.1 Investments - carrying amount

The trust holds no Investments as at 31 March 2010.

Note 12.1 - Fair value of investments in associate (and joined controlled operations)

The trust has no investments in associate (and joined controlled operations) as at 31 March 2010.

Note 13.1 - Inventories

	31 March 2010 £000	31 March 2009 £000	31 July 2008 £000
Materials	223	203	225
Total Inventories	**223**	**203**	**225**

Note 13.2 - Inventories recognised in expenses

Inventories of £20,000 were recognised as expenses in the twelve months to the end of March 2010.

Note 14.1 Trade receivables and other receivables

	31 March 2010 £000	31 March 2009 £000	1 July 2008 £000
Current			
NHS receivables	1,687	4,526	1,243
Other receivables with other government bodies	242	0	0
Provision for impaired receivables	(149)	(177)	(205)
Prepayments	1,775	1,464	2,566
PFI Prepayments			
Prepayments - Capital contributions	0	0	0
Prepayments - Lifecycle replacements	1,179	0	0
Accrued income	54	92	18
PDC receivable	99	0	0
Other trade receivables	783	1,897	1,689
Total current trade and other receivables	**5,670**	**7,802**	**5,311**
Non Current			
NHS receivables	305	398	683
Prepayments - Lifecycle replacements	0	949	777
Other trade receivables	64	67	69
Total non current trade and other receivables	**369**	**1,414**	**1,529**

Note 14.2 Provision for impairment of receivables

	£000	£000
At 1 April	177	0
At 1 July 2008	0	205
Increase/(decrease) in provision	149	0
Amounts utilised	(177)	0
Unused amounts reversed	0	(28)
At 31 March 2010	**149**	**177**

Note 14.3 Analysis of impaired receivables

	31 March 2010 £000	31 March 2009 £000
Ageing of impaired receivables		
Up to three months	63	0
In three to six months	18	0
Over six months	68	177
Total	**149**	**177**
Ageing of non-impaired receivables past their due date		
Up to three months	974	399
In three to six months	106	185
Over six months	177	78
Total	**1,257**	**662**

Note 14.4 Finance lease receivables

The trust has no finance lease receivables as at 31 March 2010 (31 March 2009, nil).

Note 15 Other Assets

The trust has no other assets as at 31 March 2010 (31 March 2009, nil).

Note 16.1 Trade and other payables

	31 March 2010 £000	31 March 2009 £000	1 July 2008 £000
Current			
NHS payables	1,006	525	2,366
Amounts due to other government bodies	542	0	0
Trade payables - capital	1,387	580	454
Other trade payables	4,284	0	0
Taxes payable	3,388	3,279	3,250
Other payables	1,523	5,062	5,480
Accruals	6,002	3,005	4,444
Total current trade and other payables	**18,132**	**12,451**	**15,994**

The directors consider that the carrying amount of trade payables approximates to their fair value.

Note 16.2 early retirements detail included in NHS payables above

There were no early retirement costs in the twelve months ended 31 March 2010.

Note 17 Other liabilities

	31 March 2010 £000	31 March 2009 £000	1 July 2008 £000
Current			
Deferred income	2,348	1,926	4,325
Total other current liabilities	**2,348**	**1,926**	**4,325**

Note 18 Borrowings

	31 March 2010 £000	31 March 2009 £000	1 July 2008 £000
Current			
Bank overdrafts	15	0	0
Obligations under Private Finance Initiative contracts	1,977	285	924
Total current borrowings	**1,992**	**285**	**924**
Non-current			
Obligations under Private Finance Initiative contracts	102,309	15,038	14,613
Total other non-current liabilities	**102,309**	**15,038**	**14,613**

PFI borrowings are in relation to West Park Hospital, Lanchester Road Hospital and Roseberry Park Hospital which all operate under a standard form PFI contract i.e. unitary payments are payable from the date construction completion and are not subject to re-pricing. Inflation linked to RPI is applied annually. Final settlements are expected in July 2033, November 2039 and March 2038 respectively.

Note 19.1 Prudential borrowing limit

	31 March 2010 £000	31 March 2009 £000
Total long term borrowing limit set by Monitor	107,100	48,600
Working capital facility agreed by Monitor	17,000	17,000
Total prudential borrowing limit	**124,100**	**65,600**
Long term borrowing available at 1 April 2009	48,600	0
Long term borrowing available at 1 July 2008	0	48,600
Net actual borrowing (repayment) in year - long term	58,500	0
Long term borrowing available at 31 March 2010	**107,100**	**48,600**
Working capital borrowing available at 1 April 2009	17,000	0
Working capital borrowing available at 1 July 2008	0	17,000
Working capital borrowing available at 31 March 2010	**17,000**	**17,000**

Note 19.2 Prudential borrowing limit ratios

	Threshold	31 March 2010
Minimum dividend cover	>1x	5.1x
Minimum interest cover	>2x	13.8x
Minimum debt service cover	>1.5x	10.1x
Maximum debt service to revenue	<10%	0.80%

Note 20 Finance lease obligations

The Trust does have any finance lease obligations other than PFI commitments.

Note 21.1 PFI obligations (on Statement of Financial Position)

	31 March 2010 £000	31 March 2009 £000
Gross PFI liabilities	301,578	44,453
of which liabilities are due		
not later than one year	9,255	1,350
later than one year and not later than five years	40,123	5,740
ater than five years	252,200	37,363
Finance charges allocated to future periods	(197,344)	(29,130)
Net PFI liabilities	**104,234**	**15,323**
not later than one year	1,976	285
later than one year and not later than five years	9,899	1,318
later than five years	92,359	13,720

Note 21.2 The trust is committed to make the following payments on SoFP PFI obligations during the next year in which the commitment expires

	12 months ended 31 March 2010 Total £000	12 months ended 31 March 2010 Roseberry Park PFI £000	12 months ended 31 March 2010 Lanchester Rd PFI £000	12 months ended 31 March 2010 West Park PFI £000	9 months ended 31 March 2009 Total £000
Within one year	0	0	0	0	0
2nd to 5th years (inclusive)	0	0	0	0	0
6th to 10th years (inclusive)	0	0	0	0	0
11th to 15th years (inclusive)	0	0	0	0	0
16th to 20th years (inclusive)	0	0	0	0	0
21st to 25th years (inclusive)	2,216	0	0	2,216	2,176
26th to 30th years (inclusive)	8,273	6,685	1,588	0	0
31st to 35th years (inclusive)	0	0	0	0	0
36th year and beyond	0	0	0	0	0

Note 21.3 PFI finance lease commitments

Other than PFI finance lease commitments the trust has no finance lease commitments

Note 21.4 PFI schemes off-Statement of Financial Position

The trust has no off-statement of financial position PFI schemes.

Note 21.5 PFI schemes on-Statement of Financial Position

The trust has three operational PFI schemes relating to West Park Hospital, Lanchester Road Hospital and Roseberry Park Hospital.

West Park Hospital was handed to the Trust in November 2004. The Trust provides all clinical and non clinical services. The PFI partner, NU Local Care Centres (West Park) Ltd provides maintenance services for the building. The trust has purchased the land and all non fixed equipment.

Lanchester Road Hospital was handed to the Trust in November 2009. The Trust provides all clinical and non clinical services. The PFI partner, GH Lanchester Road Ltd provides maintenance services for the building. The trust owns the land and all non fixed equipment.

Roseberry Park Hospital was handed to the Trust in March 2010. The Trust provides all clinical and non clinical services. The PFI partner, Three Valleys Healthcare Ltd provides maintenance services for the building. The Trust owns the land and all non fixed equipment.

Note 22 1 Provisions for liabilities and charges - 2009/10

	Total £000	Pensions - other staff £000	Legal claims £000	Other £000
At 1 April 2009	2,184	1,018	1,089	77
Change in the discount rate	0	0	0	0
Arising during the year	700	149	461	90
Utilised during the year	(596)	(101)	(483)	(12)
Reversed unused	(622)	0	(557)	(65)
Unwinding of discount	21	21	0	0
At 31 March	**1,687**	**1,087**	**510**	**90**
Expected timing of cash flows:				
not later than one year	667	67	510	90
Current	**667**	**67**	**510**	**90**
later than one year and not later than five years	266	266	0	0
later than five years	754	754	0	0
Non Current	**1,020**	**1,020**	**0**	**0**
TOTAL	**1,687**	**1,087**	**510**	**90**

Note 22 2 Provisions for liabilities and charges - 2008/09

	Total £000	Pensions - other staff £000	Legal claims £000	Other £000
At 1 July 2008 - current	560	72	305	183
At 1 July 2008 - non current	1,236	989	247	0
At 1 July 2008	**1,796**	**1,061**	**552**	**183**
Arising during the year	1,060	0	919	141
Utilised during the year	(331)	(60)	(57)	(214)
Reversed unused	(358)	0	(325)	(33)
Unwinding of discount	17	17	0	0
At 31 March 2009	**2,184**	**1,018**	**1,089**	**77**
Expected timing of cash flows:				
not later than one year	1,246	80	1,089	77
Current	**1,246**	**80**	**1,089**	**77**
later than one year and not later than five years	400	400	0	0
later than five years	538	538	0	0
Non Current	**938**	**938**	**0**	**0**
TOTAL	**2,184**	**1,018**	**1,089**	**77**

Pensions relating to other staff is a provision for injury benefit pensions.

Legal claims relate to the following; the cost of defending equal pay claims - £171k (2008-09, £171), employer/public liability claims notified by the NHS Litigation Authority - £155k (2008-09,£132k), and the provision for employment law £183k (2008-09,£783k).

£1,853k (2008-09, £1,003k) is included in the provisions of the NHS Litigation Authority at 31 March 2010 in respect of clinical negligence liabilities of the NHS Foundation Trust.

Included in the 'other' category and arising during the period is a provision for organisational change.

Note 23 Cash and cash equivalents

	31 March 2010 £000	31 March 2009 £000
At 1 April 2009	26,660	0
At 1 July 2008	0	20,359
Net change in year	14,919	6,301
At March 2010	**41,579**	**26,660**
Broken down into:		
Commercial banks and cash in hand	47	44
Cash with Government Banking Service	41,547	26,616
Other current investments	0	0
Cash and cash equivalents as in SoCF	**41,594**	**26,660**
Bank overdraft	(15)	0
Cash and cash equivalents as in SoCF	**41,579**	**26,660**

Note 24 Contractual Capital Commitment

	31 March 2010 £000	31 March 2009 £000
Property, Plant and Equipment	13,500	674
Total as at 31 March 2010	**13,500**	**674**

The significant increase in 2009-10 relates to the signed agreements with Kier Northern Ltd for capital works at Cross Lane Hospital in Scarborough.

Note 25 Events after the reporting period

There were no events after the reporting period.

Note 26.1 Contingent liabilities

	31 March 2010 £000	31 March 2009 £000
Gross value of contingent liabilities		
Net value of contingent liabilities		
	187	218
	187	**218**

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

The trust, like many NHS organisations has received notification from a number of employees for equal pay claims. There is significant uncertainty of the validity and value of these claims for inclusion in the accounts. If any are successful there will be a future charge to the trust's accounts.

Note 26.2 Contingent assets

The trust has no contingent assets at 31 March 2010.

Note 27.1 - Related Party Transactions

Tees, Esk and Wear Valleys NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the period none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Tees, Esk and Wear Valleys NHS Foundation Trust.

The Department of Health is regarded as a related party. During the period Tees, Esk and Wear Valleys NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

North East Strategic Health Authority
Yorkshire and Humber Strategic Health Authority

County Durham PCT
Darlington PCT
Gateshead PCT
Gedling PCT
Hartlepool PCT
Middlesbrough PCT
Morcombe Bay PCT
Newcastle PCT
North Tees PCT
North Tyneside PCT
North Yorkshire and York PCT
Northumberland Care Trust
Redcar and Cleveland PCT
Southampton City PCT
Sunderland Teaching PCT
Warrington PCT

County Durham and Darlington NHS Foundation Trust
East London and the City Mental Health NHS Trust
North East Ambulance Service NHS Trust
North Tees and Hartlepool NHS Foundation Trust
Northumberland, Tyne and Wear NHS Foundation Trust
Northumbria Health Care NHS Foundation Trust
Scarborough and North East Yorkshire Health Care NHS Trust
South Tees Hospitals NHS Foundation Trust
The Newcastle Upon Tyne Hospitals NHS Foundation Trust
Yorkshire Ambulance Service NHS Trust

NHS Business Services Authority
NHS Information Authority
NHS Litigation Authority
NHS Pensions Agency (NOT the pension scheme)
NHS Supplies Authority;

In addition, the trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with:

Durham County Council
Darlington Borough Council
Hartlepool Borough Council
HMP Durham
Middlesbrough Borough Council
Redcar and Cleveland Borough Council
Stockton Borough Council
North Yorkshire Council
NHS Shared Business Services

Note 28 Financial Assets by Category

	Total £000	Loans and receivables £000
Trade and other receivables excluding non financial assets at 31 March 2010	2,986	2,986
Cash and cash equivalents (at bank and in hand at 31 March 2010	41,567	41,567
Total at 31 March 2010	**44,553**	**44,553**
Trade and other receivables excluding non financial assets at 31 March 2009	6,803	6,803
Cash and cash equivalents (at bank and in hand at 31 March 2009	26,660	26,660
Total at 31 March 2009	**33,463**	**33,463**

Note 28.1 Financial Liabilities by Category

	Total £000	Other financial liabilities £000
Trade and other payables excluding non financial assets (at 31 March 2010)	14,744	14,744
Provisions under contract (at 31 March 2010)	1,687	1,687
Total at 31 March 2010	**16,431**	**16,431**
Trade and other payables excluding non financial assets (at 31 March 2009)	9,172	9,172
Provisions under contract (at 31 March 2009)	2,184	2,184
Total at 31 March 2009	**11,356**	**11,356**

Note 28.2 Fair values of financial assets at 31 March 2010

	Book Value £000	Fair Value £000
Non current trade and other receivables excluding non financial assets	369	369
Other investments	0	0
Other	41,567	41,567
Total	**41,936**	**41,936**

Note 28.3 Fair values of financial liabilities at 31 March 2010

	Book Value £000	Fair Value £000
Provisions under contract	1,687	1,687
Total	**1,687**	**1,687**

Note 29 Losses and special payments

NHS foundation trusts are required to report to the Department of Health any losses or special payments, as the Department still retains responsibility for reporting these to Parliament.

By their very nature such payments should not arise, and they are therefore subject to special control procedures compared to payments made in the normal course of business.

There were 60 cases in the twelve months to the 31 March 2010 at a value of £10k.

Note 30 Discontinued operations

The trust has no discontinued operations at 31 March 2010.

Note 31 Corporation Tax

The Trust has no Corporation Tax liability or asset at 31 March 2010.

Note 32 Third party assets and liabilities

The trust held £13,500 cash at bank and in hand at 31/03/10 (£8,995 31/03/09) which related to monies held by the NHS trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts. The Trust also has a creditor of £9,771 at 31/03/10 (£17,276 at 31/03/09) relating to patients monies held within the Trust bank account.

The trust held £18,144 cash at bank and in hand at 31/3/10 (£116,885 at 31/03/09) which related to monies held by the trust for a staff savings scheme on behalf of itself, Middlesbrough PCT and Redcar & Cleveland PCT. This has been excluded from the cash at bank and in hand figure reported in the accounts.

Note 34 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS trust has with Primary Care Trusts and the way those Primary Care Trusts are financed, the NHS trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS foundation trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

The trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the trust's internal auditors.

Currency risk

The trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The trust has no overseas operations. The trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

100% of the trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Tees, Esk and Wear Valleys NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk.

Credit risk

Credit risk exists where the trust can suffer financial loss through default of contractual obligations by a customer or counterparty.

Trade debtors consist of high value transactions with Primary Care Trusts under contractual terms that require settlement of obligation within a time frame established generally by the Department of Health. Due to this the credit risk exposure is not significant.

Credit risk exposures of monetary financial assets are managed through the trust's treasury policy which limits the value that can be placed with each approved counterparty to minimise the risk of loss. The counterparties are limited to the approved financial institutions with high credit ratings. Limits are reviewed regularly by senior management.

Liquidity risk

The trust's net operating costs are mainly incurred under legally binding contracts with Primary Care Trusts, which are financed from resources voted annually by Parliament. This provides a reliable source of funding stream which significantly reduces the Trust's exposure to liquidity risk.

The trust also manages liquidity risk by maintaining banking facilities and loan facilities to meet its short and long term capital requirements through continuous monitoring of forecast and actual cash flows.

In addition to internally generated resources the trust has a working capital facility of £17,000,000, unused at 31 March 2010.

Salary and pension entitlements of senior managers

a) Remuneration

Name and Title	2009-10 Salary (bands of £5000) £000	2009-10 Other remuneration (bands of £5000) £000	2009-10 Benefits in kind Rounded to the nearest £100	2009-10 Total salary, other remuneration & benefits in kind (bands of £5000) £000	2008-09 (1 July 2008 - 31 March 2009) Salary (bands of £5000) £000	2008-09 (1 July 2008 - 31 March 2009) Other remuneration (bands of £5000) £000	2008-09 (1 July 2008 - 31 March 2009) Benefits in kind rounded to the nearest £100	2008-09 (1 July 2008 - 31 March 2009) Total salary, other remuneration & benefits in kind (bands of £5000) £000
Mr Martin Barkley, *chief executive*	145-150	0	28,000**	170-175	105-110	0	10,800**	115-120
Mr Colin Martin, *director of finance and information*	110-115	0	7,600*	120-125	80-85	0	5,500*	85-90
Dr Chris Fisher, *medical director(Apr-Dec)*	130-135	0	0	130-135	125-130	0	0	125-130
Dr Stephen Humphries, *medical director*	0	0	0	0	15-20	30-35	3,000*	50-55
Dr Nick Land, *medical director (Jan-Mar)*	5-10	40-45***	900*	45-50	0	0	0	0
Mr David Levy, *director of HR & OD*	95-100	0	0	95-100	70-75	0	0	70-75
Mr Harry Cronin, *director of nursing*	0	0	0	0	15-20	0	700*	15-20
Mrs Chris Stanbury, *director of nursing and governance*	95-100	0	2,000*	100-105	55-60	0	0	55-60
Mr Chris Parsons, *director of estates and facilities management*	90-95	0	2,800*	90-95	70-75	0	1,900*	70-75
Mrs Sharon Pickering, *director of planning and performance*	85-90	0	2,200*	85-90	60-65	0	700*	60-65
Mr Les Morgan, *chief operating officer*	95-100	0	6,100*	105-110	70-75	0	5,200*	75-80
Mr Paul Newton, *service director - LD and forensic services*	75-80	0	8,900*	85-90	55-60	0	5,300*	65-70
Mr David Brown, *service director - MHSOP/C&YP's/Sub Misuse/NEY*	80-85	0	3,800*	80-85	55-60	0	2,500*	60-65
Mrs Lesley Crawford, *service director - adult services*	75-80	0	2,500*	80-85	55-60	0	0	55-60
Mrs Jo Turnbull, *chairman*	40-45	0	0	40-45	20-25	0	0	20-25
Mr Andrew Lombard, *non executive director, senior independent director*	15-20	0	0	15-20	10-15	0	0	10-15
Mr Paul Briggs, *non executive director*	10-15	0	0	10-15	5-10	0	0	5-10
Mr Michael Newell, *non executive director*	10-15	0	0	10-15	5-10	0	0	5-10
Mr John Robinson, *non executive director*	10-15	0	0	10-15	5-10	0	0	5-10
Mr Graham Neave, *non executive director*	10-15	0	0	10-15	5-10	0	0	5-10
Mr Jim Tucker, *non executive director*	10-15	0	0	10-15	5-10	0	0	5-10
Mr Douglas Taylor, *non executive director and chairman of the audit committee*	15-20	0	0	15-20	10-15	0	0	10-15

Benefits in kind are the provision of lease cars (*) or the reimbursement of actual expenses incurred through relocation (**)

**** other remuneration includes the full time salary for medical director work plus an additional 2 clinical programmed activities worked during the reported period, for which £6.5k was paid.*

B) Pension benefits

Name and Title	Real increase in pension at age 60 (bands of £2500) £000	Real increase in pension lump sum at age 60 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2010 (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5000) £000	Cash equivalent transfer value at 31 March 2010 £000	Cash equivalent transfer value at 31 March 2009 £000	Real increase in cash equivalent transfer value £000	Employers contribution to stakeholder pension To nearest £100
Mr Martin Barkley, *chief executive*	-2.5-0.0	-2.5-0.0	65-70	205-210	1,564	1,438	54	-
Mr Colin Martin, *director of finance and information*	0.0-2.5	0.0-2.5	30-35	100-105	579	517	36	-
Dr Chris Fisher; *medical director(Apr-Dec)*	0.0-2.5	0.0-2.5	85-90	260-265	0	1810		-
Dr Nick Land, *medical director (Jan-Mar)*			50-55	150-155	949			-
Mr Les Morgan, *chief operating officer*	0.0-2.5	2.5-5.0	40-45	120-125	813	716	61	-
Mrs Chris Stanbury, *director of nursing and governance*	5.0-7.5	15.0-20.0	40-45	125-130	832	641	159	-
Mr David Levy, *director of HR & OD*	0.0-2.5	0.0-2.5	15-20	50-55	323	284	25	-
Mrs Sharon Pickering, *director of planning and performance*	0.0-2.5	0.0-2.5	20-25	60-65	314	285	15	-
Mr Chris Parsons, *director of estates and facilities management*	-2.5-0.0	-2.5-0.0	15-20	45-50	368	340	11	-
Mr Paul Newton, *service director – LD and forensic services*	-2.5-0.0	-2.5-0.0	35-40	115-120	756	697	24	-
Mrs Lesley Crawford, *service director - adult services*	0.0-2.5	0.0-2.5	25-30	85-90	573	514	33	-
Mr David Brown, *service director - MHSOP/C&YP's/Sub Misuse/NEY*	0.0-2.5	0.0-2.5	20-25	70-75	454	404	30	-

As non-executive members do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive members.

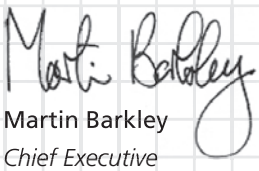
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. The reasons for the negative increase in pension and lump sum for three of the senior managers are as a result of either: the maximum allowed membership of the pension scheme having been reached in year, and therefore some service is now non recognisable, a reduction in annual salary due to the cessation of responsibility allowance, or due to increase in annual salary being lower than the inflation factor used. Real increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Pay Terms and Conditions
With the exception of directors, non executives and medical staffing the remaining workforce are covered by Agenda for Change. All inflationary pay uplifts have been in accordance with Department of Health recommendations with no performance bonus paid to any staff. All executive directors are on a permanent contract and a notice period of 6 months.

The remuneration committee is responsible for executive directors' pay.

Membership:

Mrs Jo Turnbull - chairman
All non-executive directors of the board of directors



Martin Barkley
Chief Executive

Date: 4 June 2010

Our quality report 2009/2010

CONTENTS

PART 1: CHIEF EXECUTIVE'S STATEMENT

I am pleased to be able to present the Tees, Esk and Wear Valley NHS Foundation Trust (TEWV NHS FT) Quality Report for 2009/10. The organisation, led by the Board of Directors, is fully committed to continually improving the quality of the services we provide and this is demonstrated in our Vision Statement and Strategic Goal 2.

Vision Statement

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

Strategic Goal 2

To continuously improve the quality and value of our work.

It is important to recognise that within both these public declarations we do not expect to ever reach an end point, recognising that there are always opportunities for improvements, particularly as expectations change.

Our Definition of Quality

In identifying continuous quality improvement as one of our goals we also defined what we mean by quality. We believe that to deliver high quality service that service must:

- Be appropriate – this means that it should be relevant to the needs of the individual or customer and be based on evidence.
- Be effective – this means that what we do delivers the outcomes that we expected and makes a positive difference to people's lives.
- Provide a good experience – this means that our users and customers feel that the service we provided was good and they had a positive experience.
- Reduces waste – this means that we should minimise any activity that does not add value or is wasteful.

How We Improve Quality

We believe that to improve quality, we need an effective way of doing so based on the most successful systems in the world. Therefore we have developed the Tees Esk and Wear Valleys Quality Improvement System (TEWV QIS). We believe this system (based on and supported by Virginia Mason Medical Centre in Seattle) offers a proven way to deliver long term success based on a framework that is open, with tools and techniques which are easy to learn and apply therefore being inclusive.

The TEWV quality improvement system is about improving the ways we do things within the Trust by identifying and removing, wherever possible, wasteful activities and focusing on those that add value to our customers. The following are the benefits which arise as a result of implementing this system:

- improved quality and safety
- improved delivery
- improved throughput
- accelerating momentum for change and improvement
- increased staff engagement in improvement
- improved value

Our Achievements in 2009/10

Within Section 2 of this report we provide more detail of the progress we have made against the quality priorities we identified for 2009/10. We have, however, made progress in a number of other areas as outlined below:

- In line with our estates strategy, we have improved the quality and appropriateness of accommodation in both our inpatient and community facilities. A key milestone was the opening of the new purpose built inpatient facility at Lanchester Road Hospital in Durham. We are also on track to open the new inpatient facility at Roseberry Park, Middlesbrough in April 2010.
- We have virtually eliminated mixed sex accommodation as required by the Department of Health. As at 31 March 2010 88% of our inpatient accommodation is provided in single rooms (57% is ensuite) and by May 2010 this will rise to 97% (with 73% ensuite). We recognise however that addressing accommodation alone will not address all privacy and dignity issues and we have already taken steps to raise awareness and train staff to ensure that we deliver on all the aspects of privacy and dignity that the users of our services expect.
- We achieved a score of "good" in the Health Care Commission's Annual Health Check for 2008/09 (the scores of 2009/10 will not be available until October 2010).
- We continued to implement the new electronic care record which supports improved clinical decision making and improved data quality. We recognise however that further work is needed to ensure this system works as effectively and efficiently as possible.
- We achieved NHS Litigation Authority (NHSLA) assessment at Level 2 which only a handful of mental health trusts nationally have been awarded. This reflects a significant amount of work undertaken during 2009/10
- We received very positive results in both the Annual User Survey and the Annual Staff Survey, carried out by the Care Quality Commission (CQC)
- We received an extremely positive annual Mental Health Act report from the CQC.
- We received very positive results in the CQC review on systems for Safeguarding Children
- We received a very positive report from the Royal College of Psychiatrists Quality Network for Forensic Mental Health Services in which the review team commended the unit's obvious commitment to quality
- Our Learning Disability Forensic Service have enrolled in the Learning Disability Quality Network and are an early adopter which will support us in continuing to improving the quality of the service we provide
- As the first Mental Health Trust to be involved in the national Leading Improvement in Patient Safety work we were asked to lead further work to encourage other mental health trusts across the country to participate in this programme in order to drive up patient safety nationally.

- Our staff/services won a number of prestigious awards during 2009/10 including:
    - The Primrose Programme won the World Health Organisation's 'Health in Prison Project award' for its work with female offenders who pose a risk of serious harm as a result of dangerous and severe personality disorder
    - The Trust's community veteran's mental health service pilot was awarded the Military and Civilian Health Partnership Awards 2009 Care of Veterans award
    - The Liaison Psychiatry team and the Stockton Psychosis team won the regional patient safety summit awards in the preventing suicide category and the drug safety category respectively
    - Our quality improvement team (Kaizen Promotion Office - KPO) were part of the North East team, which won the Lean Healthcare Academy Annual Awards Independent Project of the Year Award
    - Thornton ward (an acute adult mental health ward in Middlesbrough) was a runner up in the Health Service Journal Awards
    - Our acute adult mental health wards in Durham were runners up in the Nursing Times awards for The Patient Pathway: Making Quality Count Award and Mental Health Nursing Award
    - The Randomised Injected Opiate Treatment Trial (RIOTT) was highly commended in the Health Service Journal Health and Safety awards

The structure of this Quality Report is in line with guidance that has been published by both the Department of Health (DoH) and the Foundation Trust regulator Monitor and contains the following information:

- Section 2 – Information how we have performed on our priorities for 2009/10, our priorities for improvement in 2010/11 and statements of assurance from the Board
- Section 3 – Further information on how we have performed in 2009/10 against our key quality metrics and national targets.

In drawing together the Quality Report we have involved a number of stakeholders as follows:

- Service users and carers – in identifying our priorities for 2010/11 we have used information from service users and carers in terms of their experience. This information has been gathered by analysing complaints, PALs activity, compliments and common themes from incident investigations
- Our Council of Governors – in order to do this we have established a working group of the Council of Governors to support us in developing the Quality Account. This working group includes Governors who are service users, carers, commissioners and staff. The full Council of Governors has received reports on progress from this working group throughout the year.
- Other stakeholders – as part of agreeing our priorities for 2010/11 we contacted our local Primary Care Trusts (PCTs), Local Authorities and LINKs to share with them our thoughts and get their views on what our priorities should be. Their suggestions were considered formally by the Board when they debated and agreed the priorities for 2010/11 contained in Section 2. We have also shared a draft of the Quality Report with our seven local PCTs, the seven Overview and Scrutiny Committees and the seven LINKs which we cover so that they can provide comments to improve the final draft.

We recognise that we still need to do more to involve stakeholders in the production of the Quality Report and this will be something we continue to develop over time.

In terms of the content of the Quality Report I can confirm that this is accurate, to the best of my knowledge. The organisation has established a number of ways to improve data quality during 2009/10 and through our external and internal audit programme elements of this are checked to ensure our systems are reliable. (A full statement of Directors' responsibilities in respect of the Quality Report is included in Appendix 1.)

I hope you find this report interesting and informative.

Martin Barkley
Chief Executive

PART 2: PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2009/10 Priorities for Improvement – what did we do?

As part of the Quality Report that all Foundation Trust were required to produce for 2008/09 the Board agreed three quality priorities to be addressed in 2009/10. Good progress has been made against these three priorities as follows:

Priority 1: Reduce the number of incidents of violence and aggression

During 2008/09 we identified that the number of incidents of violence and aggression was higher than was acceptable across the Trust. This was reinforced by the feedback received through the staff survey in which 20% of staff who responded had 'experienced physical violence from patients/relatives in the last 12 months' compared to the national average of 19%. This represented one of our four 'bottom ranking scores' and was 'worse than average'. The number of incidents of violence and aggression towards staff and patients was 7348 in 2008/09.

We therefore identified reducing the incidences of violence and aggression as a priority because:

- Although one of the reasons patients are admitted to Trust services is their violent or aggressive behaviour, our aim is to reduce how often this behaviour occurs, through the therapeutic interventions we offer.
- There was concern that staff may not be being equipped with the skills to build engagement and relationships with patients in sufficient time to help reduce the likelihood and frequency of violence and aggression.
- High levels of violence and aggression by patients on a ward impacts negatively on the patient experience.
- The Trust wants to reduce the level of injury to patients and staff.

We therefore set ourselves a 'breakthrough' target of a reduction in physical assaults of 50 per cent each year for the next three years starting in 2009/10.

Action taken

A violence and aggression working group was established, chaired by the Service Director for Learning Disability and Forensic Services. The group then formed part of the Leading Improvement in Patient Safety (LIPS) programme (further details of which are given later in this report).

The group identified eight actions that were implemented in 2009/10 as follows:

- Introduce and implement throughout the organisation our newly developed challenging behaviour policy.
- Review and redevelop all training related to the management of violence and aggression in line with the challenging behaviour policy.
- Develop a programme of audits to provide evidence of change, improved practice and reduction in violent incidents.

- Develop a criteria, system and process for clinical review of individuals displaying high levels of violence.
- Review and redevelop the trust's policy and procedure for reporting violent and aggressive incidents to the police.
- Introduce a standardised system for recording and reporting incidents.
- Identify and introduce a violence rating tool and measures to improve analysis and feedback.
- Produce enhanced data that will aid the performance management of violent and aggressive incidents.

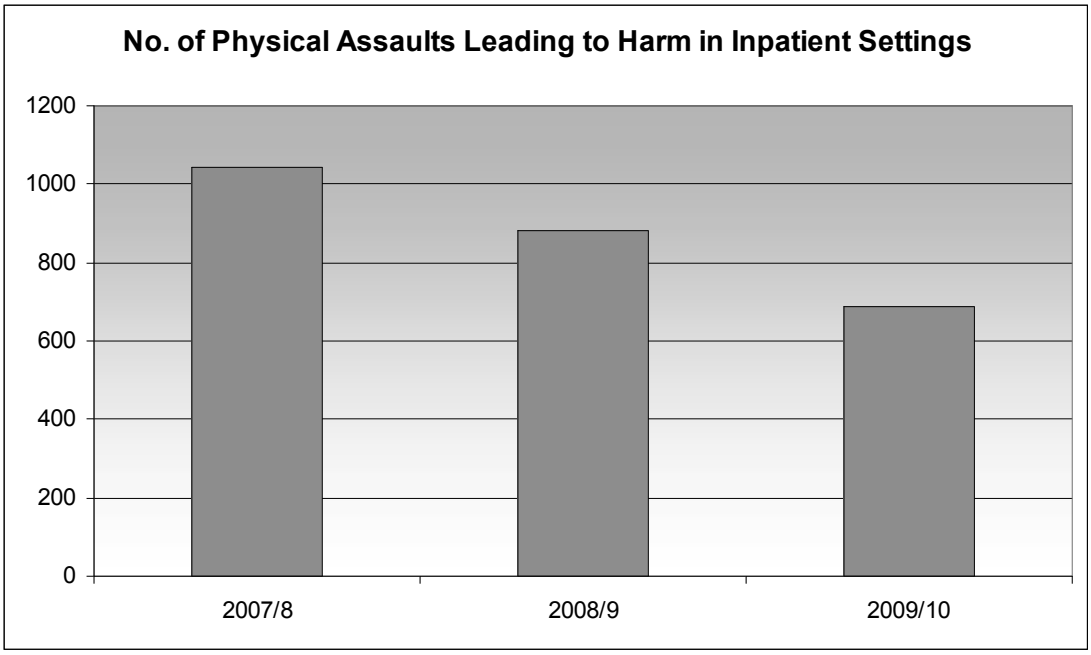
How have we done?

The following are our achievements:

- The challenging behaviour policy has been implemented, as evidenced in the NHS litigation authority Level 2 assessment.
- Training materials have been reviewed, enhanced and disseminated throughout the organisation. Furthermore we have provided enhanced mandatory training in the prevention and competent management of violent incidents.
- The way we deliver training programmes for clinical staff has been reviewed in order to improve their availability and applicability to our challenging behaviour policy. A new framework for training is to be introduced that maps out training from induction through to master's level. A process to capture whether this has changed the attitude of staff is being developed.
- An initial audit against the NICE guidance was undertaken within the Adult Mental Health Directorate and work is underway to consider how this can be rolled out across the organisation.
- The procedure for grading and reporting violent incidents has been re-developed and implemented giving much improved and consistent data in regard to the severity of the incident and how it was managed.
- A new process for the clinical review of serious or recurring incidents, as identified by the grading system, has been piloted successfully and will roll out in April 2010.
- A measure relating to the reporting of physical assaults that is consistent with the Leading Improvement in Patient Safety (LIPS) aims will be included within the dashboard for clinical teams.

  In addition specific work within the LIPS programme has begun:
  - To develop a standard process following the occurrence of a violent incident,
  - To gather more of the information available from carers and family.
  - To improve the sharing of information through handovers and within the written record.
  - To undertake patient safety walkrounds in wards and units
  - To provide a structure of reviewing and improving the quality of care records

The following graph demonstrates the reduction in physical assaults leading to harm in in-patient settings. This demonstrates a reduction of 34% over two years, where the improvement programmes began in late 2008.



As the graph demonstrates we have made good progress in reducing the number of physical assaults with a greater reduction from 2008/09 than that between 2007/08 and 2008/09. We believe this reflects the work that was started on this area in late 2008. Whilst we have made good progress to date we still believe that this remains a high priority for us. We have therefore identified it as one of our priorities for 2010/11. This will include the identification based on a categorisation of the levels of violence and aggression which will help us to concentrate on the critical areas.

Priority 2: Reduce Waiting Times for First Contact and Treatment

Whilst the services we provide are not included in the national waiting time requirements as they do not meet the national definition we still see reducing waiting times as being very important. Using our definition of quality we identified that making people wait for the treatment they need means that we cannot be delivering a high quality service. This is because:

- If a person needs care or treatment at a point in time but then has to wait, that care may no longer be appropriate if it is delivered at a much later date than first identified.
- The delivery of good outcomes is supported by early intervention and ensuring people receive the most appropriate treatment as soon as possible - this is compromised if there are long waiting times between referral and assessment and subsequent treatment.
- From a patient experience perspective waiting is not a positive experience.
- Waiting for a service is a significant waste because during that time no value is being added to the patient experience.

Therefore we identified waiting times as a key priority for 2009/10 and set ourselves the following targets:

- 80% of people will have been seen for their first appointment within 4 weeks of a referral from their GP/Primary Care

- 95% will have been seen for their first appointment within 8 weeks of a referral from their GP/ primary care
- 100% of people will be treated within 18 weeks of a referral from their GP/Primary Care.

Action taken

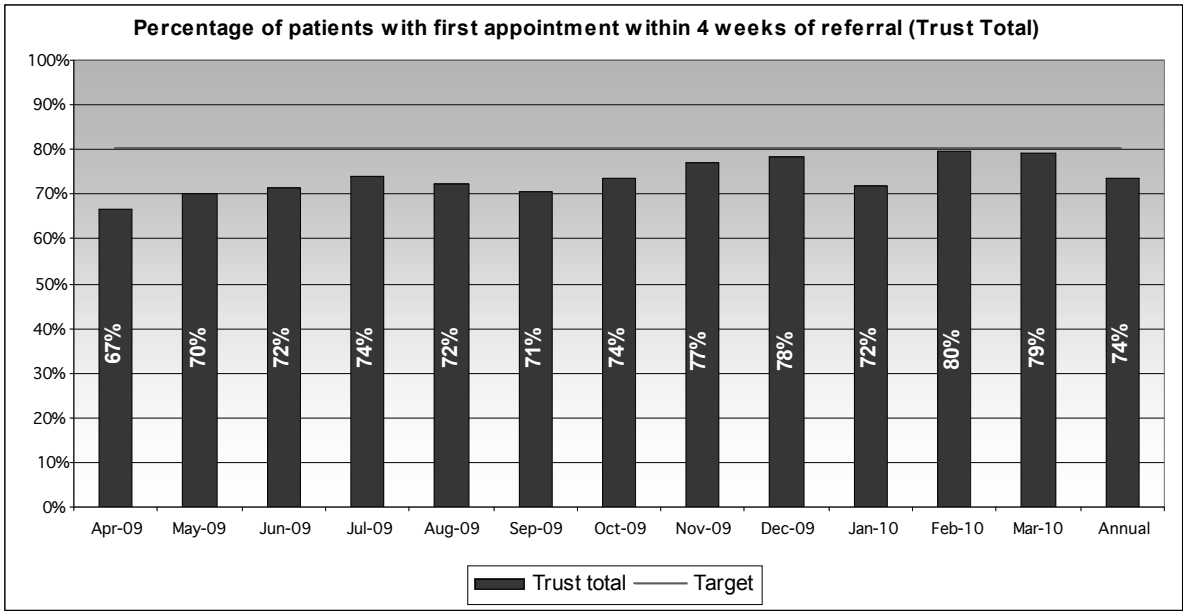
In order to drive waiting times down to the levels we set ourselves we took the following action:

- The Board of Directors agreed to drive improvements in performance through the various performance management forums, including receiving monthly information at the Board on progress against the three targets established.
- Each month all clinical services discuss waiting time performance at their management team meetings and agree local actions to improve the position.
- During the early part of 2009/10 all clinical services undertook a detailed validation exercise which identified specific system or data issues that needed to be addressed. This work continued throughout the year as issues were identified in order to improve the accuracy of the data.
- Training has been undertaken across all clinical services to ensure staff are aware of how to record waiting time information correctly. This has also been aided by the availability of waiting time reports for services, via our patient information system, which are accessed regularly by services.
- Adult Mental Health Services have held clinics on a Saturday morning to reduce their longest waiters.
- Within Children & Young People's Services 50% of clinicians' time has been ring fenced for direct face to face activity and advice has been provided on the management of demand and capacity. An improvement event (using the TEWV QIS) was carried out in Easington from which learning has been shared across the service.
- In Child & Adolescent Mental Health Services a pilot has been carried out in Easington with a group of GP practices to improve access which involved utilising NHS Net.
- Within Substance Misuse Services an issue was identified with capacity in Stockton in relation to alcohol misuse and the high number of referrals. Consequently two nurses were dedicated to work with primary care and the voluntary sector to improve the quality of referrals.
- Within North East Yorkshire Mental Health Services for Older People assessment clinics have been introduced to help address long waiting times.
- In MHSOP a dedicated steering group was set up to lead work to improve access and achieve the target.

How have we done?

Target 1: 80% of people will have their first appointment within 4 weeks of a referral from their GP/primary care

Whilst we marginally failed to meet the target by the year end, we have significantly improved our performance from 67% in April 09 to 79% in March 2010. This is an increase of 12% over the year and we did achieve the target in the month of February. This reflects the work that has been undertaken throughout the year to improve access to services.



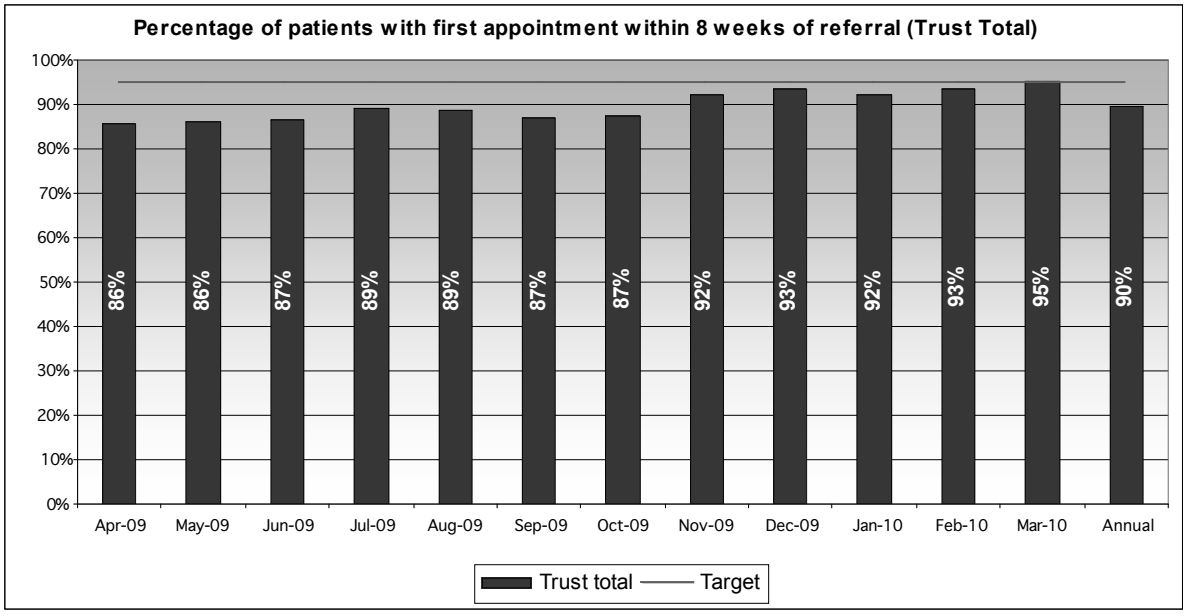
All services have improved their performance from April 09 to March 10; with Adult Mental Health Secondary Care Teams achieving over 90% in terms of their annual position. In addition Early Intervention in Psychosis (EIP) services, Mental Health Services for Older People, Substance Misuse, Forensic Learning Disability, Forensic Mental Health and North East Yorkshire Teams have all achieved the 80% annual target. However Adult Mental Health Primary Care Services, Children & Young People CAMHS and Children and Young People Learning Disability and Adult Learning Disability services have not managed to reach this challenging target level for waiting times. There are a number of reasons for this including:

- The number of staff vacancies within these services over the year
- An increase in the number of referrals received.

We will continue to drive improvement in these areas.

Target 2: 95% of people will have their first appointment within 8 weeks of a referral from their GP/primary care

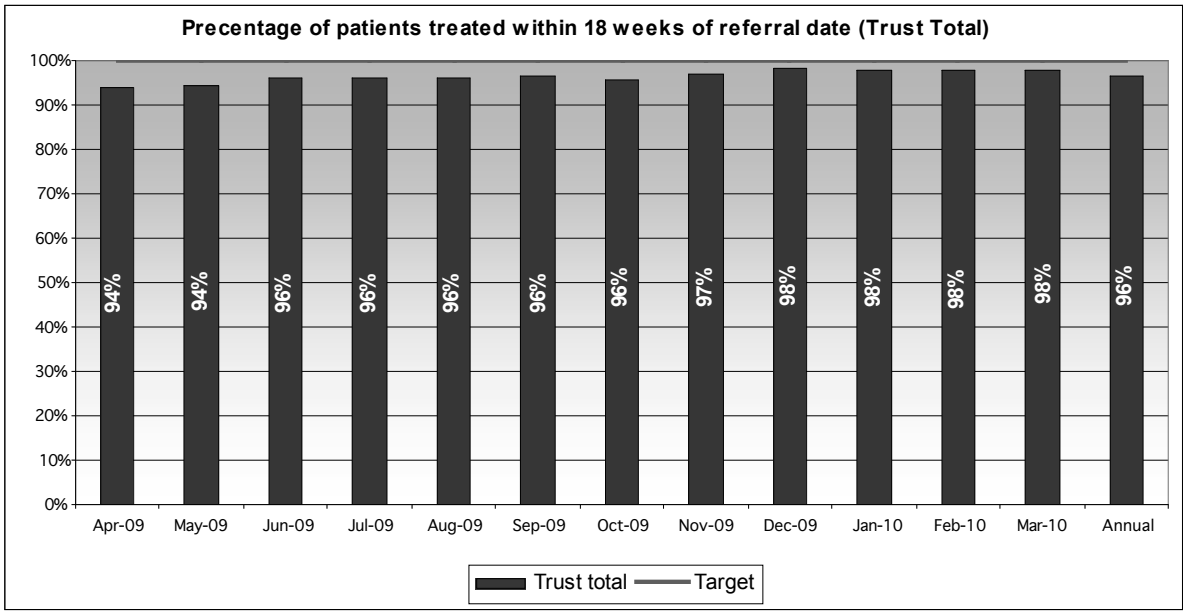
Again whilst we have delivered the target for the whole year we did achieve the target in the Month of March 2010. There has been a significant improvement over the year from 86% in April 09 to 95% in March 10, an increase of 9% which again is reflective of the work undertaken.



Adult Mental Health Secondary Care Teams, Forensic Learning Disability Services, Mental Health Services for Older People and EIP Services have all achieved the annual target of 95% and both Early Intervention in Psychosis (EIP) services and North East Yorkshire teams have under performed by less than 1%. However, those services highlighted not achieving the 4 week target are also not achieving the 8 week target, although the performance in all cases is closer to the target than is the case with the 4 week target.

Target 3: 100% of people will be treated within 18 weeks of a referral from their GP/primary care

Again whilst we have not achieved the target of 100%, we have improved our performance from 94% in April 09 to 98% in March10. We have performed at over 95% of patients being treated within 18 weeks for the majority of the year and reached a high of 99% in February 2010 as shown in the graph below.



Forensic Learning Disability Service and EIP Services are achieving 100% closely followed by Adult Mental Health Secondary Care Teams and Mental Health Services for Older People with over 99%. The one service that has a particularly low level of achievement in terms of this target is Forensic Mental Health Services at 50% however this accounts for one patient that was not seen within the required timescale as their appointment was scheduled outside of the time frames expected.

We continue to be committed to improving waiting times and have therefore set the following stretching targets for 2010/11:

- 100% of patients will have their first appointment within 6 weeks of referral date by 31 December 2010.
- 100% of patients will be treated within 13 weeks of referral date by 31 December 2010.
- 100% of patients referred on to an internal team will be seen within 18 weeks by 31 December 2010.

The current processes and systems will be used to identify where action will be needed to meet the targets.

Priority 3: Further implementation of the TEWV Quality Improvement System (QIS)

As discussed earlier we started in 2008/09 to implement our quality improvement system based on the premise of continuous quality improvement, such that everything we do adds value for our customers. We believe that this is very important to enable us to make widespread improvements to quality and it is in line with the North East Strategic Health Authority approach to quality improvement.

We therefore identified the further implementation of this system throughout the organisation as one of our key priorities for 2009/10.

Action Taken

The following provides further information on what we have achieved in 2009/10 against this priority:

- **Agreeing the Vision for Quality Improvement within the organisation**

  The QIS is a fundamental corner stone supporting the organisation to deliver real improvements in what we do. It was therefore important that we were clear about what we wanted it to deliver, which is described by a vision statement. During 2009/10 we agreed that the vision for the TEWV QIS is:

  - Improved quality and safety – fewer mistakes, accidents and errors, resulting in better patient care.
  - Improved delivery – better work done sooner.
  - Improved throughput – the same people, using the same equipment, find they are capable of achieving much more.
  - Accelerating momentum – a stable working environment with clear, standardised procedures creates the foundations for constant improvement.

- Increased staff involvement in improvement initiatives – encourage staff involvement and participation in the development of both the change plan and in the actual implementation.

- **Agreeing the Compact**

  A key part of the TEWV QIS is having an agreed understanding of what staff can expect from the organisation and what the organisation expects from its staff. This is known as the 'Compact' we have with our staff. Development of the Compact commenced in 2008 and involved focused group discussions with professional groups and with staffing groups at different levels throughout the organisation. The final Compact was agreed in December 2009 and it has now been circulated to all staff across the trust individually setting the scene for continuous improvement.

- **Training**

  A key part of the priority identified for 2009/10 was the training of additional accredited quality improvement leaders whilst also increasing the number of senior staff throughout the trust who were trained in the tools and techniques associated with the improvement system. Table 1 identifies the target we set ourselves for 2009/10 and our performance against that.

Table 1: Number of staff trained to support implementation of TEWV QIS

	Target	Actual
Number of accredited quality improvement leaders trained in 2008/09	7	7
Number of additional accredited quality improvement leaders trained in 2009/10	16	7completed in year 6 completing 19th April 2010 3 awaiting allocation of Virginia Mason Medical Centre (VMCC) accreditation slot
Number of staff trained (certified as TEWV certified leaders not Virginia Mason Medical Centre accredited)	22	13 certified TEWV productive ward leaders 8 completing awaiting 2nd Rapid Process Improvement Workshop (RPIW) completion 1 deferred
Number of senior staff trained in the tools and techniques	35	14 VMCC certified 6 VMPS completing 19th April 2010 13 certified TEWV Primary Mental Health Workers 8 awaiting 2nd RPIW 1 deferred

NB Training of certified workshop leaders can be either:
a) Virginia Mason Production System (VMPS) quality assured by VMMC or
b) TEWV certified workshop leaders' quality assured by TEWV.

Both are dependent on planned workshops which may not be completed in a financial year April 1st to March 31st as VMPS dependent on availability of VMCC staff coaching our coaches and TEWV dependent on coaching capacity from our internal team

We know we still need to do more on this so our plans for 2010/2011 are to:

- train a further 22 members of our staff as TEWV certified leaders
- train 20 staff as TEWV certified leaders across 4 organisations delivering large scale change in dementia services in Darlington. This will include staff in County Durham and Darlington Acute Hospitals NHS Foundation Trust, County Durham and Darlington Community Services, Darlington Borough Council and ourselves.

- **Activity**

  As part of the ongoing implementation of the QIS we identified that we would undertake an additional 40 Improvement Events within 2009/10. This was important because it would help us embed the system in two ways; it would drive further improvement in these key areas and it would ensure that more staff become involved in experiencing the use of the tools and the approach we are taking to improving quality.

  In fact for 2008/09 we have exceeded this target as shown below:

  - We completed 31 Rapid Process Improvement Workshops in clinical and non clinical processes. The impact of these has been measured at 30, 60, and 90 days after each event to see if the changes made have continued to deliver the improvement identified during the workshops.
  - The development of share and spread methods to share lessons learned from improvement activity across speciality areas. To date these have been successfully implemented in:
    - all 10 adult acute inpatient areas where standard work for assessment, formulation of care at 72 hours and visual control of patient flow has now been implemented.
    - 7 community teams by improvement work in provision of High Dose Anti Psychotic medication as safely as possible including formulation, monitoring and physical health checks.
  - The rapid process improvement workshop methodology has also been successfully applied to clinical pathway development with 4 pathways being developed in 2009/10 including:-
    - Challenging behaviour
    - Trauma in children and young people
    - Epilepsy
    - Personality disorder.

    All the above pathways pilots are currently being evaluated.

- **Integration of additional quality improvement/lean based tools into TEWV QIS**

  A further part of this priority identified for 2009/10 was to ensure we integrated other externally set 'quality improvement' work streams into our quality improvement system. We have been successful in doing this for the following:

  - Productive Mental Health Ward **–** A project was established that involved the training of all modern matrons to use Virginia Mason Production System Tools in support of the implementation of the Productive Mental Health Ward. This will now progress to delivery of the foundation modules.
  - Productive leader product - Four Directors and their personal assistants received training in the use of the product "releasing time to lead". This learning was subsequently shared with the remaining Executive Directors to ensure that there is a consistent approach across the Executive Management Team.
  - Leading Improvement in Patient Safety (LIPS) - The trust joined the programme as the first mental health trust to complete core modules and then subsequently went on to complete the foundation year.

- **External Validation of the TEWV QIS**

  The improvement activity described above as part of the continued implementation of the QIS saw us short listed for a number of national awards including the Nursing Times, the Health Service Journal Patient Safety and the national 'Lean Academy'.

2009/10 Developmental Areas

In addition to the key priorities we identified above we also identified three other areas that we felt were important and therefore wanted to do further work on in 2009/10. Information on these is given below.

Development Area 1 : Participating in Leading Improvement in Patient Safety (LIPS) and Identification of Global Trigger Tools for Mental Health

In 2009/10 we began participating in the work of the National Institute of Innovation and Improvement (NIII) programme on patient safety. This has included work to identify a procedure that helps identify common potential risk and harm issues to our service users as part of planning their care. These procedures are known as 'Global Trigger Tools' and are an innovation in mental health and learning disability care.

The work on Global Trigger Tools was initiated, with support from three staff seconded on a sessional basis from the Trust . The programme involved reviewing a significant number of case notes to identify what were themes of issues and events that preceded a self harm incident or an increased risk episode for service users of the Trust. Analysis of those reviews then led to the formulation of the 'triggers' that clinicians could use as a tool to assist risk assessment and care planning to reduce harm. The initial stages of the programme are now complete and the tool will be trialled as part of the Trust clinical risk assessment and care plan procedures.

In addition we identified that the LIPS programme would provide us with additional opportunities to improve patient safety because of the enhanced tools that were used as part of the LIPs programme. We therefore agreed to join the LIPS programme and a senior team from the Trust, comprising executive and non executive directors, attended an executive Quality and Safety academy event with the NIII to learn about the leadership model required to implement the LIPS programme and develop a patient safety culture in the organisation. The LIPS programme is designed to help organisations align their safety work streams to measureable patient safety improvement aims.

Following Board of Directors support for the programme a lead team was then sponsored to undertake training in the LIPS toolbox required to address the organisational improvement goals of reduction in assaults and increase in compliance with care planning standards.

The LIPS programme is now 6 months into a 3 year schedule with baseline data established and a range of change programmes have been put in place e.g. to develop assault coding tools, standardised debriefing following incidents, use of visual control boards to improve safety engagement and the use of patient stories. For each of the change programmes small pilots have been put in place, supporting local teams to try out change before extending the trial area. The changes are based on a number of important themes that have been shown to make a difference to patient safety e.g. communication, care pathways, risk assessment.

The next stage in the programme is to extend the use of the tools that have been developed on small sites and measure change. In 2010/11 the LIPS programme will be producing quantitative data to monitor improvements. The work streams will build on the challenging behaviours interventions work in reducing the most dangerous assaultative behaviour. There will be monitoring of the impact of giving staff regular feedback to assist them performance manage the safety tools. In addition the team will be testing out a new prompts system in records, using the global trigger tools and implementing standard work following assaults. The programme will be monitored through the Patient Safety group.

Development Area 2: Improvement in the use of the Care Programme Approach (CPA)

A key priority for improving patient safety in terms of mental health is the implementation and embedding in clinical practice of the CPA. The CPA provides a framework for multi-agency working in mental health and learning disability services, to ensure the identification, planning and delivery of the packages of care required to address complex health and social care needs of mental health and learning disability service users . The importance of effective and safe implementation of the CPA is underpinned by key national and local policy documents and lessons learnt from serious untoward incidents.

We have set a target that by 2012 **all** service users will have a robust risk assessment and intervention plan that is based on the risk assessment, within 72 hours of contact with the service, and that the intervention is being delivered to the patient. Year 1 of this programme began in July 2009 in Adult Mental Health inpatient services as part of the development priorities set by the Trust for quality improvement.

In 2009/10 the programme has involved:

- Data collection to establish baselines against compliance with policy in 5 in-patient pilot areas.
- Data collection to establish baselines against the target in 5 in-patient pilot areas.
- Identifying the two data sources as availability of Clinical Risk Assessment and an Intervention Plan at 3 days, registered on the Electronic Care Record (PARIS).
- Use of feedback and training of staff in the LIPS methods for change.
- Testing of visual control boards to monitor progress in the patient journey against the standards.
- Design of prompt/alert systems for the electronic care record to remind staff of key information needs.
- Testing of a communication tool called SBARD to improve concise delivery of key clinical information at handovers or in record keeping to ensure important information is available to new staff in planning and delivering care. **SBARD** stands for **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation, **D**ecision.
- Re-measurement of data in the pilot areas.

Table 2 shows the progress that has been made to date

Table 2: Improvement in compliance with LIPS Standards to date

Ward	Risk Assessment Document within 3 days		Intervention Plan produced within 3 days	
	Sep 2009	March 2010	Sept 2009	March 2010
1	97%	93%	93%	97%
2	71%	100%	100%	100%
3	97%	100%	90%	100%
4	94%	100%	84%	100%
5	80%	100%	77%	100%

The above table demonstrates that the majority of the wards involved have improved the timeliness of completing risk assessments and intervention plans with most showing 100% in March 2010. The table does however highlight that Ward 1 has not been able to achieve this position and therefore further development work with this area is due to commence in April 2010.

Work on this area will continue as part of the LIPS programme in 2010/11.

Development Area 3: Reducing Length of Stay on Acute assessment and Treatment Wards

During 2008/09 by applying the TEWV QIS we streamlined our processes within an adult mental health assessment and treatment ward (Thornton Ward) which resulted in a reduction in Length of Stay (in addition to a number of other benefits to both patients and staff). We therefore identified that in 2009/10 we wanted to explore how we could learn lessons and spread the processes adopted in that assessment and treatment ward.

In order to take this forward we undertook a staged roll out of the 'Purposeful Inpatient Admissions' (PIPA) developed on Thornton Ward in 2008 across our acute admissions units in Adult Mental Health Services. The wards at West Park Hospital were the last Adult Mental Health assessment and treatment wards to introduce the model in February 2010. The model consists of:

- The removal of weekly ward rounds with reports outs on each patient held in the first hour of every morning. This means that patients don't have to wait for the weekly ward round for elements of their care to be changed and that every afternoon is available for one to one interventions.
- Agreement of the 'standard tasks' which should be completed within the first 7 days of admission.
- The use of 'visual control boards' on each ward so that progress against the 'standard tasks' can easily be seen and discussed at each morning's report out. Tasks which are not complete can then be allocated to individual workers as necessary.
- A traffic light system (Red Amber Green) was implemented to prioritise patient care.
- The job plans of all 44 adult consultants were reviewed to ensure that we had specific inpatient consultants.

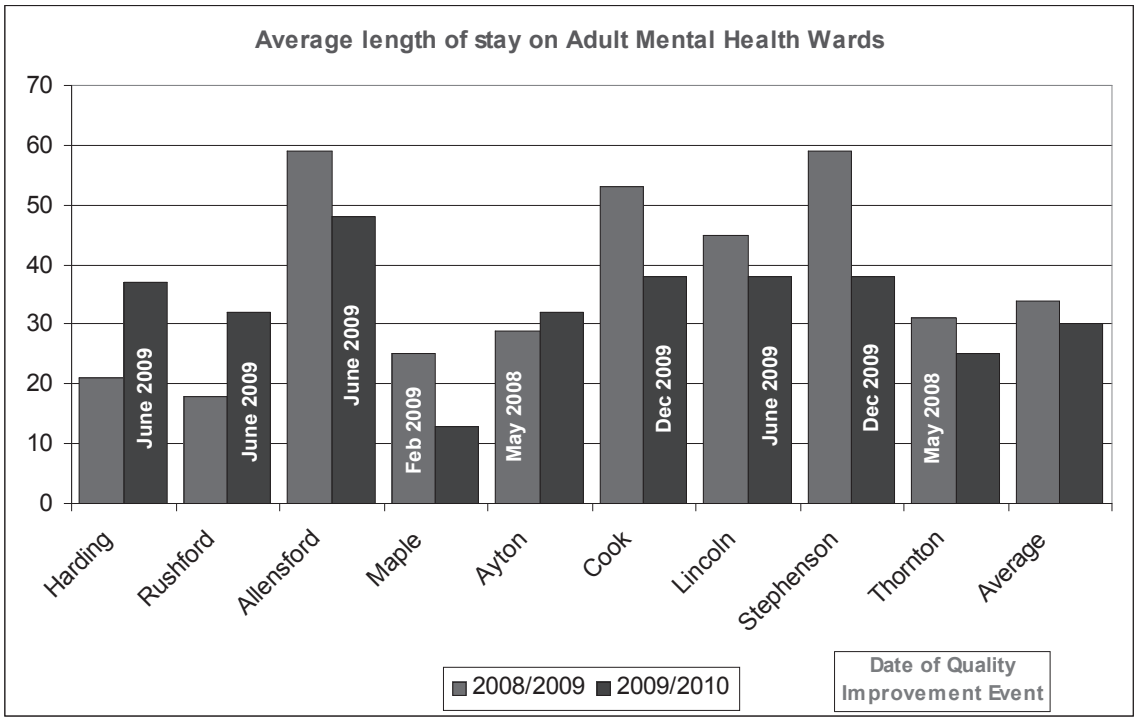
The above actions have delivered the following improvements:

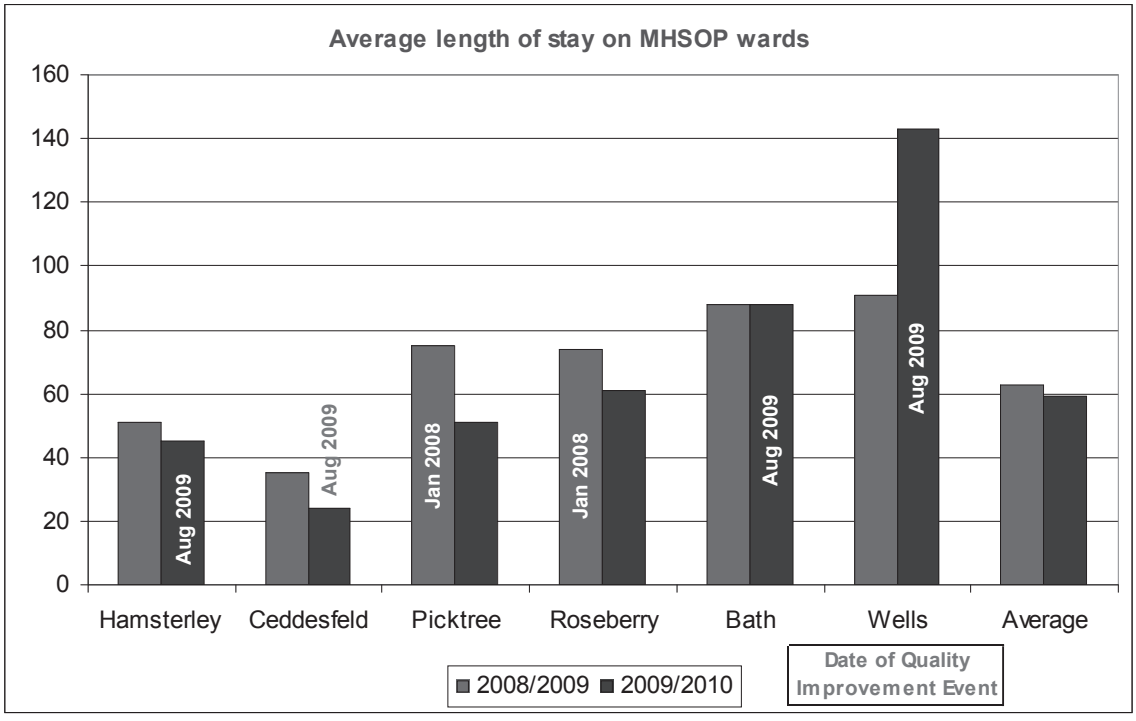
- A reduction in bed occupancy which allows more time for therapeutic interventions
- A reduction in the length of stay
- A reduction in the levels of violence and aggression
- Greater patient satisfaction evidenced by a reduction in the number of contacts with Patient Liaison and TEWV being in the top 20% of the country in the National Mental Health Patient Survey in 2009.
- Improved use of high dose anti psychotics.

In addition similar improvement work has been undertaken in a number of the MHSOP wards across the organisation.

The graph below highlights the changes to length of Stay on those wards in Adult Mental Health which have introduced the PIPA system. It should be noted that Elm Ward and Birch are not included as the Improvement Event for these wards was only held in February 2010 and there has not been sufficient time for the new processes to have impacted on the average length of stay in the year.

The graph below demonstrates the improvement to the average Length of Stay on the MHSOP wards that have held improvement events.





Both the above graphs demonstrate that the reduction in average Length of Stay is not consistent across all wards. However, both graphs show that the average Length of Stay in total across the wards has reduced both in Adult Mental health and Mental Health Services for Older People. There are a range of reasons that could have contributed to the positions of each ward shown on the graphs including:

- The transfer of Allensford Ward at Shotley Bridge Hospital, in Derwentside, into Harding and Rushford wards at the County Hospital in Durham (September 2009) and then the transfer of Harding and Rushford into the new Lanchester Road Hospital (January 2010).

- Staff still adapting to the new processes leading to a time lag in the impacts that they have.
- The fact that the processes depend on the whole care pathway working efficiently which is not always the case.

We believe the results of the work undertaken are encouraging and we will continue to roll out and embed the work done to date.

Note

The following table outlines the location of the various wards referred to above:

Ward	Hospital	Location
Adult Mental Health Wards		
Harding *	County Hospital	Durham
Rushford*	County Hospital	Durham
Allensford	Shotley Bridge Hospital	Derwentside
Maple	West Park Hospital	Darlington
Ayton	St Lukes Hospital	Middlesbrough
Cook	North Tees Hospital	Stockton
Lincoln	Sandwell Park	Hartlepool
Stephenson	North Tees Hospital	Stockton
Thornton	St Lukes Hospital	Middlesbrough
Older Peoples Wards		
Hamsterley	Auckland Park	Bishop Auckland
Ceddesfeld	Auckland Park	Bishop Auckland
Picktree	Bowes Lyon Unit	Durham
Roseberry	Bowes Lyon Unit	Durham
Bath	St Lukes Hospital	Middlesbrough
Wells	St Lukes Hospital	Middlesbrough

- Following the move to the new Lanchester Road Hospital in January 2010 Harding Ward was replaced with Tunstall Ward and Rushford Ward with Farnham Ward.

2010/11 Priorities for Improvement

Within the organisation the Clinical Governance and Clinical Risk Committee is responsible for providing assurance that appropriate structures, systems and processes are in place to deliver safe, high quality effective care, which is continuously improving. In doing so it also takes responsibility for recommending to the Board the key quality priorities to ensure that we continue to improve the quality of services we deliver.

The process of identifying the key priorities for 2010/11 involved a number of stakeholders and steps as outlined below:

- A small working group led by the Director of Nursing and Governance reviewed key sources of information to identify if any common key themes were present. This included performance information, Serious Untoward Incident investigations and reports, complaints, intelligence from our commissioners (including GPs), feedback from patients and carers and national publications around safety and quality. In addition discussions were held with the Quality Report working group of the Council of Governors in order to identify whether they had other suggestions they wanted the Board to consider. From this work a 'long list' of key quality priorities were identified and discussed at the Clinical Governance and Clinical Risk Committee which generated a recommended set of five priorities.
- The five priorities identified by the Clinical Governance and Clinical Risk Committee were then shared with a wider range of stakeholders which included our full Council of Governors, LINKS, our key commissioning PCTs and the relevant directors of adult and children's services within the seven Local Authorities with whom we share boundaries.
- The Board was then presented with the recommendations of the Clinical Governance and Clinical Risk Committee together with the other suggestions/comments put forward from the consultation process. From this it identified five key quality improvement priorities for 2010/11 and further detail of these is given below.

Priority 1: Learning Lessons from Serious Untoward Incidents

Serious Untoward Incidents (SUIs) have a major impact on patients, staff and the organisation as a whole. We recognise that it is vital both to work to prevent their occurrence by learning lessons from them and taking steps to prevent recurrence.

We have therefore identified this as one of our quality priorities for 2010/11.

What we will do.

We will ensure that when SUIs occur, we take steps to learn the lessons and disseminate these throughout the organisation.

To monitor this we will measure and monitor the percentage of serious untoward incident recommendations implemented within the agreed deadline.

How we will do it

During the year 2010/11 we will:

- Develop a team of specially trained SUI investigators to improve the quality of reports and development of recommendations
- Ensure staff are aware of recommendations made following the investigation of incidents
- Support our services to develop methods of dissemination and implementation of the lessons learned from SUIs.
- Explore the use of a 'stop the line' immediate alert approach to issues of immediate patient safety.
- Ensure that lessons from SUIs inform the content of Patient Safety Walkrounds
- Further develop the system for ensuring Safety Alert Broadcasts (SAB) are actioned, by including a response process to provide assurance that SAB recommendations have been implemented Trust wide.
- Establish follow-up and monitoring systems to ensure the completion of SUI actions. This will also allow us to provide reports that give assurance to internal and external stakeholders
- Audit the changes to practice that have occurred as a result of implementation of actions from SUI investigations.
- Monitor the themes and factors from SUI investigations for levels of recurrences.

How we will monitor progress

We will monitor progress throughout the year as follows:

- The Learning Lessons development will be project managed within the Patient Safety Team, led by a small project group that will include one of the patient safety facilitators and clinical service staff who will act as Patient Safety Associates.
- Project targets will be monitored monthly and reported on a quarterly basis through the Annual Plan performance systems for the Directorate of Nursing and Governance.
- Project development and lessons learned reports will be made through the Patient Safety Group to the Clinical Governance and Clinical Risk Committee.
- Outcomes will be fed back to the Trust commissioners as part of data requirements for the Quality Indicators element of the Trust contract.

Priority 2: Violence and Aggression

As stated earlier we have continued to identify the reduction in the number of incidents of violence and aggression as a key quality priority for 2010/11 because of the impact it has on our users and our staff.

This priority will continue to be managed as one of the 'breakthrough' targets as part of the LIPS programme.

What we will do

We will reduce physical assaults in in-patient settings by 50% each year until 2012

How we will do it

In 2010/11 it is planned that the following will be undertaken:

- Safety walkrounds
  Senior leaders will undertake regular Patient Safety Walkrounds to demonstrate the organisation's commitment to building a culture of safety. A common list of questions for these walkrounds will be developed based on information being highlighted in terms of patient safety locally and nationally.

- Visual Control Boards
  The programme will test the inclusion of aspects of care relating to the reduction of violence in the visual control boards that are proving successful in other areas of care on the wards. The programme will also establish visible information about progress against the programme targets.

- Development of Standard Working Practices
  We will develop standard work to support the above and this will include standardised communication at handovers and team meetings using the Situation-Background -Assessment-Recommendation-Decision (SBARD) approach (see earlier). Associated with this will be visual prompts to help ensure that people know what they need to do and when.

- Clinical support systems
  We will continue to develop how we use the electronic patient record on PARIS to improve the recording of risks and interventions taken associated with the management of violence and aggression.

- Post incident de-brief
  We will ensure that there is a review of incidents, including discussion with the user(s) involved, to extract lessons both for the user's intervention plan and for the staff team and clinical environment.

- Training and competence
  We will establish and test team-based approaches to training and refine methods for determining competence. This will include describing the subsequent pathway to be followed where there are gaps in competency or practice.

How we will monitor progress

We will monitor progress throughout the year as follows:

- The LIPS programme is managed through the Patient Safety Group within a three year staged framework.
- Quarterly reports on milestone achievement will be produced for the Clinical Governance and Clinical Risk Committee.

- The programme metrics will be monitored using the graded incident recording and coding tool developed in year 1 of the project.
- Directorates will be given immediate feedback on data collection as part of the programme action approaches.

Priority 3: Implementation of the Care Programme Approach (CPA)

As described earlier this was identified as an area for development in 2009/10. Given the centrality of the CPA to the delivery of safe and effective care, we have agreed that we need to build on the work undertaken in 2009/10 in inpatient areas and expand this into our community services.

We have therefore identified CPA implementation within the AMH community teams as one of our quality priorities in 2010/11.

What we will do

We will:

- Ensure that by 31st March 2011 all patients seen by the Adult Access Teams, Crisis Teams and Early Intervention Teams will have a risk assessment and intervention plan that is based on the risk assessment, within 72 hours of contact with the service.

- Ensure that by 31st March 2011 50% of patients seen by the Adult Access Teams, Crisis Teams and Early Intervention Teams will have risk assessments and interventions plans that meet the quality standards identified in the LIPS initiative.

- Ensure that by 31st March 2011 all care co-ordinators will have reached the required standard in terms of undertaking robust risk assessments and developing intervention plans based on those risk assessments.

How we will do it

During 2010/11 we will:

- Continue to deliver a comprehensive training programme to ensure that all our care coordinators are competent in implementing the CPA.
- Ensure that a competency based assessment is completed by all care coordinators.
- Undertake audit and spot checks on the implementation of the CPA policy which will be reported to and monitored by the local interagency CPA group.
- Collate data against the above targets in the relevant community teams.
- Establish and test standard methods within the community teams.
- Implement SBARD to record keeping in the relevant community teams
- Develop and implement the use of visual control boards within the relevant teams.

How we will monitor progress

We will monitor progress throughout the year as follows:

- This area of work will be project managed through the Care Programme Approach operational group, led by the Head of Patient Safety.
- The project plan incorporates all of the actions and will monitor the levels of risk assessment and care plans in place, as well as the targets for the development of tools and solutions.
- The external CPA audit will be completed and results disseminated initially internally but then to other partner agencies and PCT/commissioners.
- A bi-annual report will be made to the group for CPA implementation.

Priority 4: Transfers of Care

A transfer of care is any situation in the patient care journey where the patient moves between services. This can be a change from one therapist to another e.g. from a nurse to a social worker or a move from one care setting to another e.g. From inpatient care to the community.

It is recognised that discharge from an inpatient ward to a community setting (which is a transfer of care) is an area of high risk as identified in the following national and local policy:

- Patient Safety First (2001) identifies discharge from inpatient to community as high risk activity in patient care
- The National Patient Safety Agency Seven Steps to Patient Safety in Mental Health (2008) identified transfer of care as a high risk activity in patient care
- The Safer Care North East quality indicators (2009) identify care transfers as a key metric
- National Confidential Enquiry into Homicides and Suicide by People with Mental illness Avoidable Deaths (2006) identifies discharge from inpatient to community services as a high risk process
- 12 Points to a Safer Service formed the basis of the Mental Health section in the National Suicide Prevention Strategy for England, (2002).

We have therefore identified improving the discharge from inpatient care to community process as a quality priority for 2010/11.

What we will do

- Monitor standards of pre-discharge meeting, risk assessment, identified care co-coordinator and discharge plan from April 2010.
- Monitor the use of the discharge document, (printed from the electronic care record).
- Ensure that 95% of our patients in Adult Mental Health on CPA will be followed up in the community within 7 days of discharge from an inpatient ward (known as 7 days follow ups).
- Ensure that 90% of all 7 day follow ups will be done in person (know as a face to face contact) by 31st December 2010.

How we will do it

In 2009/10 the scoping work for this improvement priority took place, identifying discharge plans and transfer letters to GPs as areas for planned work.

In 2010 /2011 we will:

- Plan an Improvement Event (Rapid Process Improvement Workshop) on the discharge process, scoped from the point of decision to discharge to 7 day follow up.
- Implement a comprehensive ongoing training and coaching programme to ensure staff have the skills necessary to complete discharge planning safely.
- Further develop skills and competencies in CPA within inpatient and community staff (see Priority 3)
- Undertake a qualitative audit of the CPA focusing on care planning and risk assessment on discharge.
- Test the implementation of a standard GP discharge form in Adult Mental Health services. This will be followed by roll out in other specialist services and further testing. Once all the testing is complete the form will be made available on the electronic care record on PARIS which means it will be generated electronically from this system.
- Review the current standard GP discharge letter template on PARIS and test out the feasibility of agreeing a standard GP letter template in each specialist service that has some flexibility for local preferences.
- Develop standard work for discharges from inpatient to community services.
- Develop a discharge document for the electronic care record held on PARIS

How we will monitor progress

We will monitor progress throughout the year as follows:

- A work programme will be set up, project managed by the Associate Director of Nursing and Compliance.
- The targets will include progress against the improvement standards and the achievement of programme actions.
- The progress against targets in the work programme will be monitored monthly and reported quarterly as a project update to the Clinical Governance and Clinical Risk Committee.
- A programme 'newspaper' will be used for updating and reporting back into the clinical test sites.
- Customer surveys will be used for supplementary monitoring to measure quality improvement in the discharge process.

Priority 5: Development of Ways to Collect Information on Patient Experience

A key element of our quality definition is whether the users of our service feel that the experience they had whilst using our services was a positive one. Therefore we have identified the development of ways to gather this information as one of our quality priorities for 2010/11.

This will include:

- gathering the views of users of our services
- developing measures to collect both quantitative and qualitative data to evaluate the experience of patients
- using that information in the improvement of services

What we will do

By the 31st March 2011 we will have developed a robust methodology to collect quantitative and qualitative data from our patients on their experiences.

How we will do it

Throughout 2009/10 a working group has developed a framework to establish the existing measures of patient experience being used within the Trust and the methodologies being used to collect and collate data. The group identified that the measures we need to focus on are the elements of experience that were most important to users of our services. The aim therefore is to identify a core group of patient experience themes that reflect the most important issues to users of Trust services.

With this as a starting point we will:

- Build on the developmental work with pilot projects involving patients from Forensic and Learning Disability and with working age adults in 2009/10. This work has developed a variety of data collection methodologies that are being tested in real time.
- Embed a repeat programme of the core real-time patient survey questions, used in the Delivering Same Sex Accommodation project in 2009/10
- Implement a planned programme where the core themes identified from the projects will be the basis of patient experience monitoring using a range of methodologies that have been evaluated as best fit for that patient group. This will be the corporate element of the trust wide framework.
- Capture all the methods being used across the Trust to gather patient feedback and incorporate those into the framework. We will develop tools to ensure patient experience is gathered only using valid and reliable methods that meet the standards for non-discrimination and inclusion.
- Trial and evaluate at least one form of electronic patient data collection
- Develop a Patient Experience Strategy which will bring together methodologies and how services use patient experience in their service improvement programmes. This will ensure that all users of services have the opportunity to feedback on their experience of Trust services and are able to see the effects of their feedback on change and improvement programmes.

How we will monitor progress

We will monitor progress throughout the year as follows:

- The overall Patient Experience work will be co-ordinated by the Patient Experience Team
- Monitoring reports of progress against the milestones will be submitted to the Clinical Governance and Clinical Risk Committee on a quarterly basis.

- Each of the streams of work in the clinical areas will report back through that area on a monthly basis.
- Actual patient experience data will be feedback, as far as possible, on a real time basis to enable clinical staff to use the data in a meaningful way.
- The work will be visually controlled using a visual control board where each work programme can be tracked to ensure progress is being made against milestones.

Statements of Assurance from the Board

As part of the Quality Report we are required to provide statements of assurance covering a number of areas of quality. These are mandated statements set by the Department of Health and Monitor and are given below. The words in *italics* are the mandated statements with further information provided in plain text were appropriate.

Review of Services

During 2009/10 TEWV NHS FT provided and/or sub contracted 7 NHS services.

TEWV NHS FT has reviewed all the data available to them on the quality of care in 7 of these NHS services

The income generated by the NHS services reviewed in 2009/10 represents 96% of the total income generated from the provision of NHS services by TEWV NHS FT for 2009/10.

The Trust has a number of processes and systems which contribute to the review of services as follows:

- Service Performance Dashboards – each service receives a monthly performance dashboard which highlights performance against an agreed set of indicators. These dashboards are designed to give a balanced picture of performance against the five strategic goals of the organisation including quality. Each service is performance managed against these dashboards in a formal monthly Performance Management meeting with the Chief Operating Officer, the Director of Planning and Performance and the Director of Finance and Information. Furthermore each dashboard is also reviewed monthly by the Executive Management Team (EMT). A key part of these two processes is the identification of action plans where the level of performance is not as expected. These reports also started being included within the Trust Board Performance Report during 2009/10.
- Clinical Governance Reports – Each service produces a formal Clinical Governance report on a four month rolling programme which is considered by the Clinical Governance and Clinical Risk Committee.
- Structured Board Visits – Each month members of the Trust Board visit a service within the Trust. The visiting team is made up of the Chairman, the Chief Executive, a Non Executive Director and an Executive Director. The visits allow Board members to see and hear about the services and ask questions around delivery, quality and any issues that staff may have. A key part of the visit is the production of a report and action plan which is then presented to the Board at its next formal meeting for approval and subsequent monitoring. A list of the service visited in 2009/10 is provided in Appendix 2.
- Executive Management Team (EMT) visits – in order to supplement the structured board visits and to increase the visibility of the Executive Team a system of EMT visits were established during 2009/10. These take place every other month with a total of 6 visits taking place at any one time, which will result in 36 services being visited by EMT members in any given year.

Participation in clinical audits

During 2009/10, 8 national clinical audits and 1 national confidential inquiry covered NHS services that TEWV NHS FT provides.

During that period TEWV NHS FT participated in 63% national clinical audits and 100% national confidential inquiries of the national clinical audits and national confidential inquiries which it was eligible to participate in.

The national clinical audits and national confidential inquiries that TEWV NHS FT were eligible to participate in during 2009/10 were as follows:-

- *Royal College of Psychiatrist (RCP) Continence Care Audit*
- *Prescribing Observatory in Mental Health (POMH) UK Topic 1 – Re-audit High dose and combined antipsychotics in acute adult inpatient settings*
- *POMH UK Topic 2 – Screening for metabolic side effects of antipsychotic drugs in patients treated by assertive outreach teams*
- *POMH UK Topic 5 – Benchmarking the prescribing of high dose and combination antipsychotics on adult acute and PICU wards*
- *POMH UK Topic 8 – Medicines Reconciliation*
- *POMH UK Topic 9 – Use of antipsychotic medication in people with Learning disabilities*
- *POMH UK Topic 6b – Re-audit Assessment of the side effects of depot antipsychotics*
- *Pilot Phase of the National Audit of Psychological Therapies in 2009*
- *National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)*

The national clinical audits and national confidential inquiries that TEWV NHS FT participated in during 2009/10 are as follows:-

- *RCP Continence Care Audit*
- *POMH UK Topic 1 – Re-audit High dose and combined antipsychotics in acute adult inpatient settings*
- *POMH UK Topic 8 – Medicines Reconciliation*
- *POMH UK Topic 9 – Use of antipsychotic medication in people with Learning disabilities*
- *POMH UK Topic 6b – Re-audit Assessment of the side effects of depot antipsychotics*
- *National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)*

The national clinical audits and national confidential inquiries that TEWV NHS FT participated in, and for which data collection was completed during 2009/10 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the national audit or inquiry.

Audit Title	*Cases Submitted*	*% of the number of registered cases required*
RCP Continence Care Audit	*86*	*108%*
POMH UK Topic 1 – Re-audit High dose and combined antipsychotics in acute adult inpatient settings	*180*	*100%*
POMH UK Topic 8 – Medicines Reconciliation	*83*	*100%*
POMH UK Topic 9 – Use of antipsychotic medication in people with Learning disabilities	*214*	*100%*
POMH UK Topic 6b – Re-audit Assessment of the side effects of depot antipsychotics	*70*	*100%*
National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)	*-*	*(98.1% = National % returns)*

The reports of 3 national clinical audits have been formally reviewed by the provider in 2009/10 and TEVW NHS FT intends to take the following actions to improve the quality of healthcare provided:-

- *POMH UK Topic 1 – Re-audit High dose and combined antipsychotics in acute adult inpatient settings*
  Actions:-
  - *The Trust has made use of the following POMH-UK interventions: the ready reckoner and slide sets (used in training sessions).*
  - *There have been a number of events as part of the TEWV QIS, including a 'rapid process improvement workshop' and a 'share and spread event' to highlight the issue to community teams, and to introduce the visual control board system and standard working practices to them.*

- *POMH UK Topic 8 – Medicines Reconciliation*
  Actions:-
  - *The full report will be reviewed by the Pharmacy Team and information provided to Directorates.*
  - *POMH is developing a patient-led intervention that highlights the importance of telling the doctor about all medicines that are currently being taken.*
  - *Pharmacy Reference Group advocating 'green bag' scheme to get patients to bring in medicines when admitted to hospital.*
  - *Template for recording medicines reconciliation developed for use by pharmacy team.*
  - *Contacting GPs for the record of current medicines prescribed as part of standard working practice for some adult mental health acute admission wards.*
  - *Record of number of medicines reconciliations undertaken to be used as monthly performance indicator for the trust.*
  - *Trust participation in a national conference addressing medicines reconciliation and the quality of lithium monitoring 1st December 2009, at the RSM.*
  - *A re-audit will be conducted in September 2010.*

- *POMH UK Topic 9 – Use of antipsychotic medication in people with Learning disabilities*
  Actions:-
  - *Learning Disability consultants have met to compare and review Trust and individual performance.*
  - *Action points have been agreed to improve assessment and monitoring of side effects in which individual teams will examine barriers and develop solutions.*
  - *Re-audit January 2011*

In addition to the above the following is the position regarding action plans for a further 2 national clinical audits:

- *POMH UK Topic 6b – Re-audit of the Assessment of the side effects of depot antipsychotics*
  Actions:-
  The report was received via POMH UK on 26 February 2010 and an action plan is currently in development.
- *RCP Continence Care Audit- The Trust data collection is complete. We are awaiting the report which will be published after 29 March 2010, following which an action plan will be developed.*

The reports of 47 local clinical audits were reviewed by the provider in 2009/10 and TEWV NHS FT intends to take actions to improve the quality of healthcare provided. The actions are included in Appendix 3.

(It should be noted that 217 local clinical audits were undertaken in 2009/10)

Mental health trust are expected to participate in the National Audit of Psychological Therapies for Anxiety and Depression, however this was still in development phase and was not active in 2009/10. However recruitment to this audit has commenced nationally in 2010/11 and the Trust is preparing to participate.

Research

The number of patients receiving NHS services from TEWV NHS FT in 2009/10 that were recruited during the reporting period to participate in research approved by a research ethics committee was 132.

Of these, 106 were recruited to National Institute for Health Research (NIHR) portfolio studies. The Trust's managed shift towards participation in studies adopted onto the (NIHR) Portfolio is evidenced by the metrics summarised below.

The Trust was involved in conducting 58 clinical research studies, completing 20 of these as designed within the agreed time and to the agreed recruitment targets. During this reporting period, the NIHR supported 23 of these studies through its research networks. National systems to manage studies in proportion to risk (NIHR Coordinated System for gaining NHS Permission) were employed in managing approvals for 17 studies. For over 80% of these currently active NIHR supported research studies, the Trust's participation was initiated during the second half of the

reporting year. This steep increase in NIHR portfolio involvement by the Trust continues, with participation in an increasing number of research studies adopted by the Mental Health Research Network.

Of the 40 studies permitted to start in the reporting period, 16 were given permission by an authorised person less than 30 days from receipt of a valid and complete application, including favourable opinion from ethics committee. 2 studies are being managed under national standard agreements and to date 6 researchers have been granted access under the Research Passport scheme.

The rapidly increasing level of participation in clinical research through 2009-2010 and in particular in multi-site large scale trials, demonstrates the Trust commitment to improving the quality of care offered in addition to delivering value adding contribution to the broader goals of mental health research.

Goals agreed with commissioners

Use of the Commissioning for Quality and Innovation Payment Framework (CQUIN)

TEWV NHS FT income in 2009/10 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework because the approach set out by the North East SHA was that the available resources should be used to establish systems and processes in the first instance. It is expected that this will enable the CQUIN scheme to run effectively in 2010/11.

Within the 2009/10 contract agreed with commissioners there was an additional £966,000 available linked to CQUIN. TEWV NHS FT received £966,000 additional funding in 2009/10 as 'CQUIN payments' however as stated above this was not conditional upon achieving any particular quality improvement and innovation goals.

Within the contract with our main commissioners there was the inclusion of a number of quality indicators which we have monitored in year (as a shadow CQUIN scheme).

Further details of the indicators used in 2009/10 and for the following 12 month period are available on request from sharon.pickering@tewv.nhs.uk

What others say about the provider

TEWV NHS FT is required to register with the Care Quality Commission and its current registration status is fully registered under the Health Care Associated Infection registration. TEWV NHS FT has no conditions on this registration.

TEWV NHS FT was informed on 23 March 2010 that it would receive full CQC registration with no conditions from 1st April 2010.

The Care Quality Commission has not taken any enforcement action against TEWV NHS FT during 2009/10.

TEWV NHS FT was not subject to periodic review by the Care Quality Commission during 2009/10.

TEWV NHS FT has not participated in any special reviews or investigations by the CQC during the reporting period.

However the Care Quality Commission published in March 2010 information about a special review that will take place in early 2010/11. This review is concerned with 'Meeting the Physical Health Needs of those with Mental Health Needs and Learning Disabilities' It will focus on:

- access,
- assessment,
- care delivery
- communication with patients and their carers.

The CQC will be conducting this area based assessment across PCTs, Acute Trusts and Specialist Mental Health & Learning Disability Trusts with data collection concluding May 2010 and national reporting anticipated Autumn 2010. We will provide information as required by the CQC and we will take any appropriate action required in response to the findings when published.

In 2010/11 the Trust may be subject to the following special reviews/ studies (dependent upon final agreement on special reviews) :

- Pathway for Dementia Care
- Nutrition and Hydration
- Carers and Hospital Discharge
- Review of the Care Programme Approach (CPA) in mental health
- Quality of Nursing Care
- Use of Restraint
- Health & Social Care Needs of Offenders
- Unmet need in Social Care

Other Work with the CQC

Care Quality Commission Review of Arrangements in the NHS for Safeguarding Children

The results of the Care Quality Commission's review of safeguarding children within the NHS gave the position of all NHS organisations in relation to their arrangements for safeguarding children. These results have been published and we have come out favourably overall in comparison with other NHS organisations.

We have clear governance arrangements for Safeguarding Children which are reflected throughout the organisation. The Board lead for Safeguarding Children is the Director of Nursing and Governance. The CQC review showed that we were within the top11% of Trusts that had discussed safeguarding children more than 6 times during the previous 12 months.

This is evidenced via written safeguarding children reports submitted to the Clinical Governance and Clinical Risk committee on a quarterly basis with an additional monthly verbal exception report and an annual submission, which identifies any

issues and progress on any actions required. It provides the committee with information regarding any ongoing serious case reviews and internal management reviews in which we are involved. In addition, the Trust Board receives regular reports regarding safeguarding children issues and activity which ensures that they are kept updated formally and have the opportunity to seek assurance on our safeguarding activity.

The work of all our staff in Safeguarding Children is supported by specific safeguarding children training and the Trust's Safeguarding Children policy. The review showed that our policy had been recently updated and the majority of staff were up to date with their level 1 training. To further improve this position a First Contact Advisor and Trainer has been appointed to provide more training for all staff. Also the introduction of e-learning training has enabled more staff to access training at level one.

We showed full compliance with Criminal Records Bureau (CRB) checks (over one tenth of Trusts showed they did not comply with the relevant legislation).

Only 7% of Trusts recorded that they covered three Local Safeguarding Children's Boards (LSCB's) or more. We cover seven. These have regular attendance by the Director for Nursing and Governance or senior safeguarding professionals. We also have regular attendance at the LSCB sub-groups by a member of the safeguarding team.

This review demonstrates that by having representation on all our LSCB's and robust governance arrangements we are able to demonstrate compliance with safeguarding children legislation and a strong commitment to safeguarding children.

Care Quality Commission Annual Statement on Mental Health Act Activity

The CQC Mental Health Act Commissioners visit the Trust regularly to meet detained patients and appraise the systems, processes and practices being implemented across the Trust to ensure we comply with the Mental Health Act and Mental Capacity Act legislation. Mental Health Act Commissioners meet and talk to detained patients in private and also talk to with staff and managers about how services are provided. The inspection visits also monitor the quality standards of the environment, clinical care and social/occupational activity which are available to detained patients. The lead Mental Health CQC commissioner attends the Trust Mental Health Act Committee, a sub-committee of the Board of Directors , where the assurance and administrative business of Mental Health legislation is managed. All visits are followed up by a CQC feedback summary and Trust response/action plan. These are all monitored by the Committee.

The CQC then produce an annual statement for the Trust which is presented to the Board of Directors. We received our report in January 2010, for the 12 months ending September 1st 2009. The statement was extremely positive overall with particular reference to:

- the positive relations with the CQC
- the prompt responses to any issues raised in the visits,
- the standards of care
- the positive application of the Act by staff.

The report stated, "*It is reassuring to note that, with very few exceptions, detained patients spoke highly of their care and of the staff who looked after them.*" *"Commissioners continue to report many instances of excellent interactions observed between staff and patients and of the implementation of effective patient centred care pathways*".

The statement gave very complimentary feedback about the high standard of application of the Act and the compliance with the legal detention framework.
"The Care Quality Commission is impressed with the diligence of the Mental Health Act Managers in ensuring that all detentions sampled were lawful. There was consistent evidence of effective systems supporting the operation of the Mental Health Act and compliance with the Code of Practice including medical and administrative scrutiny."

There were two areas that require further development and both relate to clinical administration of the Act. Medical staff are now tasked with improving their use of Section 58, recording information about patients' response to being asked to consent to treatment and all staff to improve their use of Section 132, recording of when patients are told about their rights. We have drafted an action plan to improve these areas further this year.

Data Quality

TEWV NHS FT submitted records during 2009/10 (currently as at 31/01/10) to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- *which included the patient's valid NHS number was: 99.8% for admitted patient care; 99.9% for out patient care;*
- *which included the patient's valid General Medical Practice Code was: 95.9% for admitted patient care; 99.6% for out patient care;*

We recognise that data quality is important both in terms of being able to provide safe and high quality services to patients and in ensuring clinical and managerial decisions we take are based on good information. We have therefore established a number of ways to monitor and improve data quality as follows:

- We have established a data quality improvement group chaired by the Director of Finance and Information
- We have established regular reports on key elements of data which shows how well data is being recorded on the patient information services. These are available to all services so that they can target improvement work on areas where problems occur.
- Data Quality is discussed each month at the Executive Management Team meeting dedicated to Performance.

Information Governance Toolkit Attainment Levels

TEWV NHS FT score for 2009/10 for Information Quality and Records Management assessed using the Information Governance Toolkit was 84.2% (as at 1 March 2010)

We have identified responsible officers for requirements within the Information Governance Toolkit who monitor and progress improvement during the year. With

regard to Data Quality, 11 of the 19 relevant requirements are maintained at level 3 and 8 at level 2, with responsible officers ensuring that quality is maintained and any identified changes are adopted within the latest versions of the toolkit.

We have action plans for further improvement against eight of the data quality requirements; these include clinical coding, corporate records, completeness and validity and checking information at source. The requirements that need improvement are all scored at level 2 and some of these will reach level 3 in the next financial year.

We have implemented a proactive Information Governance campaign to enhance staff understanding and/or confidence in using the Trust information systems. This commenced in 2009/10 and will be continuing for the 12 months with direct on site coaching for staff focussed on the data quality issues we need to further improve.

Clinical Coding Error Rate

TEWV NHS FT was not subject to the Payment by Results clinical coding audit during 2009/10.

PART 3: REVIEW OF QUALITY PERFORMANCE 2009/10

Our performance against our quality metrics

The following table provides detail of our performance against a set of agreed quality metrics in 2009/10. These metrics are the same as those we reported against in our Quality Report 2008/09 which allows us to monitor progress.

		2009-10		2008-09 for comparision	2007-08 for comparision
		Target	Actual		
Patient safety measures					
1	Number of unexpected deaths	35	**32**	40	38
2	Number of outbreaks of Healthcare Associated Infections	0	**0**	0	0
3	Number of Patient Falls	270	**245**	284*	442
Clinical effectiveness measures					
4	CPA 7 day follow up *(as at end of Feb 10)*	95.0%	**97.5%**	97.3%	99.0%
5	Implementation of NICE Guidance	N/A	75.0%	75.0%	26.5%
6	Average length of stay for patients in AMH & MHSOP Assessment & Treatment wards	N/A	47	47	45
Patient experience measures					
7	Delayed Transfers of Care	7.5%	**2.9%**	4.8%	N/A
8	Complaints	97	**111**	104	96
9	National Patient Survey				
	Score wiithin highest performing 20% of trusts	N/A	16 (42%)	18 (49%)	7 (19%)
	Scores within intermediate 60% of trusts	N/A	22 (58%)	17 (46%)	30 (81%)
	Scores within lowest performing 20% of trusts	N/A	0 (0%)	2 (5%)	1 (3%)

* denotes update to previously reported information (278) due to late receipt of forms after publication last year.

Notes on selected metrics

1. The heading of 'Unexpected deaths' was shown in the 2008/09 Quality report as number of suicides – this was in fact an error in the metric description in 2008/09 as the data reported was in fact unexpected deaths. Data for this metric is taken from Incident Reports which are then reported via the National Strategic Executive Information System (STEIS).

2. Outbreaks of healthcare associated infections relates to those of MRSA bacteraemia and C Difficile. The Infection Prevention and Control Team would be notified of any outbreaks direct by the Ward and would then be recorded on an 'outbreak' form before being reported externally.

3. Patient falls excludes the categories 'found on floor' and 'no harm'. Data for this metric is taken from Incident Reports which are then reported via the Trust's Risk Management System, DATIX.

4. Data for CPA 7 day follow up is taken from the Trust's patient system, PARIS and is aligned to the national definition.

5. Implementation of NICE Guidance is based on the percentage of audits of NICE guidelines that we completed compared to those that we planned for 2009/10. Data for this metric is taken from audits undertaken by the Clinical Directorates supported by the Clinical Audit Team.

6. Data for average length of stay is taken from the Trust's patient system, PARIS.

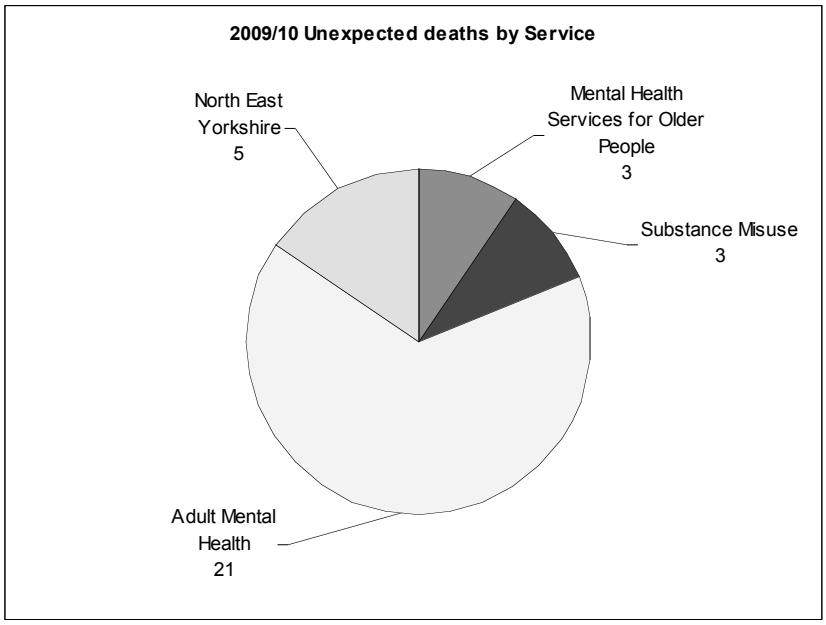
7. Delayed transfers of care is based on Monitor's definition and therefore exclude children and adolescent mental health services. Data for this metric is taken from the Trust's patient system, PARIS.

8. Complaints data is compiled from the number of written complaints received by the Trust and is reported annually to the Department of Health.

9. The National Patient Survey for 2009/10 is an Inpatient Survey which is not directly comparable to the Community Surveys undertaken in 2007/08 and 2008/09.

Comments on performance

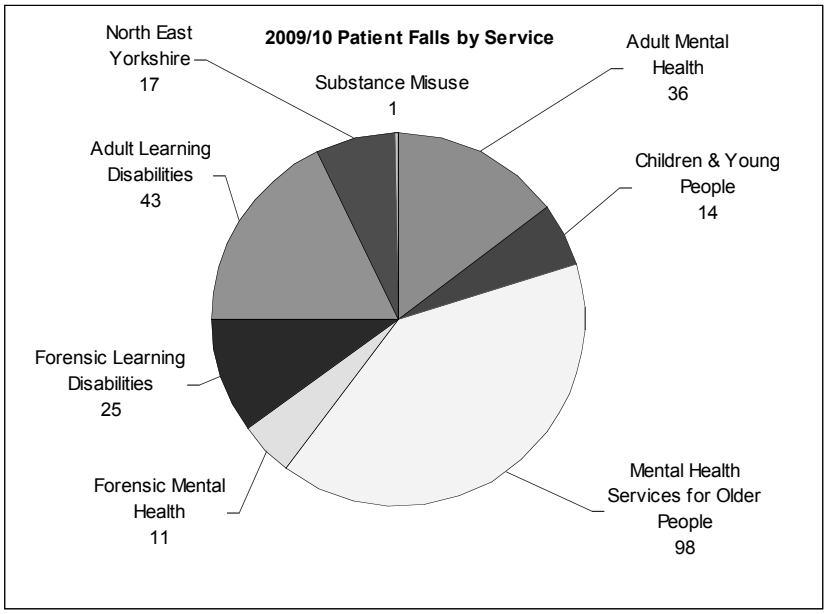
Metric 1 - We aim to deliver safe, high quality care and are actively working towards reducing the number of unexpected deaths which is demonstrated by the reduction in numbers between 2008/09 and 2009/10. However we will continue to work to reduce the number of people who die unexpectedly. All unexpected deaths are investigated fully with action taken where appropriate. The following chart shows the breakdown by services for 2009/10. Whilst the majority of unexpected deaths are within Adult Mental Health Services, there are no obvious trends or clusters identified.



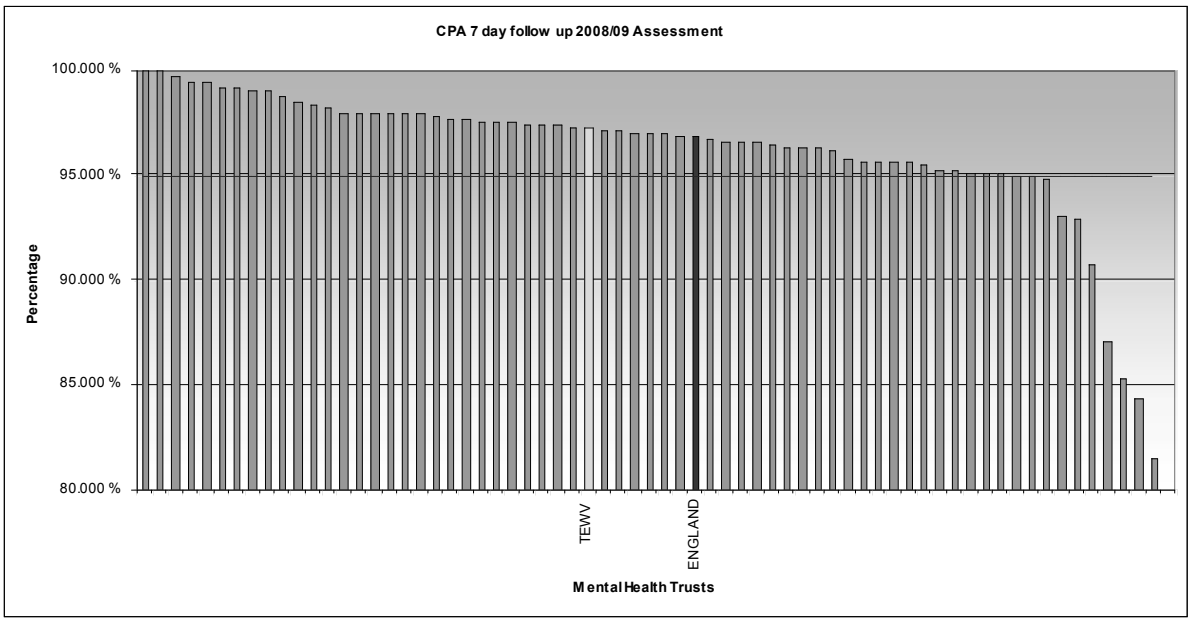
Metric 3 – The majority of patient falls occur within the Older People's Service therefore extra support in managing falls has been made available:

- Falls Assessment Teams are operational in most localities assessing people in wards and community teams.
- Audits have been undertaken against Guideline 21 falls and the fracture neck of femur audit.
- The Falling Stars initiative is being extended as an alert on the patient information system PARIS.
- Work has also been undertaken around unobserved falls.
- The service have identified link people from each ward and work to ensure access to supervision around this aspect of care has been undertaken.

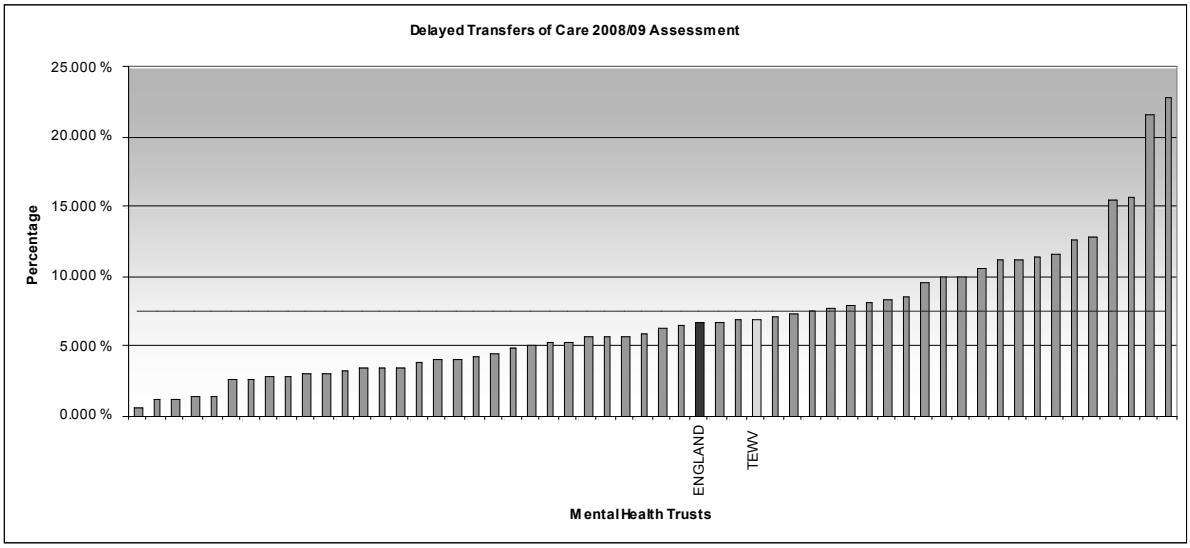
The following chart shows the breakdown by services for 2009/10.



Metric 4 – The trust continues to meet the nationally set target for CPA 7 day follow up; however focus is now also on the number of follow ups which are face to face with the patient as opposed to a telephone call. A target of 75% has been agreed with commissioners for 2009/10 in relation to the percentage of follow ups completed face to face. The latest available benchmarking information for this metric is that published by the Care Quality Commission in the **2008/09 Annual Assessment of Quality of Services**. The Trust (TEWV) achieved this indicator and was higher than the England average as illustrated below.

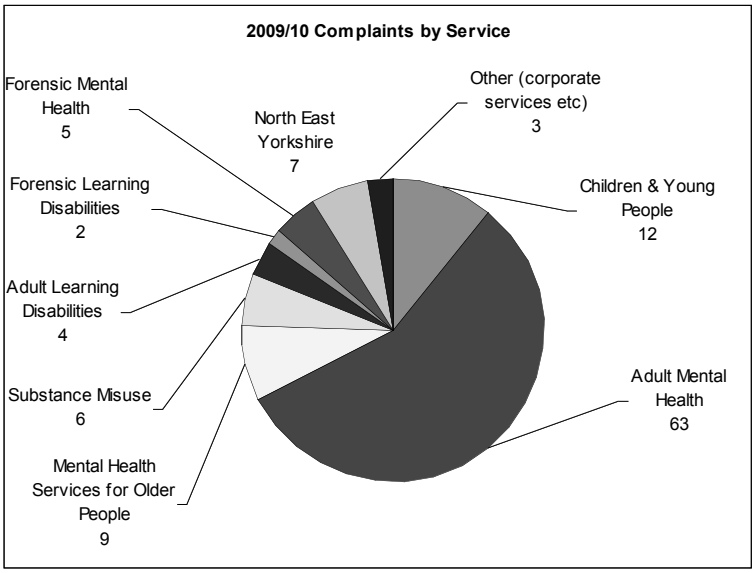


Metric 7 – The trust continues to reduce delayed transfers of care by monitoring the number of delays on a weekly basis. The latest available benchmarking information for this metric is that published by the Care Quality Commission in the **2008/09 Annual Assessment of Quality of Services**. Please note the calculation used by the Care Quality Commission in their assessment is different to that used by Monitor hence the different figure presented for the Trust in the following graph. The Trust achieved this indicator as illustrated below.



Metric 8 –The Trust received more complaints than expected and is therefore above the annual target with the majority of complaints received relating to Adult Mental Health Services however there is no specific theme or trend. Complaints are monitored by the Clinical Governance & Risk Committee and are thoroughly investigated. Both the Patient Liaison Department and Patient Advice and Liaison Service (PALS) strive to resolve as many concerns/complaints as possible informally. For 2010/11 the trust will monitor the percentage of complaints satisfactorily resolved by the Trust as opposed to an absolute number as this if felt to be a more effective measure of quality.

The following chart shows the breakdown by services for 2009/10.



Metric 9 – Whilst we cannot compare the Inpatient Survey of 2009/10 directly with the Community Surveys of 2008/09 and 2009/10, the trust is in the highest performing 20% of trusts for 16 measures and has no scores in the lowest 20%.

In 2009 37 Trusts also undertook a voluntary survey on community mental health services and we received the highest overall level of satisfaction of any of the 37 trusts.

Our performance against national targets and regulatory requirements

The following table demonstrates how we have performed against a wide range of targets set for us by the Department of Health, our regulator Monitor and our commissioners.

		2009-2010						2008-09 for comparision	2007-08 for comparision
		Target	2009-10	Q4	Q3	Q2	Q1		
a	The Trust has fully met the HCC Core Standards at year end	Fully met	Fully met	N/A				Fully met	Fully met
b	Registration re: Health Care Associated Infections	Fully comply	Fully complied	N/A				N/A	N/A
c	Number of occupied bed days of under 18s admitted to adult wards	N/A	173	3	59	42	69	104	79
d	Retention Rate: Substance Misuse (rolling 12 months) *(as at end of Nov 09)*	87.8%	89.7%	Not available until 3 months passed		89.3%	88.8%	87.8%*	82.6%
e	Number of Early Intervention in Psychosis New Cases (cumulative position)	230	407	407	305	205	119	301	236
f	Number of Crisis Home Treatment Episodes	2978	5191	1413	1256	1275	1247	3944	3865
g	Percentage admission to inpatient services that had access to CR/HT Teams	90.0%	97.2%	98.3%	97.0%	96.6%	96.9%	94.5%	N/A
h	CPA 7 day follow up	95.0%	97.5%	97.3%	98.7%	97.5%	96.6%	97.3%	99.0%
i	Maintain level of Crisis Resolution Teams set out in 03/06 planning round	Maintain	Maintained	N/A				Maintained	Maintained

* denotes update to previously reported information as this figure is reported nationally 3 months behind to allow for the 12 week period in this target to finish therefore this was not known at time of publishing last year's Quality Report.

Notes on national targets and regulatory requirements
b This target is a new regulatory requirement from 1st April 2009 and therefore no data is available for comparison.
c. Retention rate - the information shown for 2009/10 is the latest published position (Nov 08-Oct 09).
g. This target did not exist in 2007/08 and so no data is available for that period.

Comments on performance

a - All Trusts are required to make a declaration that their organisation has met the core standards between 1st April 2009 and the 31st October 2009. This was submitted to the Care Quality Commission in December 2009 and based upon the controls and evidence provided within the Standards for Better Health self assessment proformas, Trust Board has declared full compliance with the core standards.

b - We applied for registration against Healthcare Associated Infection from 1st April 2009. The requirement of the registration was that:

'a service provider in respect of carrying on of a regulated activity must, so far as reasonably practicable, ensure that patients healthcare workers and others who may be at risk of acquiring a health care associated infection are protected against identifiable risks of acquiring such an infection by the means specified in the regulations'.

We declared full compliance to this and will be measured on the nine criterion elements of the Code of Practice, which is part of the associated guidance from the Health and Social Care Act 2006, (updated in 2008 when the full registration process came into place) We received unconditional registration in April 2009 in relation to Healthcare Associated Infection.

c - We have had more occupied bed days for under 18s on adult wards compared to that in 2008/09 however we continue to only admit patients where it is deemed clinically appropriate in line with guidance published during 2008/09. Whilst the number of occupied bed days has nearly doubled between 2008/09 and 2009/10, the number of patients has only risen slightly from 17 to 20.

e – We achieved the required level of Early Intervention in Psychosis New Cases prior to financial year end.

f – We achieved the required level of Crisis Home Treatment Episodes prior to financial year end.

g – We continued to achieve above the target level for percentage of admissions to inpatient services that had access to crisis teams throughout 2009/10.

h – We continued to achieve above the target level for CPA 7 day follow up throughout 2009/10 and as mentioned previously, the focus is now on the number of follow ups which are face to face with the patient as opposed to a telephone call.

STATEMENTS FROM COUNTY DURHAM AND DARLINGTON PCT, DARLINGTON HEALTH AND WELL BEING SCRUTINY COMMITTEE AND DARLINGTON LINKS

We shared the final draft of our Quality Report with our 3 main commissioners, our seven Overview and Scrutiny Committees and our seven LINks organisations and asked them for comments. In line with the guidance we have included below the comments received from the commissioner that covers the largest population, and the OSC and LINks in the local authority I which our main office is located. (Darlington). (In addition presentations were given to Darlington Health and Wellbeing Scrutiny Committee and County Durham Overview and Scrutiny Committee at their request.)

We always welcome feedback on the work we do and try to act on that feedback. Therefore in response to the feedback from Darlington Health and Wellbeing Scrutiny Committee we have included a Contents page and a Glossary in our final Quality Report to help make the Report more accessible. Furthermore we have received feedback on how we have implemented the guidance on which comments a provider should include. The Board have given a commitment to review this approach for 2010/11 if the guidance from the Department of Health remains the same.

County Durham and Darlington PCT Statement

NHS
County Durham and Darlington

Our Reference YC/BK/sh
Your Reference

Direct line 0191 374 4169
Main number 0191 301 1300
Fax 0191 374 4103
E-mail cd-pct.offenderhealth@nhs.net
yasmin.chaudhry@nhs.net

John Snow House
Durham University Science Park
Stockton Road
Durham
DH1 3YG

19th May 2010

Martin Barkley
Chief Executive
Tees Esk and Wear Valley NHS Foundation Trust
West Park Hospital
Edward Pease Way, Darlington,
County Durham
DL2 2TS

Dear Martin,

Thank you for the opportunity to comment on your quality account for 2009/10.

I confirm the accuracy and fairness of your report's account of the range of services provided by Tees, Esk and Wear Valley NHS Foundation Trust.

Your three priorities of:

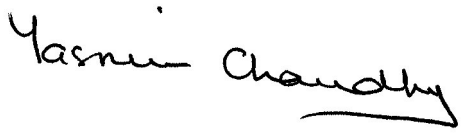
- Reducing the number of incidents of violence and aggression
- Reducing waiting times for first contact and treatment
- Further implementation of the TEWV quality improvement system

aligned well with our commissioning perspectives and continue the trust`s commitment to quality innovation and cost effectiveness.

Commissioners were particularly pleased to see the trust`s clear plan for innovation and improvement, its strong emphasis on partnership planning and delivery for children and young people and the demonstrable progress you have made in reducing length of stay in adult and older people's in patient care.

As we move into 2010 and the first year of implementing the new national contract and its associated incentives, we look forward to working in renewed partnership with you to further enhance patient safety, experience and outcomes.

Yours sincerely



Yasmin Chaudhry
Chief Executive
NHS County Durham and Darlington and Chair of North East MH/LD Commissioning Group

Cc Brian Key, North East Director of Commissioning Mental Health, Leaning Disabilities and Offender Health
Sharon Pickering, Director of Quality

Darlington Health and Wellbeing Scrutiny Committee Statement

Quality Accounts – Tees, Esk and Wear Valleys NHS Foundation Trust

The Health & Well Being Scrutiny Committee recognises the constraints imposed upon the Trust by the requirement to conform to the guidance provided with the regulations. Members have recognised the amount of work that has gone into producing the document and acknowledge the difficulties that have arisen this year.

A Group of Members of the Health & Well Being Scrutiny Committee were charged with scrutinising in detail the draft Quality Accounts. Members noted that the Trust has received full registration with the Care Quality Commission.

Members' perception is that the Trust has produced a lengthy technical document that will not be readily accessible to the general public and if the document remains in its current form will fail in its aim of improving public accountability. The format was satisfactory, but could be improved to make it more user friendly. Although, they welcomed the use of colour, but thought that the use of more and pictures would add to the document.

Members feel that their comments are limited on this year's document as they found it difficult commenting on an incomplete document. Having said that, they thought the priorities are explained very well.

Members would welcome the inclusion of a Contents and Glossary of Terms pages. There was a high volume of abbreviations/acronyms used throughout the document with no explanations.

Members have expressed concerns about the process involved in the production of the Quality Accounts and the involvement of other Stakeholders. Members have a keen desire to be more involved during the production of the Quality Accounts, in future years, from the beginning of the process. They would like to see the process through and watch the document evolve.

Overall, Members thought that the document was representative of Trust and its services and do not believe that there are any considerable omissions.

DARLINGTON LINks Statement

Darlington LINk
eVOLution
Church Row
Darlington
DL1 5QD
info@darlingtonlink.co.uk
Tel: 01325 380145

Chief Executive Office
West Park Hospital
Edward Pease Road
Darlington
DL2 2TS

Ref:-Tees Esk Wear Valley 2009/2010 Quality Accounts

Dear Sharon

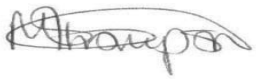
Thank you for the opportunity to meet, discuss and view Tees Esk and Wear Valley Foundation Trust's Quality Accounts for 2009/10.

Darlington LINk feels that the Trust's Quality Accounts seems accurate and representative of the quality of service provided by the Trust from the information available and it has given us comprehensive details of the services delivered over the year.

LINk members did however find some of the report hard to read and would welcome an opportunity to be involved in the development of the Trust's quality agenda and priorities in future years.

We hope the Trust will find the comments helpful. We look forward to working with you in the future.

Yours sincerely



Michelle Thompson
Chair
Darlington LINk

Appendix 1

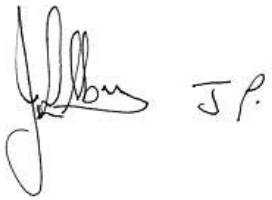
STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor 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 quality report presents a balanced picture of the foundation trust's performance over the period covered;
- the performance information reported 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 Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at http://www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at http://www.monitor-nhsft.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.
By order of the Board

Martin Barkley
Chief Executive



John Robinson
Deputy Chairman
(on behalf of the chairman)

3 June 2010

Appendix 2

STUCTURED BOARD VISITS APRIL 2009 – MARCH 2010

VISIT	VISITING PANEL MEMBERS
3.00 p.m. – 5.00 p.m. **Tuesday 28 April 2009** **Old Vicarage, Station Road,** **Seaham, SR7 0BH**	Jo Turnbull, Chairman Martin Barkley, Chief Executive Mike Newell, Non Executive Director Chris Parsons, Director of Estates and Facilities Management
3.00 p.m. – 5.00 p.m. **Tuesday 26 May 2009** **Adult Community Mental Health Team,** **Hundens Lane, Darlington**	Jo Turnbull, Chairman Martin Barkley, Chief Executive Jim Tucker, Non Executive Director Les Morgan, Chief Operating Officer
3.00 p.m. – 5.00 p.m. **Tuesday 30 June 2009** **Child Short Break Service** **179 Normanby Road,** **Middlesbrough, TS6 6SR**	Jo Turnbull, Chairman Martin Barkley, Chief Executive Graham Neave, Non Executive Director Sharon Pickering, Director of Planning and Performance
3.00 p.m. – 5.00 p.m. **Tuesday 28 July 2009** **Substance Misuse** **Ellis Centre, Dean Road,** **Scarborough, YO12 7SN**	Jo Turnbull, Chairman Martin Barkley, Chief Executive John Robinson, Non Executive Director Chris Parsons, Director of EFM
3.00 p.m. – 5.00 p.m. **Tuesday 29 September 2009** **Adult Mental Health Services,** **Derwent Clinic, Derwentside**	Jo Turnbull, Chairman Martin Barkley, Chief Executive Andrew Lombard, Non Executive Director David Levy, Director of HR and OD
3.00 p.m. – 5.00 p.m. **Tuesday 27 October 2009** **Psychology,** **Viscount House, Stockton on Tees, TS18 3TX**	Jo Turnbull, Chairman Martin Barkley, Chief Executive Paul Briggs, Non Executive Director Colin Martin, Director of Finance and Information

3.00 p.m. – 5.00 p.m. **Tuesday 24 November 2009** **Mental Health Services for Older People** **Sedgefield Community Hospital, TS21 3EE**	Jo Turnbull, Chairman Martin Barkley, Chief Executive Douglas Taylor, Non Executive Director Chris Stanbury, Director of Nursing and Governance
3.00 p.m. – 5.00 p.m. **Tuesday 26 January 2010** **Adult Mental Health Services, New Lanchester Road Hospital, Durham**	Jo Turnbull, Chairman Martin Barkley, Chief Executive Jim Tucker, Non Executive Director Les Morgan, Chief Operating Officer
3.00 p.m. – 5.00 p.m. **Tuesday 2 March 2010** **Learning Disability Services, Green Lane, Spennymoor**	Jo Turnbull, Chairman Martin Barkley, Chief Executive Mike Newell, Non Executive Director Chris Stanbury, Director of Nursing and Governance
3.00 p.m. – 5.00 p.m. **Tuesday 30 March 2010** **Learning Disability Services Upperthorpe, Darlington**	Jo Turnbull, Chairman Martin Barkley, Chief Executive John Robinson, Non Executive Director Chris Parsons, Director of EFM

Appendix 3

ACTION TO BE TAKEN FROM 47 LOCAL CLINICAL AUDITS THAT HAVE BEEN REVIEWED BY TEWV NHS FT

Clinical Audit of FACE Risk Profile Screening Tool Mental Health Services for Older People (MHSOP)

Actions
- Staff to ensure that the FACE risk assessment tool has been fully completed and that all available information is used to complete the tool.

Clinical Audit of NICE CG22 – Management of Anxiety MHSOP

Actions
- Collect local information on self help methods or support groups.
- Ensure patient information leaflets re: medication and anxiety management are available.

National Audit/ Privacy and Dignity – linked with Productive Ward Programme MHSOP

Actions
- Individual action plans have been issued to each ward and department highlighting areas for actions/ consideration. These are to be monitored by Modern Matrons and Associate Modern Matrons to ensure that actions have been completed.

Care Co-ordination (CPA) in Mental Health Services for Older People

Actions
- Ensure comprehensive assessment is completed within 28 days of receipt of referral.
- Wherever a carer is identified there must be evidence a carer's assessment is offered.
- Ensure that ICD10 codes are recorded where appropriate (on comprehensive assessment and care plan review documents in PARIS).
- Ensure that ethnicity, religion and language of the service user are recorded on the comprehensive assessment document.
- Following assessment, the summary of needs section must be completed on the assessment document in order to inform the care plan.
- All service user records must have their CPA or Standard care level identified at the care plan and care plan review stage.
- Every service user record must evidence they have an identified Care Co-ordinator/ Lead Professional at the care plan/ care plan review stage.
- All care records must demonstrate that copies of care plans (following assessment and review) are given to service users.
- Care records must contain evidence of service user involvement / views expressed in care plans and care plan reviews.
- As part of every care plan and care plan review the service user record must show the next agreed review date.

- Carer involvement (where applicable) must be evidenced in the service user record with care plans and care plan reviews.
- Care records must contain evidence of a medication side-effects monitoring tool being used where applicable at assessment and care plan review stages.
- Every service user record must evidence, at care plan review that all services/professionals involved in the delivery of the care plan contributed to the review.
- Ensure that a copy of the care plan has been sent to the service user GP and other relevant service providers who do not have access to Paris.
- A care plan review must be carried out and recorded prior to discharge of a service user from inpatient care.
- Following discharge from inpatient care (except respite care) a 7 day follow-up contact must be carried out and recorded.
- On every occasion when a service users' care/support/treatment is transferred their record must evidence a care plan review took place prior to this transfer.

Electroconvulsive Therapy Accreditation Scheme (ECTAS) Interim Self-Review (Royal College of Psychiatrists) re-audit (Central)

Actions
- Mini Mental State Examination (MMSE) and Adenbrookes Cognitive Examination (ACE-R) to be completed pre, mid and end point of treatment, incorporated within ECT Pathway.
- All referring medical Staff must comply with ECT National Institute for Health & Clinical Excellence (NICE) Guidelines/ECTAS Standards and document this within PARIS Record.
- All Anaesthetists to be aware of the need to document ASA Grade pre Treatment as per ECT Pathway.

Clinical Audit of Physical Health Assessments for Inpatients (admitted more than15 months ago) (Central)

Actions
- Policy amendment or Clinical Directorate action. Clinical Directorate action should be in the context of the strategy which describes a number of steps to improve the audit results, including the development of PARIS incorporating the identification of staff responsible for each piece of information and the development of local visual quality indicators.

Clinical Audit of Physical Health Assessments for Community Patients (Central)

Actions
- A standard template for *'physical health information to be requested from GPs'* to be developed and discussed with Primary Care Trusts (PCTs), with the aim that this information is available at the time of the annual review.

Emergency Equipment (re-audit) (Central)

Actions
- All emergency equipment is checked daily and the check recorded. All areas to have a full set of replacement equipment for implementation of resuscitation.
- All staff receive cascade training on the use of the backpack and equipment which is recorded on the appropriate documentation.

Do Not Attempt to Resuscitate (DNAR) Audit (Central)

Actions
- DNAR forms are to be completed appropriately including completion of review dates and using the correct documentation.
- DNAR order documents to become part of the controlled stationery system.

Audit of all TEWV NHS Trust Rented Oxygen Cylinders and Regulators (Central)

Actions
- All areas ensure their oxygen cylinders are stored safely and securely.
- Spare cylinders that are stored upright should be adequately restrained, they should not be free standing as they risk falling over injuring staff or service users, and could also damage cylinders.
- Oxygen warning signs to be displayed where oxygen is stored.
- The Medical Devices & Clinical Procedures group to look at standardising to one supplier of oxygen for larger cylinders and minimise the range of cylinder sizes available. The standardisation of integrated oxygen cylinders would also be preferable for ease of use and maintenance.
- The Medical Devices & Clinical Procedures group to develop procedural guidelines regarding oxygen administration, storage and safety.

Clinical Audit of CG38 – Bipolar Disorder: The management of bipolar disorder in adults, children and adolescents, in primary and secondary care (AMH)

Actions
- All female patients of child-bearing potential where no effective alternative to valproate had been identified must receive an explanation regarding the need for adequate contraception and the risks of taking valproate during pregnancy.
- All patients must receive an annual physical health review and the results documented fully in PARIS.
- All patients must have a relapse prevention plan that includes coping strategies, self monitoring and lifestyle patterns.
- Following an ineffective trial of a combination of prophylactic agents patients should be referred or discussion takes place with a specialist in Bipolar disorders.

Clinical Audit of CG31 (Re-audit) – Obsessive-Compulsive Disorder: Core interventions in the treatment of obsessive-compulsive disorder (OCD) and body dysmorphic disorder (BDD) (AMH)

Actions

- All practitioners to ensure clients with OCD/BDD diagnosis have the ICD10 code recorded on PARIS enabling a higher sample size to be extracted for the re-audit in 2010/2011.
- A minimum of one person per team should have undergone CBT training for anxiety disorders.
- All areas to have lists of self help/groups where clients can access information on OCD or BDD disorders.
- Information prescription to be developed for OCD/BDD and to be made available through the Trust intranet site.

Care Co-ordination in Adult Mental Health Services

Actions

- All service users' records must (where applicable) include details of the identified nearest relative and contact information.
- All new assessments will be completed and signed off within the agreed 28 days from acceptance of referral time-frame.
- Ensure that every service user record has detail of any known allergies for that individual.
- Every service user record must show their religion, ethnicity and language (or an indication they have declined to share this information).
- A summary of needs must be recorded for all service users in the comprehensive assessment document.
- CPA/Standard Care levels must be recorded for all service users at care planning and review stage.
- Evidence of service user involvement must be recorded at care planning and review points in care.
- An assessment of side-effects of prescribed medication must be carried out where applicable at assessment and review points in care.
- Where a service user has had an in-patient episode, the care record must demonstrate a pre-discharge review has taken place.
- On every occasion when a service users' care/support/treatment is transferred their record must evidence a care plan review took place prior to this transfer.
- Every service user record must show, following assessment and at every care plan review, a diagnosis and ICD10 code.
- Every service user discharged from a hospital stay (except respite) must be followed up and a record made in their notes within seven days.
- A "next review date" must be indicated in every service user record as part of every care plan and care plan review.
- Care records for every service user must evidence that they were given a copy of the agreed care plan and subsequent care plan following review.
- The service user's record must show that the persons GP was sent a copy of the care plan and subsequent care plan following review.
- The service user's record must evidence that all involved professionals, services & agencies (outside the trust) have been sent a copy of the care plan and subsequent care plan following review.

Clinical Audit of NICE Clinical Guideline 22 – Anxiety in Secondary and Community Care (AMH)

Actions
- All clients must have a comprehensive holistic assessment documented on PARIS within 28 days.
- Outcomes of interventions should be monitored using short, self-complete questionnaires.
- All clients must be informed on the nature and course of their illness as well as side effect profiles which must be documented on PARIS. Cultural characteristics, that may be important considerations in subsequent care, must be documented on PARIS.

Clinical Audit of NICE Clinical Guideline 22 – Anxiety in Adult Mental Health (AMH) Primary Care

Actions
- Primary Care clinical teams to be made aware of audit recommendations.
- Recommendations relating to medication and provision of support groups details to be discussed for individual patients during relevant clinical supervision sessions.

Delivering Single Sex Accommodation – Privacy and Dignity Audits (AMH)

Actions
- Individual action plans have been issued to each ward and department highlighting areas for action/consideration. These are to be monitored by Modern Matrons and Associates to ensure that actions have been completed.

Clinical Audit of NICE Clinical Guideline 25 – Violence (AMH)

Actions
- Service user's preferred strategies in the event of a disturbed/ violent incident must be documented on the Care Plan.
- Risk assessments must be fully completed with no areas of omission. Re-audit 2010/2011 extending the sample size.
- All information given to service users on admission must be documented on PARIS.
- Results of the audit to be publicised via relevant Governance systems to ensure nursing staff involved in risk assessments and disturbed/ violent incidents are informed.

Clinical Audit of FACE Risk Profile Screening Tool (AMH)

Actions
- Good standards achieved – re-audit in 12 months.

Clinical Audit of Suicide Prevention (Central) (re-audit)

Actions
- Local action plans will be developed by February 2010 and the Suicide Audit Project Group (commencing August 2010) will review progress against these plans.

Clinical Audit of Dual Diagnosis Training & Clinical Structure (Central)

Actions
- Trust wide policy implementation plan to be devised relating to nomination, capability appraisal, training and development of dual diagnosis leads across all Trust localities and directorates covered by the policy.
- Trust wide policy implementation plan to also include arrangements for assessing and Trust executive lead for Dual Diagnosis/General Managers/Team Managers developing staff capabilities across all professional groups. This is to include flexible ways of accessing training and development including e-learning.
- Review Trust wide Dual Diagnosis Practitioner roles to ensure that sufficient staff are in place to support dual diagnosis leads.
- Trust wide monitoring and audit arrangements of training and clinical structure implementation to be agreed.

Audit of Compliance with 'Care and Management of Dual Diagnosis' Policy (Central)

Actions
- Trust wide policy implementation plan to include clarifying arrangements for conducting and recording screens. To include completion of fields relating to substance use in Lifestyle checks on PARIS at Initial assessment and CPA review and clarification of clustering for dual diagnosis cases in summary of assessment of risk need (SARN).
- Trust wide policy implementation plan to include arrangements for improving dual diagnosis care planning. This will include Substance Misuse staff being involved in Service Users' Care must be invited to care planning meetings and CPA reviews.
- Trust wide policy implementation plan to be agreed to outline arrangements for nomination of dual diagnosis leads and development of dual diagnosis capabilities within teams.
- Agree Trust wide arrangements to monitor and audit widespread staff compliance to the policy.

Clinical Audit of Trauma: NICE Clinical Guideline 26 – Post Traumatic Stress Disorder (PTSD) (AMH)

Actions
- All patients prescribed medication must be informed of side effects and discontinuation withdrawal symptoms and this must be evidenced in patient's care record.
- Consider if improvements required within teams in the screening and diagnosis of PTSD and trauma.
- Ensure all staff are aware of the trauma pathway for the Trust.

Clinical Audit of NICE CG9 - Eating Disorders (AMH) (re-audit)

Actions

- Increased number of written agreements between health care professionals to identify who is responsible for monitoring the service users' needs.
- Standardised information leaflet for service users on course, nature and treatment of eating disorders.
- Standardised self help and support information for carers.
- Identify interpersonal therapy (IPT) supervisor to all specialist practitioners to continue their training.
- Identify access to cognitive analytical therapy (CAT) practitioner as required e.g. through team or accessing the trust's CAT service.

Clinical Audit of NICE TA97 – Computerised Cognitive Behavioural Therapy (CCBT) (AMH)

Actions

- Monitor recommendations via psychological therapies governance group.
- Interpret and disseminate the reappraisal of CCBT by NICE (expected completion autumn 2009).
- Repeat audit in 2011.

Care Co-ordination in Children and Young People's Services (C&YPSs)

Actions

- All service users' records must (where applicable) include details of the identified nearest relative and contact information.
- All new assessments will be completed and signed off within the agreed 28 days from acceptance of referral time-frame.
- Ensure that every service user record has detail of any known allergies for that individual.
- Every service user record must show their religion, ethnicity and language (or an indication they have declined to share this information).
- A summary of needs must be recorded for all service users in the comprehensive assessment document.
- CPA/Standard Care levels must be recorded for all service users at care planning and review stage.
- Evidence of service user involvement must be recorded at care planning and review points in care.
- An assessment of side-effects of prescribed medication must be carried out where applicable at assessment and review points in care.
- Every service user record must show, following assessment and at every care plan review, a diagnosis and ICD10 code.
- A "next review date" must be indicated in every service user record as part of every care plan and care plan review.
- Every service user record must evidence that all services/ professionals/ agencies involved with the care plan has contributed to the review process
- Care records for every service user must evidence that they were given a copy of the agreed care plan and subsequent care plan following review.
- The service user's record must show that the person's GP was sent a copy of the care plan and subsequent care plan following review.

- The service user's record must evidence that all involved professionals, services & agencies (outside the trust) have been sent a copy of the care plan and subsequent care plan following review.
- The Care Co-ordinator or Lead Professional should be identified at the care planning stage.
- The appropriate risk assessment tool should be completed for all service users at the assessment and care planning stages.
- The appropriate outcome tool should be completed for all service users at the assessment and care planning stages.
- Every service user record, where there is a period of admission (except respite), must evidence a pre-discharge care plan took place.
- Wherever the transfer of care/support/treatment takes place every service user record must evidence a care plan review took place prior to the transfer.

National Audit /Privacy & Dignity - linked with Productive Ward Programme of Work –Young People's Inpatient Services

Actions
- Individual action plans have been issued to each ward highlighting areas for action/consideration. These are to be monitored by Modern Matrons and Associates to ensure that actions have been completed.

Clinical Audit of NICE Clinical Guideline 38 Bipolar Disorder: The management of bipolar disorder in adults, children and adolescents, in primary and secondary care (C&YPS)

Actions
- Training of staff in assessment tools such as the Kiddie SADS (Schedule for Affective Disorders and Schizophrenia) and Comprehensive Assessment for At Risk Mental State (CAARMS).
- Present audit results at a peer forum, for example, C&YPS Medics, Continuing Professional Development and multi-disciplinary Clinical Audit and Effectiveness meetings.
- Re-audit in 18 months' time.

Re-audit of Clinical Audit of Standards for Drug Administration Recording (Omissions) December 2009 (Pharmacy)

Actions
- Ward/unit managers should discuss with staff:
  - the importance of correctly completing the administration record on the Drug Prescription and Administration Record Charts in respect of professional and legal accountability.
  - possible reasons for non-recording of drug administration and look at ways to remedy this in order to continually improve the standards of recording and ultimately patient care.

Red Border Screening Tool (C&YPS)

Actions
- The action plan specifies regular review of the risk assessment tool, to comply with the standards described in the Clinical Risk Assessment and Management Policy is completed.
- All Red Border Risk assessment tools are fully completed.

Clinical Audit of FACE Risk Profile Screening Tool (Early Intervention in Psychosis)

Actions
- The action plan specifies all risk assessments document information regarding the severity, frequency and potential outcome of the risk behaviours.

START Risk Profile Screening Tool

Actions
- Staff to evidence on the PARIS system that discussions have been held with service users and their carers, where appropriate, and that individuals agree with the assessment and subsequent care plan.

Samurai III - Risk Profile Screening Tool

Actions
- Staff to ensure a review of risk assessment tools and practice is completed as described in the Clinical Risk Assessment and Management Policy.

Delivering Single Sex Accommodation Privacy and Dignity Audits (Forensic Services)

Actions
- Individual action plans have been issued to each ward and department highlighting areas for action/consideration. These are to be monitored by Modern Matrons and Associates to ensure that actions have been completed.

Care Co-ordination in Adult Forensic Services

Actions
- Services need to establish, as routine, the collection of nearest relative details. Where applicable the recording of nearest relative should be held in every service user record.
- An ICD10 (Diagnosis code) must be completed for all services users (at assessment and care plan review).
- An assessment of health and social care needs (comprehensive assessment) should be completed within 28 days of acceptance of referral for every service user.
- Upon discharge from an in-patient unit the service user's record must demonstrate the GP received a copy of the agreed discharge care-plan and up to date risk assessment.
- Following agreement of a care plan or completion of a care plan review the next review date must be indicated in the service user's record.

- All service users' records must show we have asked them to identify their "Religion", "Ethnicity" and "Language" (are there any language issues?)
- A summary of needs must be recorded in the comprehensive assessment document for each service user. This is vital for informing the subsequent care plan.
- Wherever a service user is discharged from an in-patient stay their record must show a seven day follow-up contact within seven days of the discharge date.

Care Co-ordination (CPA) in Learning Disability & Learning Disability (LD) Forensics Services

Actions

- All service user records must hold contact details for their nearest relative (wherever applicable).
- Every service user record must have a completed risk assessment at the point of assessment and care plan review, as a minimum standard.
- A service user record must show whether they have any known allergy.
- A diagnosis and ICD10 code must be identified in the service user record at assessment and as part of the care plan review.
- The appropriate outcome must be completed as part of the service user record for every assessment and care plan review.
- Every service user record must evidence that a copy of the agreed care plan, at assessment and care plan review, has been sent to their GP and to any other services/ professionals.
- Every care plan and care plan review for a service user must show their CPA or Standard care level.
- The service user record must show evidence that they were involved in the development of a care plan and at the point of care plan review.
- The service user record must evidence that the service was given/offered a copy of the agreed care plan.
- All service user records must show the next planned review date following the development of a care plan (including following care plan review).
- All service user records must show (where applicable) they were offered the option of direct payments to support appropriate elements of their care plan.
- The service user record must show a contemporaneous account of progress against intended outcomes.
- All new assessments must be signed off as completed and agreed within 28 days.
- Every service user record, who has had an in-patient episode, must demonstrate a pre-discharge review has taken place.
- On every occasion when a service users' care/support/treatment is transferred the record must evidence a care plan review took place prior to this transfer.
- Care records for every service user must evidence that they were given a copy of the agreed care plan and subsequent care plan following review.

Clinical Audit of Methadone and Buprenorphine for the Management of Opioid Dependence (NICE Technology Appraisal 114) (Substance Misuse)

Actions
- Document discussions relating to assessing the patient's commitment / motivation needs and medication options.
- Re-audit to be conducted in 2010.

Re-audit of Clients Suspended from Treatment (Substance Misuse)

Actions
- Ensure incident forms are completed fully and sent in a timely manner
- All other options have been explored before suspension, risk assessed and documented prior to suspension taking place.

Clinical Audit of Shared Care (Substance Misuse)

Actions
- Continue to report incidents to PCTs re: lessons learnt and continuation of communication.
- Supervision and support arrangements should be available to all GPs providing Shared Care.
- NICE guidance should be followed in Services delivering Shared Care. Incorporate review of Shared Care Guidance and care record systems via Directorate Governance.
- Encourage service user involvement in the development of the service to include service user satisfaction cards.

Clinical Audit of FACE Risk Profile Screening Tool (EIP – North East Yorkshire)

Actions
- All risk assessments to document information regarding the severity, frequency and potential outcome of the risk behaviours.

Care Co-ordination (CPA) in North East Yorkshire

Actions
- Services need to establish, as routine, the collection of nearest relative details. Where applicable the recording of nearest relative should be held in every service user record.
- All records must show the comprehensive assessment of health and social care has been completed within 28 days.
- Every service user record must show ICD10 codes and diagnosis are recorded at the point of assessment (where this can be identified) and at care plan review.
- As part of every assessment the service user record must show a completed "Summary of Needs".
- Comprehensive assessments must identify religion/ethnicity/language as well as any unmet needs in every service user record.
- Care plan and care plan review must evidence, in every record, that the service was involved and had an opportunity to share their view.
- As part of every care plan (and care plan review) every service user record must indicate the agreed CPA or Standard Care level.

- Every service user record must show, where applicable, that housing, financial and employment issues are addressed as part of the care plan and care plan review.
- Care records must indicate that the service user, GP and other involved professionals/services/agencies have received a copy of the care plan
- The next care plan review date must be indicated in all records following the development of the care plans and in all care plan reviews.
- The service user record must show that all services/professionals involved in the delivery of the care plan contributed to the care plan review process.
- Every service user record must show evidence that the agreed outcome measure must be completed at assessment and every review.
- As part of every care plan and care plan review every service user record must evidence that direct payment was offered as an option to meet, the appropriate, aspects of the care plan.
- At assessment and care plan review every service user record must evidence the use, wherever applicable, of a medication side-effect monitoring tool.
- Following hospital discharge there must be evidence, in applicable service user records, that a pre-discharge care plan review has been completed.
- There must be documentary evidence, in every service user record where applicable, that the 7 day post discharge follow-up took place.
- On every occasion when a service user's care/support/treatment is transferred their record must evidence a care plan review took place prior to this transfer.

Controlled Drugs Audit (Pharmacy)

Actions
- The action plan specifies a copy of the three monthly controlled drug check report is to be sent to the ward manager. A resume of amalgamated results highlighted in the Safe Medication Practice Update action points for standards below 90%.

Clinical Audit of Obesity (NICE CG43) (AMH)

Actions
- Service users to be clinically assessed for either the presence of, or the risk of developing the following:- diabetes, hypertension, cardiovascular disease, osteoarthritis.

Clinical Audit of Rapid Tranquillisation (RT) (Central)

Actions
- Results of the audit to be publicised via relevant communication systems to ensure nursing staff involved in rapid tranquillisation are made aware of them
- Ward Managers will be informed of the need to discuss with staff the need for appropriate monitoring following the use of RT.
- Staff to be reminded via training that individuals should receive frequent and intensive monitoring following the administration of rapid tranquillisation whether administered parenterally or orally.
- Staff to be reminded via training that individuals who are subjected to RT should be debriefed and offered the opportunity to write their own account in the notes; if the patient declines this should be documented.
- IR1 incident reporting documentation to include specific code for the use of rapid tranquillisation.
- The audit cycle to be repeated in 12 months' time.

Clinical Audit of Supervision Manager's Questionnaire (Central)

Actions

- Ensure competence of Supervisors:-
  - Establish competence framework.
  - Measure competence of supervisors.
  - Support development of supervisors.
- Improve awareness of Supervisees -Deliver clinical supervision awareness training to all clinical staff
- Address issues in maintaining supervisory contracts:-
  - Assure that importance of contracts and issues in agreeing them are addressed in supervisor and supervisee training.
  - Assess impact of education – is this resolving the concern.

Clinical Audit of Supervision Staff Questionnaire (Central)

Actions

- Address variations in frequency of supervision – significant minority lower than trust policy standard
  - Clear direction as to frequency to supervisors and supervisees through mandatory training.
  - Support in-patient services to explore more efficient use of supervision time:-
    - Formalising supervision
    - Using group supervision
- Raising experience of empowerment for supervisees:-
  - Raising awareness of correct supervision process for supervisees.
  - Ensure that supervisee support and empowerment are identified in supervisor competency and training.
- Confirm number of nurses receiving supervision - next audit to confirm staff numbers per service and prompt to ensure high response rate

Clinical Audit of NICE CG21 Falls: The Assessment and Prevention of Falls in Older People

Actions

- Ensure that all patients are asked by clinical staff whether they had fallen, as part of the initial assessment.
- Education and guidance required on the use of Intervention Plans.
- Development of Trust standard Falls Assessment Tool.
- To utilise existing Falls Assessment Teams where applicable.
- Development of a Trust standard Osteoporosis Risk Assessment Tool.
- To ensure all staff utilise the Trust's Physical Examination Policy and adhere to its standards.
- Ensuring specialist assessment and FACE documents are completed appropriately.
- Education required for the correct procedure for lying and standing BP.
- Highlight the need for a Post Falls Checklist to the Trust Falls Pathway Group.
- Consideration to be given to adding the question "Is the patient frightened of falling?" to PARIS.
- Standard Falls Education Leaflet to be considered for the use of MHSOP patients/carers.

Nursing Collaborative Roseberry Ward, Bowes Lyon Unit, Durham (MHSOP) (Re-audit)

Action

- Nurses to inform patients and carers regarding their availability and ensure maximum visibility in the clinical area.

Appendix 4

GLOSSARY

Addenbrooke's Cognitive Examination (ACE-R): a more comprehensive tool used to screen for cognitive impairment, in particular dementia, which uses the Mini Mental State Examination (MMSE) as one of its components.

Annual Health Check: the Care Quality Commission's (formerly the Health Care Commission) method for assessing the performance of NHS organisations against national targets and standards associated with the quality of services and quality of financial management. Superseded in 2010/11 by a new system of registration

Annual Service User Survey: the annual survey of service users' experience of care and treatment received by NHS Trusts. In different years has focussed both on inpatient and community service users.

Annual Staff Survey: an annual survey of staffs' experience of working within NHS Trusts.

Care Programme Approach (CPA): describes the approach used in specialist mental health care to assess plan review and co-ordinate the range of treatment care and support needs for people in contact with secondary mental health services who have complex characteristics. It is a called "an approach" rather than just a system because the way that these elements are carried out is as important as the actual tasks themselves.

Care Quality Commission (CQC) ***(formerly the Health Care Commission):*** the independent regulator of health and social care in England who regulate care provided in hospitals, care homes and people's own homes by the NHS, local authorities, private companies and voluntary organisations, including protecting the interests of people whose rights are restricted under the Mental Health Act.

Cognitive Analytical Therapy (CAT): is a psychological approach to treatment in which the therapist helps the patient to understand why things have gone wrong in the past – and explores how to make sure that they don't go wrong in the future. Often viewed as a pragmatic approach.

Cognitive Behavioural Therapy (CBT): is an evidence-based psychotherapeutic approach that aims to solve mental health problems concerning dysfunctional emotions, behaviors and cognitions through a goal-oriented and systematic procedure.

Commissioning for Quality and Innovation (CQUIN): is a payment framework such that a proportion of NHS providers' income is conditional on quality and innovation. Its aim is to support the vision set out in *High Quality Care for All* of an NHS where quality is the organising principle.

Comprehensive Assessment for At Risk Mental State (CAARMS): an evidence-based tool designed to assess the risk of and imminence of a first episode of psychosis.

Computerised Cognitive Behavioural Therapy (CCBT): is a new method for delivering CBT via a computer (standalone PC or internet). Research has shown that CCBT improves anxious/depressed patients about as much as face to face therapy, but is also more cost- and time- efficient without any side effects. It provides a solution for many sufferers who often prefer its convenience, confidentiality and reduction of stigma.

Council of Governors: the Council of Governors is made up of elected public and staff members, and also includes non elected members, such as the Prison Service, Voluntary Sector, Acute Trusts, Universities, Primary Care Trusts and Local Authorities. The Council has an advisory, guardianship and strategic role including developing the Trust's membership, appointments and remuneration of the Non Executive Directors including Chairman and Deputy Chairman, responding to matters of consultation from the Trust Board, and appointing the Trust's auditors.

Dual Diagnosis: a diagnosis referring to a person with both mental health needs complicated by an alcohol or drug problem.

Electroconvulsive Therapy Accreditation Service (ECTAS): a service launched in May 2003 by the Royal Collage of Psychiatrists with the purpose to assure and improve the quality of the administration of Electroconvulsive Therapy – a well-established psychiatric treatment in which seizures are electrically induced in anesthetized patients for therapeutic effect..

Functional Analysis of Care Environments (FACE) Risk Profile Screening Tool: a portfolio of assessment tools designed for adult and older people's mental health settings. Risk is assessed using the FACE Risk Profile based on four factors: violence; self-harm / suicide; and self neglect / vulnerability.

General Medical Practice Code: is the code of the practice for patients registered with a GP which enables the GP to be notified about treatment received by the patient given that the registered GP may or may not be the same as the referring GP.

Health & Social Care Act (2008): contains significant measures to modernise and integrate health and social care. The Health and Social Care Bill contains four key policy areas: establishing the Care Quality Commission as a new integrated regulator for health and adult social care; reforming professional regulation in response to the Shipman Enquiry; a comprehensive set of public health measures to help prevent and control the spread of serious diseases caused by infection and contamination; and the Health in Pregnancy Grant - a one-off payment to expectant mothers, ordinarily resident in the UK, to help with the costs of a healthy lifestyle, including diet, in the later stages of pregnancy.

Hospital Episode Statistics (HES): is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, Government and many other organisations and individuals.

Information Governance Toolkit: is a national approach that provides a framework for assuring information quality against national definitions for all information that is entered onto computerised systems whether centrally or locally maintained.

International Classification of Diseases Version 10 (ICD-10): the international standard diagnostic classification. Used mainly for the analysis of the health of population groups and monitoring of the incidence and prevalence of diseases and other health problems in relation to other variables such as: the characteristics and circumstances of the individuals affected; resource allocation; quality and guidelines.

Kaizen: Japanese for "improvement" or "change for the better" and refers to a philosophy or practices that focus upon continuous improvement of processes. Underpins the TEWV Quality Improvement System (QIS)

Leading Improvement in Patient Safety (LIPS): a programme, led by the National Institute of Innovation and Improvement (NIII), to building the capacity and capability within hospital teams to improve patient safety, by helping NHS Trusts to develop organisational plans for patient safety improvements and build teams responsible for driving improvement across their organisation.

Learning Disability Quality Network: a network, led by the British Institute of Learning Disabilities, aimed at working together with people with learning disabilities, their families and supporters to bring about better outcomes, by helping organisations to look at what life is like for the people with learning disabilities they support, and to look at ways to improve.

Liaison Psychiatry: the branch of psychiatry that specialises in the interface between medicine and psychiatry often taking place in acute hospital settings.

Local Involvement Networks (LINks): local bodies made up of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services. They aim to ensure that each community has services that reflect the needs and wishes of local people.

Local Safeguarding Children's Boards (LSCB's): local arrangements based on a national framework within which agencies and professionals – individually and jointly – work together to safeguard and support the welfare of children.

Mental Capacity Act (2005): provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It makes it clear who can take decisions, in which situations, and how they should go about this. It enables people to plan ahead for a time when they may lose capacity.

Mental Health Act Report: an external review of NHS Trust's compliance with the Sections of the Mental Health Act (1983) Amended (2007) regarding the care and treatment of people detained under Sections of the Act.

Mental Health Research Network (MHRN): is part of and funded by the National Institute for Health Research and provides the NHS infrastructure to support commercial and non-commercial large scale research in mental health including clinical trials.

Mini Mental State Examination (MMSE): a brief 30-point questionnaire test that is used to screen for cognitive impairment. It is commonly used to screen for dementia. It is used to estimate the severity of cognitive impairment at a given point in time and to follow the course of cognitive changes in an individual over time, thus making it an effective way to document an individual's response to treatment.

Monitor: the independent regulatory body for NHS Foundation Trusts

National Confidential Inquiries (NCI): research projects funded largely by the National Patient Safety Agency (NPSA) that examine all incidents of, for example suicide and homicide by People with Mental Illness, with the aim is to improve mental health services and to help reduce the risk of these tragedies happening again in the future.

NHS Litigation Authority (NHSLA): the NHS body that handles negligence claims and works to improve risk management practices in the NHS.

National Institute for Clinical Excellence (NICE): NHS body that provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health. NICE works with experts from the NHS, local authorities and others in the public, private, voluntary and community sectors - as well as patients and carers - to make independent decisions in an open, transparent way, based on the best available evidence and including input from experts and interested parties.

National Institute for Health Research (NIHR): an NHS research body aimed at supporting outstanding individuals working in world class facilities to conduct leading edge research focused on the needs of patients and the public.

National Institute of Innovation and Improvement (NIII): NHS body supporting the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world-class leadership

PARIS: the Trust's electronic care record, product name PARIS, designed with mental health professionals to ensure that the right information is available to those who need it at all times

Patient Advice & Liaison Team (PALs): the team working with the Trust that provides advice and information about Trust services or signposting people to other agencies, and manages service users' and carers' comments, concerns or complaints.

Patient Safety Walkrounds: a trade-marked technique for improving quality within the overall TEWV Quality Improvement System (QIS)

Payment by Results: a new system being implemented across the NHS, and piloted in mental health Trusts, to provide a transparent, rules-based system for paying NHS Trusts. The system aims to reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity, adjusted for case-mix, and outcomes. Importantly, this system aims to ensure a fair and consistent basis for hospital funding rather than

being reliant principally on historic budgets and the negotiating skills of individual managers.

Prescribing Observatory in Mental Health (POMH): a national agency, led by the Royal College of Psychiatrists, that aims to help specialist mental health services improve prescribing practice via clinical audit and quality improvement interventions.

Productive Ward Programme: an initiative led by the NHS Institute for Innovation & Improvement. The programme comprises 13 modules which are designed for self directed learning by inpatient ward staff. The programme provides a no nonsense structure to enable front line staff across the multi disciplinary team to identify and implement improvements within clinical areas with the aim of releasing more time to care.

Purposeful Inpatient Admissions (PIPA): a model adopted within the Trust, that aims to ensure that all acute inpatient admissions have clarity in relation to three areas: reason for admission; a clear formulation as to the underpinning factors of this reason; a clear plan as to goals to be achieved to facilitate discharge, as quickly as is clinically appropriate

Quality Network for Forensic Mental Health Services: a network, led by the Royal College of Psychiatrists, aiming to facilitate quality improvement and change in forensic mental health settings through a supportive, multidisciplinary and peer-review network with the fundamental principle of listening to and being led by frontline staff and service users.

Randomised Injected Opiate Treatment Trial (RIOTT): a multisite, prospective open-label randomised controlled trial (RCT) examining the role of treatment with injected opioids (methadone and heroin) for the management of heroin dependence in patients not responding to conventional substitution treatment.

Rapid Process Improvement Workshop (RPIW): a technique for improving quality within the overall TEWV Quality Improvement System (QIS)

Rapid Tranquillisation (RT): is a management strategy, not regarded as a primary treatment technique, considered once de-escalation and other strategies have failed, normally employed to avoid prolonged physical intervention and when medication is required to calm a psychotic or non-psychotic behavioural disturbance, and describes the safe, effective and skilful use of medication to achieve sufficient sedation levels to minimise the risk posed to the patient or others.

Red Border Risk Assessment Tools: a technique used to ‘red flag’ to all members of the multidisciplinary team and partner organisations that a person has been assessed as ‘high risk’.

Safety Alert Broadcast System (SABs): an national electronic web based system accessed by NHS Trusts, which brings together all safety alerts from the National Patient Safety Agency (NPSA), Medicines and Healthcare Products Regulatory Agency (MHRA) and NHS Estates, which holds copies of all alert notices together with statistics on responses from NHS Trusts and Strategic Health Authorities.

Samurai III Risk Profile Screening Tool: a tool to assess risk and formulate care plans for young people with learning disabilities

Schedule for Affective Disorders and Schizophrenia for School-Aged Children (Kiddie SADS): is a semi-structured diagnostic interview designed to assess current and past episodes of mental illness, mental distress and abnormal or maladaptive behavior in children and adolescents.

Situation-Background -Assessment-Recommendation-Decision (SBARD) approach: a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety. Can also be used effectively to enhance handovers between shifts or between staff in the same or different clinical areas.

Summary of Assessment of Risk Need (SARN): a tool being developed and piloted by mental health NHS Trusts to cluster groups of patients by diagnosis and severity with a view to assigning resource requirements, essential to the implementation of Payment by Results in mental health.

TEWV Quality Improvement System (QIS): the Trust's framework and approach to continuous quality improvement.

Visual Control Boards: a technique for improving quality within the overall TEWV Quality Improvement System (QIS)

If you would like additional copies of this report please contact

The communications team
West Park Hospital
Edward Pease Way
Darlington
Co Durham
DL2 2TS
Email: enquiries@tewv.nhs.uk
Tel: 01325 552223

Our chairman, directors and governors can be contacted via the trust secretary's office at West Park Hospital (see above address).
Tel: 01325 552314
Email: ft.membership@tewv.nhs.uk

For more information about the trust and how you can get involved visit our website www.tewv.nhs.uk

info@belongcreative.co.uk