Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Annual report and financial statements 2010/11

Making a difference together

Tees, Esk and Wear Valleys NHS Foundation Trust

Annual report and financial statements 2010/11

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

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Introduction

Foreword by the chief executive

Reviewing the past

This has been an outstanding year for the trust and I am very proud of what we have accomplished. Despite setting ourselves some very challenging targets we achieved 95% of our business plan objectives.

We also received excellent feedback from staff, our service users and external assessors, which demonstrate that TEWV is a great place to work and receive treatment. We achieved some of the best results in the country in the national staff and patient surveys (see pages 19 and 20) and we have continued to meet our Care Quality Commission (CQC) requirements. The feedback from their visits has also been extremely positive with each of the sites achieving full compliance.

I would like to thank everyone who has contributed to our success in achieving our goals and, more importantly, in providing excellent care to the people who use our services.

As I wrote last year's report we were about to move into our flagship development in Middlesbrough. Roseberry Park is now providing first class accommodation for our mental health and learning disability services on Teesside (see page 18). The high quality of this environment was recognised at a national and international level when Roseberry Park was highly commended in the Building Better Healthcare awards and the Design and Health International Awards.

One of our greatest achievements was enabling more and more people to receive the specialist support they need locally without having to travel outside of our region. We were delighted to secure the contract to provide specialist inpatient services for adults and children with eating disorders for the whole of the North East and North Cumbria (see page 26). And our work with commissioners to bring back forensic patients treated outside of our area to new, medium and low secure accommodation at Roseberry Park is a reflection on the high quality of our services and environment (see page 18).

Our reputation for providing excellent services is helping us secure other contracts. We successfully tendered to provide mental health and learning disability services in the Harrogate, Hambleton and Richmondshire districts of North Yorkshire (see page 27) and worked with partners to secure the contract to provide talking therapy services in County Durham and Darlington (see page 25) We are also looking forward to working with Care UK to provide mental health services in North East prisons (see page 26).

"I know of no other organisation in the UK or Europe that is so comprehensively implementing kaizen (continuous improvement) in a health care setting to the obvious benefit of patients, staff and users of resources. The whole of the NHS needs to follow where Tees, Esk and Wear Valleys NHS Foundation Trust have led."

Sir John Oldham, national clinical lead for quality and productivity

In the current financial climate it has never been so important to improve the quality of what we do whilst reducing costs. Over the last year we have continued to successfully use the tools of our quality improvement system to drive up quality and save money. One of the most important elements of this system is that it empowers staff to make changes. It gives them the tools to identify and remove waste so that they can focus on doing what adds value – improving the lives of the people who use our services. I was delighted when the trust was singled out for praise by the Department of Health's clinical quality lead, Sir John Oldham who encouraged others to follow where we lead.

The Reference Costs published by the Department of Health also showed that TEWV has the lowest costs in England for the services we provide.

We are working hard to realise our vision and to achieve our goals and I am delighted with the progress we have made this year. The highlights section of this report contains some excellent examples of the work we have done over the last twelve months towards our strategic goals.

Our success to date would not have been possible without the continued support of our staff, our partner organisations, our service users and their carers, our governors and members and our volunteers. I would like to thank each and every one of them for their commitment to the trust.

Looking to the future

We have had an extremely successful year but we must not be complacent. There are many challenges ahead, not least the financial outlook and the need to further reduce our expenditure, and we must not let up on our drive to improve quality and cut costs.

One of our key priorities next year will be to strengthen our interface with general practitioners (GPs) and to ensure they are able to access our services easily. We will continue to work hard to reduce waiting times and improve access.

As this report was finalised we were preparing to welcome staff from Harrogate, Hambleton and Richmondshire to the trust. We are looking forward to working with them to build on the excellent care they provide for local people.

As we extend our boundaries it is more important than ever that we engage effectively with our commissioners and partner organisations. Planned changes to some of our management and leadership arrangements will help us strengthen our links with the communities we serve.

The final phase of our long term investment strategy to radically transform our inpatient facilities will be completed in 2011/12. The £10.4 million development at Cross Lane Hospital in Scarborough will make a huge difference to local people and give them the standard of hospital accommodation they deserve (see page 19).

We are also committed to establishing our regional inpatient eating disorder service as a recognised centre of excellence. The Northern Centre for Eating Disorders is an important development for TEWV and for local people and its success is a key priority for the trust.

This is an exciting time for TEWV and we have much to look forward to in the months ahead, particularly in those areas which are new to the trust.

We welcome the opportunity of working with new and existing staff, service users and carers, partner organisations and commissioners, governors and members to further develop and strengthen services.

Martin Barkley
Chief Executive

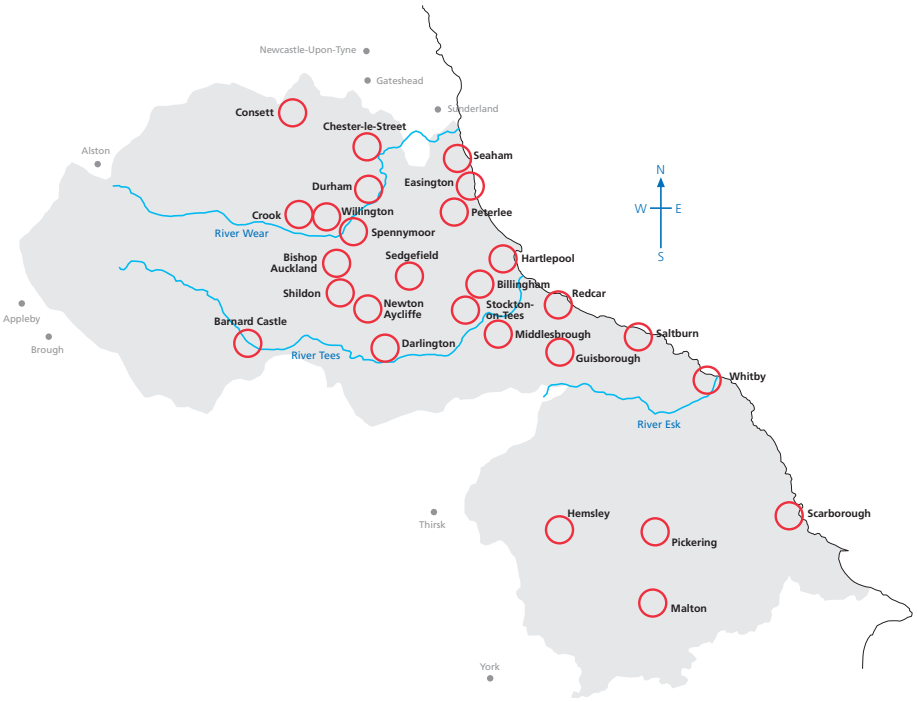
TEWV at a glance

Tees, Esk and Wear Valleys NHS Trust was created in April 2006, following the merger of County Durham and Darlington Priority Services NHS Trust and Tees and North East Yorkshire NHS Trust. In July 2008 we 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 parts of North Yorkshire. We have an increasingly ageing population but have also seen higher birth rates over the last five years. With around 5,200 staff and an annual income of £246 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 and diverse geographical region which includes coastal, rural and industrial areas, some with high levels of deprivation.



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 pages 18-27
- Respond better to market opportunities (for examples see pages 18 -27)
- Invest in capital developments such as the new hospital in Scarborough (see page 19)

Note: *Figures and map are pre 1 June 2011*

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 are seen when they want to be seen, have no unnecessary transfers and have timely access to treatment.
- Users will be offered appropriate choices 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.

2.

To continuously improve the quality and value of our work

This means that…

- We will continually improve patient safety at all levels of the organisation.
- 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.

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.
- The trust will give staff the technology and infrastructure to work flexibly from different locations.
- 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 enable participation.
- We encourage clinicians at all levels to be involved in the leadership and management of the trust.
- We align the clinical qualifications and skills of our staff to our clinical pathways

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 to be effective commissioners of mental health, learning disability and substance misuse services .
- We will engage with the NHS Commissioning Board at the national and local level.
- We articulate and advocate the needs and views of the people who use our services to local organisations and local communities.
- We will work with our local authority social services partners to deliver a seamless service for our users and carers.
- We are an active participant in each Health and Wellbeing Board and partners value our contribution to the partnership.
- We will have close and supportive working relationships with our local directors of public health.
- We will work closely with all GPs in our

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 are the provider of choice with all of 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 encourage patient and public involvement in the governance of our trust through our membership scheme.
- We are accountable to our stakeholders and external regulators through robust governance arrangements.
- We can demonstrate that our services are cost effective using national comparisons and outcomes data.

- We actively seek feedback about the services we provide from our service users and carers, and inform them of our response.
- We have a reputation for excellence amongst the people who currently use our services or who may use them in the future.
- We will be the information provider of choice for patients, carers and GPs who want to know more about their condition, treatments and the services that are available from TEWV and our partners and how to access them.
- Service users consider that they have been helped and supported to restore a self-determined, effective, functioning lifestyle.
- 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.
- Inpatients will have access to the same communications technology they would do at home.

- Our whole organisation has a culture of continuous improvement, with customers at the heart of our clinical and business decision-making.
- Our staff will only do things that add value.
- We have an active programme of research and development to deliver better ways of helping our service users.
- We will actively seek and report good practice and build in processes to disseminate and spread it across the organisation.
- We will promote a culture of actively challenging and reporting unsafe practice and we will learn from, and take action at all levels of the organisation in response.
- Pathways of care will enable consistent outcomes across the trust.
- We have common high standards implemented consistently across the trust but we will be responsive to local commissioner's intentions and resourcing decisions.

through targeted education and training.
- 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 achieve their full potential within the context of the trust's business needs.
- 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 and retain high quality staff, with the attitudes needed by our business and manage succession through the deployment of effective recruitment and selection and development strategies.
- We will grow and support our leaders locally.

area to help them provide effective primary care and referrals for patients with mental health, learning disability or substance misuse needs.
- We fully engage 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 engage with national and local organisations which represent the needs and views of service users and carers (e.g. HealthWatch).
- We will engage with partners who seek to improve value for money through shared services / facilities / approaches.

- We proactively publish data and information about the trust's performance – to CQC and HealthWatch – which builds our reputation for transparency.
- The trust will identify and eliminate waste while maintaining quality standards.
- The trust will use new technology and practices to improve efficiency.
- We can demonstrate that we are a environmentally friendly and socially responsible organisation.
- We will seek to influence national mental health policy and systems development.
- We will promote our reputation and brand to potential employees and commissioners.
- We continuously develop new business opportunities which are consistent with our vision.
- We will minimise the loss of existing business.
- 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.

TEWV Quality Improvement System (QIS)

Our aim is to deliver high quality services which:

- are appropriate – relevant to the needs of the individual or customer and based on evidence
- are effective – what we do delivers the outcomes that we expect and makes a positive difference to people's lives
- provide a good experience – our service users and customers feel that the service we provided was good and that they had a positive experience
- reduce waste – we should minimize 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. TEWV QIS is about improving the ways we do things within the trust by identifying and removing wasteful activities and focusing on those that add value to our customers (our service users, their carers and the people who commission our services).

Our services

Adult mental health services

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

- a wide range of community based assessment and treatment services including crisis intervention, assertive outreach, community affective disorders and psychosis teams and eating disorders
- inpatient assessment and treatment services, including acute, intensive care, challenging behaviour, 24 hour nursed care and rehabilitation services
- improving access to psychological therapy (IAPT) services in Durham, Darlington and Teesside
- an assessment service for attention deficit hyperactivity disorder (ADHD)
- a new specialist regional inpatient eating disorder service which will open in Spring 2011

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

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 the early intervention in psychosis teams.

Most services are provided in the community with inpatient services being located on the West Lane Hospital site in Middlesbrough where we will also open a new specialist regional inpatient eating disorder service in July 2011.

Mental health services for 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:

- a wide range of community based services include community mental health teams, acute liaison, care home liaison and memory clinics
- inpatient assessment and treatment services, including acute and challenging behaviour 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 community and inpatient specialist assessment and treatment services to people with learning disabilities and mental health problems, epilepsy and challenging behaviour, many of which are provided in partnership with social services.

Our main sites include Bankfields Court in Middlesbrough, the Dales in Stockton-on-Tees and units within Lanchester Road Hospital in Durham.

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 mainly at Roseberry Park in Middlesbrough with step down units in Lanchester Road Hospital in Durham.

We provide community forensic services including criminal justice liaison services that work across the whole offending behaviour pathway. We also provide services to the North East cluster of prisons.

Substance misuse services

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

97%

of our inpatient accommodation in single rooms

Directors' report

The highlights

Our goal:

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

We want to do everything we can to minimise the impact that a person's mental health or learning disability has on their lives. Over the last year we have worked with service users and their carers to develop and modernise services that promote recovery and wellbeing.

More and more people are able to receive the care they need in or near their own homes and we continue to develop and strengthen our community services so that they receive the appropriate level of support.

Some people need to spend time in hospital and our focus here is on making sure that individuals receive effective, therapeutic care. The roll out of the trust's purposeful inpatient admission (PIPA) project is a good example of how we are making sure people are assessed quickly and have clear care plans and discharge arrangements in place at an early stage.

It is also important that the standard of the environment matches the high quality care that we provide and the trust is nearing the end of a major long term investment strategy to improve our facilities.

This section contains other examples of how we are achieving our goal.

Flagship development on Teesside

The new £75 million Roseberry Park became fully operational at the beginning of May 2010. This state-of-the art mental health and learning disability development in Middlesbrough is a key part of the trust's plans to fundamentally modernise the way it provides services and has dramatically improved the inpatient environment. It also enabled us to expand our forensic mental health services including opening a new 13 bedded female low secure unit.

The self contained ward units are clustered around closed landscaped courtyards and each of the 312 single en-suite bedrooms are on the ground floor. Art played an important part in helping to create a therapeutic and relaxed environment at Roseberry Park and the stunning artwork was designed with the help of staff and service users. Roseberry Park was built under the government's private finance initiative (PFI) scheme. The trust's partners are John Laing.

New nutrition and dysphagia service

A new service was launched last year for older people. The team provides advice on diet and nutrition as well as speech and language therapy. They visit people in their own homes as well as hospitals and nursing homes. Over 40 staff champions from across the trust provide a vital link between the trust's inpatient and community teams and the nutrition and dysphagia team.

New bases for community teams in Whitby and Ryedale

Anne McIntosh with staff outside Malton's new clinic

Our new community mental health centre for adults and older people in Malton was officially opened in November 2010. Princess Road Clinic is a £1.3m facility, which provides much improved accommodation for staff and dedicated rooms for patient clinics. Community teams for both adult services and older people's services are now able to work together under one roof, improving communication between colleagues.

The re-design of The Anchorage in Whitby was completed in October 2010. This community mental health centre for adults and older people underwent a major refurbishment to transform it into a modern, fit for purpose building for local patients and our two Whitby community mental health teams.

New autistic spectrum disorder service

Last year we launched a new diagnostic, assessment and treatment service for adults with autistic spectrum disorder (ASD) in County Durham. This specialist service will make a huge difference to people with ASD who can often remain socially and economically excluded. Many are dependent on benefits for their income and on the care and support of their families not only for housing but to cope with everyday activities. Early diagnosis and treatment can prevent people from deteriorating further and developing associated mental health problems. The aim of this new service is to provide timely diagnosis and to develop an ASD pathway which will ensure people get the support and treatment they need.

Building work on track

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

Work is also well underway on the new assessment and treatment unit for adults with learning disabilities in Redcar and Cleveland. The £6.2 million development at Bankfields Court has been designed to meet the needs of a modern service and will support personalised care by providing much improved living accommodation and space for therapeutic activities.

Breaking down stigma. Children and young people join in the challenge

Tackling stigma

A project to actively break down mental health stigma among young people received national recognition last year. Children visiting the Mulberry Centre in Darlington were encouraged to physically break down a 'stigma wall' to reveal positive messages about good mental health.

The aim of the stigma wall, which was developed as part of a regional project, was to encourage children and young people to think more positively about mental health problems. It was funded by the National Child and Adolescent Mental Health Services Support Service and it has been featured in their national tackling stigma toolkit.

Short break respite care

Children's respite care services in County Durham and Teesside moved from cramped accommodation into two modern, spacious units better suited to the needs of young people with learning disabilities.

The short break service is now provided from much improved facilities at Roseberry Park in Middlesbrough and West Park Hospital in Darlington. Families are delighted with the new accommodation.

These moves are an interim measure while NHS County Durham and Teesside review the longer term design of these services.

Patients give us their feedback

We received some very positive results from last year's national patient survey, which focussed on adult community mental health services. The Care Quality Commission's survey captured the views of more than 17,000 people receiving community services from 66 NHS trusts (a random sample of 850 of our service users received questionnaires). The survey aims to determine whether people are getting the care and support that meets their needs. We scored significantly better than average in 10 of the areas covered and this included our overall rating of care in the last twelve months where we scored 76% (best score was 78%). These important surveys help us to focus on areas where we need to improve.

Improving patient and carer information

We want to provide our service users, their families and carers with good quality, appropriate and accessible information, to help them make informed choices about their care. Last year, building on the success of pilots in two areas of the trust, we introduced information prescriptions in all our acute inpatient areas and at six memory clinics.

We have also continued to develop and update our website to provide a resource of reliable, current information direct to the public as well as to clinicians supplying information to service users and carers.

The highlights

Our goal:

To continuously improve the quality and value of our work

As a trust we are committed to continually improving the quality of our services. Our aim is to make sure

- we provide appropriate services which are relevant to the needs of the people who use them and are based on evidence
- our services are effective, that they deliver the outcomes we expect and make a positive difference to people's lives
- we provide a good experience and our service users and customers feel that the service we provide was good
- we reduce waste and minimise any activity that does not add value

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. TEWV QIS is about improving the ways we do things within the trust by identifying and removing wasteful activities and focusing on those that add value to our customers (our service users, their carers and the people who commission our services).

We have included examples of how we are achieving our goal and how TEWV QIS is helping us improve quality. You will find more examples in the quality report on page 41.

Investing in research

Last year in collaboration with the school of medicine and health at Durham University we launched a major new research centre focussing on young people's mental health research.

The new partnership will lead research programmes looking at improvements in the safety of psychotropic drug prescribing and psychological interventions for young people with severe and enduring mental ill health. This is a significant milestone for the trust and places us firmly on the map as a national and international centre of NHS driven mental health research.

Reducing falls

The trust's older people's services have been cited as an example of good practice in the National Patient Safety Agency's (NPSA) "How to Guide" for reducing harm in falls in mental health inpatient settings.

Falls are a serious issue for older people and particularly those with mental illness who are vulnerable to falling because of dementia or side effects from medication. TEWV now has robust processes in place for assessing and monitoring patients and has seen significant reduction in the number of falls in its older people's wards (between 2007 and 2010 there was a sustained reduction of 58% in the number of falls causing injury).

Excellence in practice

Mental health services for older people in Scarborough, Whitby and Ryedale have been recognised for their good practice. The teams received four stars in the well respected Excellence in Practice Accreditation Scheme (EPAS), the final stage of a three year journey of practice development. A few examples of their many areas of excellent practice included the involvement of service users and carers in the Cross Lane Hospital development, introduction of activity workers on the inpatient unit and a day community treatment service.

Staff celebrate their four star recognition

Improving the patient experience

An innovative way of recording patients' views is helping us focus on what matters to our service users. Over the last year we have been using a new hand held device, a patient experience tracker (PET), to ask people what they think of our services.

This was set up after we had worked with service users across the trust to identify their top ten quality indicators. People told us these were:

- positive attitudes of staff
- being treated with respect and dignity
- being involved in and informed about decisions
- a high quality care environment
- safety
- activities
- care and treatment including treatment options
- access to services and appointments
- staff knowledge and expertise
- food

Over 1100 service users gave us their views either by using the PET or filling in paper surveys. The wards have used the results to focus on what they need to do to improve the patient experience.


Anne Carbin uses the PET

Pioneering new ways of working

Occupational therapists (OTs) across County Durham and Darlington have achieved outstanding results by using QIS to improve services.

OTs in mental health services for older people have eradicated long waiting lists and doubled the amount of clinical time they are able to spend with patients. By streamlining processes and minimising waste this award winning team (see page 23) are now providing a truly patient-focussed service.

Our community substance misuse team in Darlington far exceeded expectations and targets after taking part in one our rapid process improvement workshops. The team focussed on the needs of service users, listened to what they said and then used QIS to help them dramatically change the way they work. They have introduced evening clinics, to make the services more accessible and to reduce waiting times and changed prescribing practice to reduce errors and eliminate waste.

The excellent work done by our **child and adolescent mental health community services** in Easington to improve access to services and the quality of care provided has been shared across young people's services. The team reduced waiting lists, developed a team compact and increased involvement with local services and their success is now being replicated across the trust.

Adult community mental health teams in Redcar and Cleveland led the way last year in implementing innovative ways of working.

Health and social care staff from four different bases were brought together under one roof at Foxrush House rear Redcar. The move to a single base is allowing teams to work together more closely, strengthening communications and improving patient care.

As well as providing excellent accommodation for staff, this important development has also cut costs. The teams are pioneering an innovative approach to hot desking, reducing the amount of office space needed.

Staff outside their new base

97%
of patients received their first appointment within six weeks of referral

99%
of patients received treatment within 13 weeks of referral

The highlights

Our goal:

To recruit, develop and retain a skilled and motivated workforce

We want to be the best employer we can be and this means making sure our staff feel supported and valued in their role and that they are able to:

- acquire the skills and expertise they need to do their jobs well and to develop their careers
- get involved and contribute to decision making within the trust
- develop as leaders and managers to help us successfully lead the organisation

The health and wellbeing of our staff is also vitally important and we have worked hard over the last year to promote and support the wellbeing of our staff (see page 32).

Over the last year our staff and external assessors have told us that TEWV is a good place to work and this section includes a number of examples of how we are achieving our goal.

94%

of staff feel their role makes a difference to patients

TEWV is a great place to work or receive treatment

staff survey 2010

Investing in our staff

At the start of last year TEWV was officially recognised as an Investor in People (IiP). The highly prestigious national standard was awarded showing the trust as a top quality employer.

This is a nationally recognised people management standard, which assesses how well organisations manage and develop their staff. Gaining accreditation involves a rigorous assessment process and achieving IiP is a significant accomplishment for the trust.

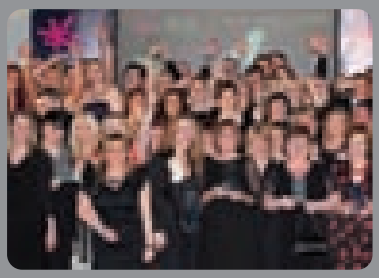
The reviewers commented that they were particularly impressed with the enthusiasm of the people they met. They highlighted a wide range of areas of strength such as the use of the trust's quality improvement system and good support for staff wellbeing.

A great place to work

TEWV staff recommended their trust as a great place to work or receive treatment in the 2010 national NHS staff survey.

The results of the annual survey placed the trust in the top 20% of mental health and learning disability trusts in the country in half of the 38 areas covered.

The trust received the highest rating in the country for the number of staff (94%) who felt their role made a difference to patients and it was in the top 20% of trusts as being somewhere staff would recommend as a place to work or receive treatment. More information on the survey is included on page 34.



Staff recognised for making a difference

Staff from across the trust were once again recognised at the annual Making a Difference Awards. These awards, which are in their fourth year, continue to grow in popularity. Over 200 teams and individuals were nominated for the ten awards by colleagues, managers, service users, carers and partner organisations. The high standard and the volume of nominations is a reflection of the quality of our staff and the esteem in which they are held. Our staff work extremely hard to make sure that the people who use our services receive the best possible care and support and it is important that their dedication is recognised.

National recognition

Over the last year our staff have once again been recognised at a national and regional level for their outstanding work.

Top award for occupational therapists

Health and social care awards

- Occupational therapists (MHSOP) across County Durham and Darlington won the regional award for mental health and wellbeing.
- Andrew McQuade, a support worker with assertive outreach services in Redcar and Cleveland was highly commended in recognition of the football group he set up.

Health Service Journal awards

- The community veterans mental health service was a finalist in innovation in the mental health category.
- Auckland Park assessment and treatment teams were finalists in the clinical service redesign category.
- Mental health services for older people - early warning score – were finalists in the patient safety category.

Nursing Times awards

- Delivering same sex accommodation – we reached the final in the patient dignity category.
- Mental health services for older people (early warning score) were finalists in the patient safety category.

Royal College Psychiatry awards

- Angus Bell, clinical director adult services was shortlisted for medical manager / leader of the year award.
- Joe Reilly, clinical director for R&D was shortlisted for psychiatric academic of the year award.
- The trust was shortlisted for the mental health services provider of the year award.

Patient safety awards

- Adult acute inpatient teams North Durham were finalists in the mental health and data information management categories.
- The falls initiative in MHSOP was a finalist in the mental health category.
- The RIOTT team (randomised injecting opioid treatment trial) in Darlington was a finalist in the mental health category

Building better healthcare awards

- Roseberry Park was highly commended in best mental health design.

Design and Health International awards

- Roseberry Park was highly commended in mental health design category.

Other individual awards:

- Kelly-jayne Johnson, senior accountancy assistant received the highest mark in the world for one of her papers in the CIMA qualifications.
- Linda Sidgwick, physiotherapist was a finalist in the Great British Care awards.
- John Potts, project manager, Lanchester Road Hospital was awarded project manager of the year by the Health Estates and Facilities Management Association.
- Melissa White, alcohol nurse in Middlesbrough received the multi-agency working award in the Safer Middlesbrough Partnership awards.
- Rose Mennell – Primrose Programme HM Durham won two categories at the HM Prison Service North East Region Performance Recognition awards.


Kelly-jayne Johnson

Valuing our staff

We held our first celebration event in November 2010 to recognise those trust staff with 25 years or more service in the NHS. The trust introduced this new initiative last year to reward long serving employees for their dedication and loyalty to the NHS.

We also held a 'learners' celebration event in October 2010 to recognise the 140 staff, between the bands of 1-4, who had completed a vocational qualification.

Unique trainee opportunity for pharmacists

Last year the trust joined up with Lloydspharmacy to introduce an innovative new scheme for trainee pharmacists. The preregistration training programme is believed to be the first of its kind in the country and offers pharmacists experience in both community and mental health hospital pharmacies.

The trainees spend six months with the mental health trust and six months working in a local Lloydspharmacy branch before they are registered as fully qualified pharmacists. This innovative new scheme has received approval from the Royal Pharmaceutical Society of Great Britain (RPSGB).

The highlights

Our goal:

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

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

The success of our organisation and our partner organisations is dependent on the success of our relationships. This means listening to and learning from our partners so that we can continuously improve our services and achieve sustainable success.

We do not work in isolation and over the past year we have continued to work with our existing partners and to develop new partnerships so that the people who need our services get the best possible care.

This section contains some examples of how we are achieving our goal.

Mental health and deafness

Last year we worked jointly with Northumberland Tyne and Wear Foundation Trust to set up a specialist community deaf mental health team covering the North East region.

This important new service, which was previously only provided out of Manchester, is making sure that deaf people get the support they need locally. The team are on hand for complex cases but perhaps more importantly they are making sure that staff across our community teams receive the training they need to support deaf patients.

"I found that it is easy to speak to someone in the team, response visits are quick and patients are very appreciative."

A GP

Transforming services for people with dementia

A commitment to improve services for people with dementia by health and social care organisations in **Darlington** has led to dramatic improvements in patient care.

The four organisations (TEWV, Darlington Borough Council, County Durham and Darlington NHS Foundation Trust and NHS County Durham and Darlington) have worked closely together, using the tools of the trust's quality improvement system, to bring about dramatic improvements to the care of people with dementia. Staff from the different organisations trained and worked collaboratively to not only bring about change and but also to build stronger relationships which will benefit patients in the future.

Closer working between our liaison psychiatry staff and ward staff at Darlington Memorial Hospital is having a significant impact on the care of people with dementia. The liaison psychiatry nurse is now based at the hospital and ward staff are trained in assessing patients for dementia and delirium, ensuring they get the support they need at an early stage.

The trust has been working closely with health and social care partners in the **Durham Dales** to improve care for older people.

One of the key aims of the Durham Dales Integrated Care Organisation was to improve services for dementia, including screening for early signs of the disease. The two year pilot is already seeing an increase in the number of people who are being diagnosed at an early stage and improvements to the care pathway.

97% of inpatients had access to crisis services

Kenny gets the keys to his own home in Hartlepool

Moving on

A number of organisations across Hartlepool have worked together to give people with learning disabilities the support they need to set up and live independently in their own homes.

The trust has worked with commissioners, local housing providers, Endeavour Housing, and Creative Support to help six people move from hospital (campus) accommodation to become tenants in their own homes.

One man who now shares a bungalow with a friend had lived in hospital accommodation for over 40 years. He was fully involved in choosing his new home and buying the furniture for it. He moved into his spacious bungalow in July 2010 after signing his own tenancy agreement and is now an active member of the local community.

Recovery and rehabilitation

The trust has been working with Middlesbrough Council and Mind to improve services and facilities for service users. The reconfigured service at Lothian Road in Middlesbrough, which will be managed by Mind, will support people's rehabilitation and recovery by providing much needed advice and support on employment, housing and training opportunities.

New look for care centre

We worked closely with Middlesbrough Council to transform a centre for adults with complex health and social care needs. The Orchard in the town received a £500,000 face lift and clients can now access a wider range of services under one roof.

talking changes

improving access to psychological therapies in county durham and darlington

Back to front, Gail Richardson service manager, David Ekers clinical lead and Martin Armitage operational director

A new service was launched in County Durham and Darlington last year to help people suffering from depression and anxiety.

Talking Changes is a joint venture between the trust, NHS community services and the national charity, Mental Health Matters and its aim is to improve access to psychological therapies.

Thousands of people each year will benefit from the service which is making talking therapies more accessible to local people. People have a choice of where and when to see their therapist and this could mean booking appointments near where they work instead of where they live. Some treatments are also offered over the phone or via the internet.

As well as individual therapy sessions the team provides group sessions to help people better manage their anxiety and depression or to share experiences and develop treatment programmes.

The highlights

Our goal:

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

Over the last year we have continued to make the best use of our resources, working with our council of governors and our members to make sure this is for the benefit of our communities.

We have been successful in securing a number of contracts that are consistent with our vision, which is a reflection of the high standard and cost effectiveness of our services.

The quality of our services has been endorsed by the Care Quality Commission (CQC). We have continued to meet their requirements and the feedback from the unannounced visits they have made over the last year has also been excellent with each of the sites achieving full compliance.

We are also committed to reducing our carbon footprint and our environmental strategy and implementation plan was approved in April 2010. We are monitoring our performance against the Good Corporate Citizenship assessment model and we are steadily making improvements from a baseline figure of 21% in November 2009 to 43% in March 2011.

This section includes examples of how we are achieving our goal.

Be a friend

A trust wide campaign to recruit new members and to help us tackle the stigma that surrounds mental illness was hailed a success.

The aim of the 'be a friend' photography and art competition was to raise awareness of the importance of friendship for people with mental health problems. The fourteen winning images which portrayed what friendship meant to the entrants featured in a colourful calendar, which was distributed to our public members.

Trust awarded regional contract for eating disorders

Northern Centre for Eating Disorders

In 2010/11 the trust was awarded the regional contract to provide specialist inpatient services for adults and children with eating disorders. This was an important contract for the trust and for the people who need these vital services.

As a result of winning the tender the trust set up the Northern Centre for Eating Disorders and our aim is to provide people with the help they need to reach a point in their lives when they no longer need hospital care.

Birch at West Park Hospital has been refurbished to meet the specific needs of this specialist service. The 15 bedded adult centre, which opened in May 2011, also has two high dependency beds for nasogastric (NG) feeding and medical interventions. The Evergreen Centre at West Lane Hospital in Middlesbrough, is a purpose built unit, which is due to open in summer 2011. It will provide 15 inpatient beds for young people with eating disorders.

Mental health care in prisons

The trust was delighted to be given the opportunity to work with Northumberland, Tyne and Wear NHS Foundation Trust to provide mental health services in North East prisons.

We signed the contract with Care UK, the organisation which was awarded the regional offender healthcare contract, at the end of 2010/11. This is excellent news and it means our experienced staff will remain employed by the trust, other mental health staff will transfer into the trust and we will be able to recruit to a number of additional posts. Care UK already works successfully in partnership with other trusts and we are confident our contract will be another example of this.

£9.3m cost savings achieved

£12.3m invested in our facilities

Keynote speakers from the event

On the international stage

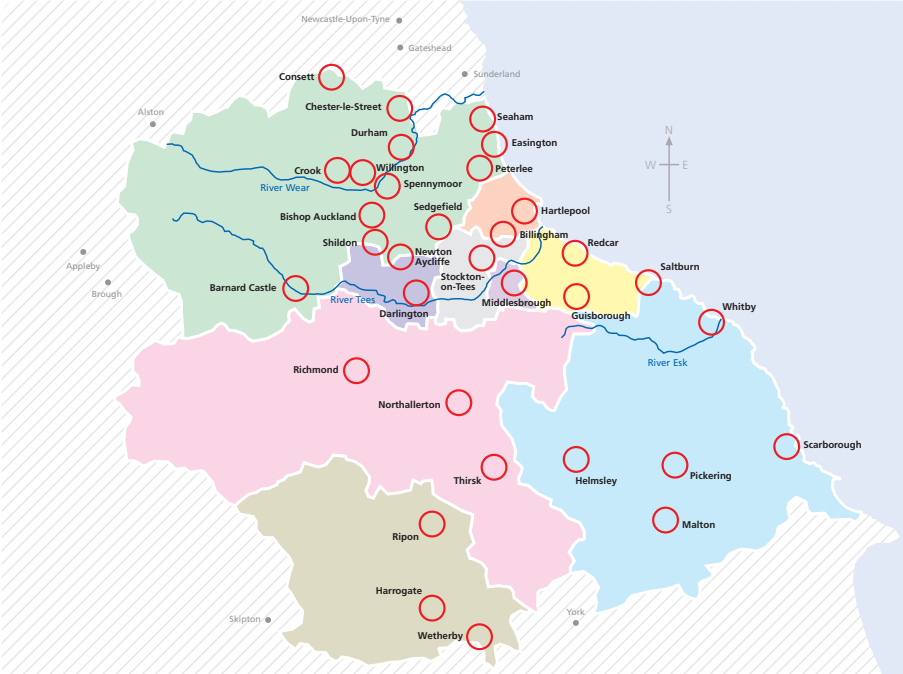
The trust held its second international forensic conference last year. 'Hearts and Minds' focussed on managing risk in forensic mental health and the event brought together specialists from around the world including key note speakers from the Victorian Institute of Forensic Mental Health in Australia and the Olympia Police Department in Washington, USA.

Professionals from adult, learning disability and adolescent forensic psychiatry came together to share good practice, develop networks and make new contacts, placing the trust once again at the centre of the international stage.

West Park Hospital

In 2010 we became the first NHS trust in the country to voluntarily terminate a PFI contract. We paid £18 million to buy out West Park Hospital and we now completely own the hospital. In very simple terms this is similar to early repayment of a mortgage and it will save the trust £14 million.

We still have two other PFI hospitals, Roseberry Park in Middlesbrough and Lanchester Road Hospital in Durham. These are newer developments which were negotiated more recently using different funding models. They give good value for money and we have no plans to change these arrangements.



New services in North Yorkshire

In 2010/11 the trust was also awarded the contract to provide mental health, learning disability and substance misuse services in Harrogate, Hambleton and Richmondshire.

These services moved to TEWV from North Yorkshire and York PCT in June 2011 and around 500 staff will transfer to the trust. We are looking forward to working with the people in these areas to build on what has been achieved and further improve services for the people of Harrogate, Hambleton and Richmondshire.

Principal risks and uncertainties

Our business 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 on page 80.

Reform of the NHS

The Government has proposed significant reforms to the National Health Service within its Health and Social Care Bill.

At a national level organisations such as the British Medical Association and the Royal College of Nursing have identified a number of risks arising from the changes including the replacement of primary care trusts with GP consortia to lead local commissioning.

At the time of writing, the Government has paused the passage of the bill to enable further dialogue and the final shape of the reforms remains uncertain.

Whatever the outcome we will continue to support the PCTs and seek to develop and strengthen our relationships with the emerging GP consortia.

Expansion of the trust in North Yorkshire

On 1 June 2011 we became the main provider of mental health, learning disability and substance misuse services in Hambleton, Richmondshire and Harrogate.

We are aware of the challenges that the expansion will bring as we integrate the new area within our existing services and seek to develop relationships with new partners.

Since being awarded the contract we have been working with NHS North Yorkshire and York to identify and address risks and uncertainties. We will continue to implement and monitor our robust mobilisation plans.

Increasing competition

Through our success in winning tenders, for example to provide eating disorder services and services in Hambleton, Richmondshire and Harrogate we have demonstrated that we are competitive against both other NHS trusts and the independent sector.

However, we recognise that competition will increase and we will need to work harder and be second to none in terms of quality and value.

Implementation of new leadership and management arrangements

During 2011/12 we will be implementing revised management and leadership arrangements which are aimed at providing greater external focus whilst retaining strong clinical leadership.

In developing our plans we have sought to minimise risks by consulting widely with staff including clinicians.

It is our intention to implement the changes as soon and as smoothly as practicable.

Implications arising from the reduction in public expenditure

Although the NHS budget has increased in 2011/12 we recognise that spending reductions for our partners and increased demands on services will create financial pressures in the medium term.

In response we will continue to improve the productivity of our services using our well established quality improvement system and work with our partners.

Regulatory compliance

The compliance framework and the 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

The risk ratings are expressed as:

- green (no material concerns)
- amber-green (limited concerns surrounding authorisation)
- amber – red (material concerns surrounding authorisation)
- red (potential or actual significant breach of authorisation)

The variance between our expected and actual financial risk ratings in 2010/11 is due to the trust achieving a surplus in excess of plan and improvements to the trust's liquidity position.

Risk rating performance 2009/10 and 2010/11

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

	Annual Plan 2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
Financial risk rating	4	5	5	5	5
Governance risk rating					

Regulatory interventions

Monitor did not use its formal powers of intervention against the trust in 2009/10 and 2010/11.

Further information

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

Involving and listening

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 influence the way our services are delivered and improved. We are developing a patient experience and involvement strategy to ensure our continuing commitment to involve service users and learn from their experiences of using services. This will help us to continuously monitor and improve the quality of service we deliver.

A carers strategy is also being developed which will outline the key priorities carers have told us are important to them such as access to timely information, being involved in decisions about care and treatment and helping us to develop and improve trust services.

There are a number of ways that service users and carers have been helping us and the following are a few examples:

- attending meetings such as the Mental Health Act committee, acute care forums, pharmacy, psychological therapies and essential standards reference groups
- attending mental health services for older people, forensic and North East Yorkshire involvement groups
- being part of the patient environment action team visits, working alongside staff checking the cleanliness of our wards
- participating in the student nurse programme, giving presentations about their perspective on living with mental health conditions and using our services
- taking part in the medical development programme, helping to train doctors and assisting with the recruitment and selection of new staff
- reviewing new patient and carer information as part of a readers panel
- being part of a learning disability reference group who are supported by advocacy to have a voice in many aspects of our trust services, including the recruitment of staff, a programme of staff training and clinical research

Public consultations

The trust worked closely with the local overview and scrutiny committees on a number of proposals for changes to services.

Older people's services

The trust supported NHS County Durham and Darlington to consult with local people about proposals to reconfigure mental health services for older people inpatient services in South Durham and Darlington.

The 14 week consultation focused on options for reconfiguring inpatient beds across South Durham and Darlington, which would result in 15 fewer assessment and treatment beds.

Although assessment and treatment wards are seeing an increase in the number of admissions, lengths of stay are decreasing and we therefore need fewer beds. With lower bed occupancy rates we can use our resources more effectively by reducing the number of beds.

Patients and their families have also said that they prefer inpatient wards where people with functional illness such as depression, psychosis and anxiety and those with organic illnesses such as dementia are nursed separately.

Following the consultation in April 2011 the PCT and trust board of directors approved the option to create a specialist functional inpatient centre in Darlington and to maintain a specialist organic assessment and treatment ward at Auckland Park. It was also agreed to relocate Hardwyke Ward from Sedgefield Community Hospital to Auckland Park Hospital.

Short break services

The trust also carried out a public engagement exercise with NHS Tees and NHS County Durham and Darlington about the proposed relocation of short break services for children and young people with learning disabilities.

The existing facilities for these services in Teesside and County Durham were far from ideal and the proposal was to move them on a temporary basis into new accommodation at Roseberry Park in Middlesbrough and West Park Hospital in Darlington.

The trust wrote to and met with the families of the people who use these important services, giving them the opportunity to ask questions and to see the new accommodation and the moves took place in March and April 2011 (see page 19).

Local involvement networks (LINks)

These important networks aim to give local people a stronger voice in how their health and social care services are delivered. The trust has continued to develop working relationships with members of the LINks and staff working in the LINks host organisations. Regular quarterly network meetings have continued with the leads from the LINks host organisations. Members have attended trust public meetings, including the annual general meeting and positive practice meetings in different constituencies. They have assisted with identifying priorities for the trust's quality account.

We have responded to requests for information and involvement which has included the statutory right of LINks members to enter our premises. The visits are an opportunity for members to monitor

the quality of the service through observation and discussions with staff and patients and they produce a report based on their findings.

Patient advice and liaison service (PALS)

PALS continue to visit wards across the trust area, seeking the views of patients, carers and relatives about their contact with our services. People contact PALS using the freephone, send messages by the PALS mobile, send e mails and write letters raising concerns or comments about services. Between 1 April 2010 and 31 March 2011 1093 contacts were recorded and responded to by PALS (this was an increase of 87 contacts from 2009 – 10).

Formal complaints

In 2010 -11 we received 125 written complaints (this was an increase of 14 complaints compared to the 111 complaints received in 2009 -10).

The Parliamentary and Health Service Ombudsman is responsible for operating the second stage (independent review) of the NHS complaints regulations process.

Although we were contacted ten times by the Ombudsman concerning requests for information relating to trust complaints, they decided not to investigate any of the complaints further. At the end of the year we had no outstanding cases with the Ombudsman.

We continue to learn valuable lessons from complaints and concerns raised with PALS from service users and their carers. Over the past year we have made a number of improvements because of the comments and feedback we have received including:

- **children's learning disability services** - improving communication for review meetings, including ensuring parents and carers feel they have been listened to at the meetings
- **adult mental health services** - improving patient choice in regard to the administration of a certain type of medication
- **forensic learning disability services** - improving communication with patients before a visit to a new unit, when they are referred to another agency and relating to their diagnosis
- [a] **forensic services** - improving the records being kept for patients property when admitted to the ward
- **trustwide** - ensuring effective consultation takes place with service users and carers on proposals to relocate services
- **mental health services for older people** - improving the care programme approach process with a clear transfer protocol/pathway between services which is clearly documented and the creation of a short patient leaflet regarding dementia diagnosis
- **mental health services for older people** - improving communication between clinical staff and patients by nurses and care co-ordinators regularly checking that patients have a copy of their intervention and care plans
- **trustwide** - improving patients' safety and understanding of staff roles by staff wearing their ID badge at all times, introducing themselves and explaining their roles clearly

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

Supporting our staff

At the end of 2010/11 we employed around 5,200 staff (compared to 5000 at the end of the previous year) including over:

- 280 doctors
- 3000 nurses
- 400 psychologists and allied health professionals and
- 1000 admin and estates staff

Our workforce is primarily white (95%), which is broadly in line with our local population, and is made up of 70% female and 30% male.

Health and wellbeing

The health and wellbeing of our staff continues to be a priority. This has been the first year of having a single provider for occupational health services for the whole trust which has improved consistency and access for our staff.

A new health and wellbeing strategy was consulted on and agreed. It provides a clear and coherent framework for activities over the next few years.

A quality improvement event was held to increase early intervention by occupational health and managers to support staff on long-term sickness. We are also piloting the use of an external sickness reporting system which aims to provide early advice for staff at the point of reporting sickness. Reducing the level of sickness absence within the trust to 5% remains a challenging target for us and at the end of March 2011 our rate was 5.56%.

Developing our staff

We have continued to support staff to develop themselves to provide high quality services to the people we serve.

Staff have welcomed the newly refurbished education and training centre that opened early 2010 and all of its resources. We have been encouraged by the number of staff who have participated in developing literacy and numeracy skills across the trust. We have increased the number of e-learning opportunities for all staff, providing improved access to training (at the end of February 2011 we had seen a 547% increase in staff completing and passing e-learning training).

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 the trust's excellent facilities and resources go a long way to supporting the trust's commitment to training and development.

Communicating and engaging with our staff

Good two-way communications with staff is essential to our success. If staff are to do their job well they need to be well informed about what's going on within their own area and to be aware of what's happening across the wider trust. They should be involved in, and be able to have say about, key decisions and plans that may affect them and their work.

We have a number of key corporate mechanisms for communicating and engaging with staff including

- team briefing system
- trust magazine (Insight)
- intranet (inTouch)
- weekly e-bulletin
- informal visits by directors and formal board visits

We continually review our internal communication mechanisms to make sure they are effective and look for new and improved ways of engaging with staff.

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. In the last staff survey 73% of staff said they regularly attended team meetings which included core and/or directorate briefings and over 90% of those found the meetings useful. Our intranet (inTouch) is also becoming an increasingly vital communication tool and source of information for staff.

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 have monthly meetings at the well established Joint Consultative Committee (JCC). A number of staff representatives receive paid, planned

"Every member of the team was interested in my learning outcomes and professional development. Any future student will gain excellent experience from this placement. "

A student

facilities time to participate in the policy sub-group, the workforce and development and job evaluation panels and to represent their individual members.

Over the last year we have used many different ways such as focus groups, team meetings and project groups to involve staff in trust wide and local developments that impact directly on them. Staff engagement is also at the heart of our quality improvement system and hundreds of staff from all areas of the trust continue to be involved in quality improvement events.

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 or other characteristics protected through the Equality Act 2010.
- 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 regardless of their background or any protected characteristic they may have. This policy ensures the trust is compliant with the Equality Act 2010.
- In response to recent guidance we have revised (in conjunction with staff side) the whistle blowing policy which has been consulted upon and agreed. This will be implemented with a staff communication plan during 2011/12.

Staff survey

The results of the national staff survey were announced in March 2011. They placed our trust in the top 20% of mental health and learning disability trusts in the country in half of the key areas (19). Our response rate was 64% (an increase of 4% over the previous year).

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

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

- percentage of staff agreeing that their role makes a difference to patients (94% compared to 90% nationally) **KF2**
- percentage of staff believing the trust provides equal opportunities for career progression or promotion (95% compared to 89% nationally) **KF37**
- percentage of staff receiving job-relevant training, learning or development in the last 12 months (85% compared to 80% nationally) **KF 11**
- percentage of staff feeling there are good opportunities to develop their potential at work (55% compared to 45% nationally) **KF10**

The three 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 the last 12 months (18% compared to 14% nationally). This is, however, an improvement on last year's figure of 21% **KF23**
- percentage of staff receiving health and safety training in the last 12 months (74% compared to 80% nationally). Our result remained the same as last year's **KF16**
- staff motivation at work (3.80 compared to a national average of 3.82 – a higher score is better). Our result has not changed significantly since last year when the trust scored 3.83 **KF35**

Our fourth bottom ranking score was in relation to

- percentage of staff experiencing physical violence from staff in the last 12 months (2% compared to 1% nationally) **KF24**

The trust's score was average when compared with other similar trusts. Because of changes to the format of the survey questions this year, comparisons with the 2009 score are not possible.

Our sole purpose is to improve the lives of the people who use our services by minimising the impact that mental ill health or learning disability has on their lives. We were therefore particularly pleased to see that our staff gave us the top score in the country when asked whether their role makes a difference to patients and that their recommendation of TEWV as a place to work or receive treatment placed us in the top 20% of trusts.

Over the last year we have worked hard to address the issues highlighted in the previous staff survey, particularly around reducing the levels of violence and aggression against staff. We are reassured to see that the numbers of violent incidents are coming down but there is still more to do and work will continue to address this. We are also pleased that our commitment to reducing the incidence of violence and aggression is reflected in this survey with staff telling us that we are taking effective action.

Another area we have focussed on this year is staff appraisals. It is important that all staff receive an annual appraisal and it was good to see a 5% increase reported in the survey. We hope to see this figure increase further next year.

TEWV is also committed to improving the health and wellbeing of staff. This benefits not only our staff but also, indirectly, the people who use our services. Our health and wellbeing strategy is currently out for consultation and we have committed to fund four more retreats for staff this year. We were therefore pleased to see the positive responses about this in the survey. However, it is concerning to see a slight deterioration in the work pressure felt by staff and the support available from immediate managers and we need to monitor this carefully.

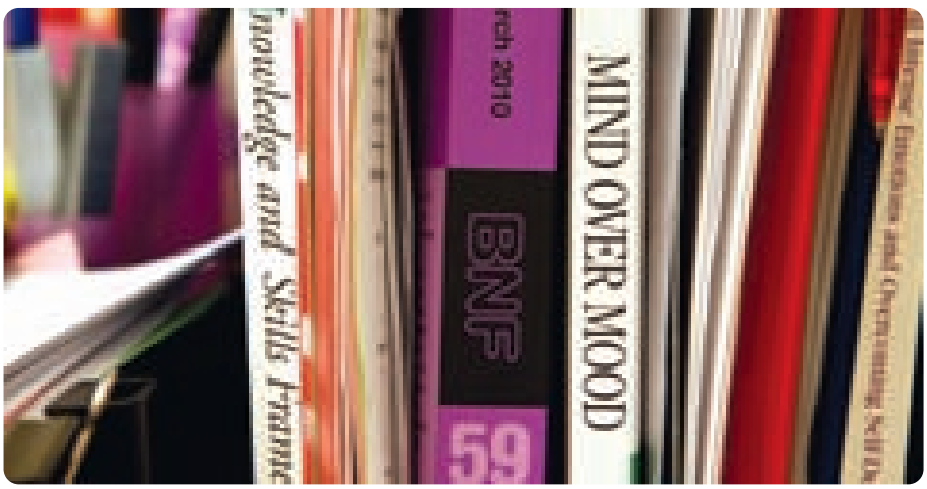
Last year's feedback from the staff survey, Investors in People assessment and the Health and Safety Executive stress survey were pulled together into a workforce development plan to incorporate feedback from these three sources. Progress on the plan has been reported to the executive management team and workforce and development group. It is important that we feed in the results of the staff survey 2010 and work is underway to develop an action plan by the end of June 2011.

Summary of Staff Survey Results

	2009-10		2010-11		
	Trust	National Average	Trust	National Average	Trust improvement / Deterioration
Response Rate					
	60%	55%	64%	54%	Increase in % points
Top 4 Ranking Scores					
KF2	92%	90%	94%	90%	Increase in % points
KF37	94%	90%	95%	89%	Increase in % point
KF11	86%	81%	85%	80%	Decrease in % point
KF10	57%	48%	55%	45%	Decrease in % points
Bottom 4 Ranking Scores					
KF23	21%	18%	18%	14%	Improvement in % points
KF16	74%	75%	74%	80%	No change
KF35	3.83	3.84	3.80	3.82	No real change
KF24	Comparison not possible		2%	1%	Comparison not possible due to changes in survey format

Health, safety, security and emergency planning

Throughout the year we have continued to ensure that staff receive advice, support and training on health, safety, security and emergency planning issues. We relaunched the updated health, safety and security workbook (the trust's health and safety management system) including the implementation of an audit programme. We also ran a business continuity plan exercise and review programme and carried out table top exercises to test and improve resilience of these plans.



Our performance

Trust dashboard

Users of Our Services	Actual	Target	Comment
Percentage of patients attending a first appointment within 6 weeks of external referral date	97.45%	100.00%	Incremental target of 100% by December 2010 therefore March 11 position detailed rather than 2010/11 outturn
Percentage of patients seen within 18 weeks of internal referral date	98.41%	100.00%	
Percentage of patients receiving treatment within 13 weeks of external referral date	99.49%	100.00%	
Percentage of complaints satisfactorily resolved by the trust	86.00%	90.00%	2010/11 position
*** Percentage CPA 7 day follow up validated**	98.45%	95.00%	
*** Percentage of CPA patients having a formal review documented within 12 months**	96.79%	95.00%	Snapshot
*** Percentage of admissions to inpatient services that had access to Crisis Resolution Home Treatment Teams prior to admission validated**	97.00%	90.00%	2010/11 position
Average number of days from when a patient is discharged as an inpatient to their next admission as an inpatient	194.53	115.00	

Quality	Actual	Target	Comment
Number of reported outbreaks healthcare associated infections: MRSA Bacteraemia & Clostridium Difficile	0	0	2010/11 position
Percentage of Improvement event targets at 90 day report out sustained or improved after 1 year	83.82%	85.00%	
*** Data completeness: outcomes**	91.24%	85.00%	Snapshot
*** Data completeness: identifiers**	99.65%	99.00%	
*** Self certification against compliance with requirements regarding access to healthcare for people with a learning disability**	100.00%	100.00%	
Total number of unexpected deaths reported - trust position	28	36	2010/11 position
*** Percentage of non acute patients (aged 18 and over) whose transfer of care was delayed, summed across the period (Paris Monitoring)**	1.6%	7.5%	

Staff	Actual	Target	Comment
% Sickness Absence Rate	5.15%	5.00%	Incremental target of 5.0% by March 11 therefore March 11 position detailed rather than 2010/11 outturn
Assessment of current establishment (target is 98-100% but is shown as 99% with a 1% threshold on either side)	100.58%	99.00%	Snapshot
Total number of RIDDOR incidents - trust position	63	36	2010/11 position
Percentage of disciplinary investigations/hearings held that result in no formal disciplinary action being taken	26.67%	10.00%	Rolling 12 month period
Percentage of disciplinary cases completed (including the disciplinary hearing but excluding the appeal hearing stage) within 3 months	41.67%	75.00%	

Partnerships	Actual	Target	Comment
*** Number of new cases of psychosis served by Early Intervention Teams**	455	230	2010/11 position
Number of home treatment episodes by Crisis Home Treatment Services	5,751	2,976	

Sustainable Organisation	Actual	Target	Comment
Finance Risk Rating (trust level only)	5	4	Snapshot
Cash Releasing Efficiency Savings Delivery	108.61%	100.00%	2010/11 position
% of CQUIN indicators achieved	90.22%	100.00%	

* Monitor targets

The trust had an outstanding year, achieving over 95% of the 650 actions outlined in our business plan.

Notes on our performance

The scorecard is the trust's dashboard of key performance indicators for 2010/11.

The board received a monthly performance dashboard during 2010/2011 which contained performance against a range of indicators linked to our strategic goals as well as national requirements. The table (trust dashboard) shows the 2010/2011 annual position.

- **Percentage of patients attending a first appointment within 6 weeks of external referral date** – we have continued to improve our performance throughout year from 90% in April 2010 to 97% in March 2011 although this was slightly below our target 100%. This reflects the work that has been undertaken by services to improve access to services.

- **Percentage of patients seen within 18 weeks of internal referral date** - we have maintained above 98% between April 2010 and March 2011, which again, although slightly below target, is reflective of the work undertaken

- **Percentage of patient receiving treatment within 13 weeks of referral date** - we have improved our performance from 97% in April 2010 to 99% in March 2011. We have performed at over 95% of patients being treated within 13 weeks for the majority of the year.

- **Percentage of complaints satisfactorily resolved by the trust** - the majority of complaints have been satisfactorily resolved although we did fall short of the annual target. Complaints are monitored by the quality assurance committee and are thoroughly investigated. Both the patient liaison department and patient advice and liaison services (PALS) strived to resolve as many concerns/complaints as possible informally.

- **Percentage of improvement event targets at 90 day report out sustained or improved after 1 year** – the trust achieved 84% during 2010/11 which slightly below the 85% target.

- **Percentage sickness absence rate** - the March 2011 position is 5.15%, which is slightly above the target of 5.0%. The trust continues to manage sickness absence in line with the health at work policy.

- **Assessment of current establishment** - The trust has reported slightly above target at 100.6%; however, this does not give cause for concern and is due to skill mixing as services re-align through developments and also prepare for CRES for 2011/12.

- **Number of RIDDOR Incidents** – The trust has reported 63 RIDDOR incidents during 2010/11 which is significantly higher than the target of 36. The health and safety team investigate all the RIDDOR incidents and there are no underlying trends or lessons to be learnt from them. The team have re-launched the health, safety and security workbook, including a presentation on RIDDOR reporting, and this has raised awareness within the trust, which may be linked to the increase in RIDDOR incidents. Analysis of the categories of RIDDOR incidents indicates that the highest proportion (40.6%) are physical assaults against staff. Whilst the trust is one of the highest reporting trusts nationally, there has been a consistent year on year reduction and there is a positive culture of reporting within the organisation. This is a significant reflection of the work undertaken within the trust by the violence and aggression group, together with the implementation of a challenging behaviour policy and the training provided to frontline staff by the in house management of violence and aggression team (MOVA) in terms of promoting safer and therapeutic services. (see page 45 In the quality report for more information).

- **Percentage of disciplinary investigations/hearings held that result in no formal disciplinary action being taken (rolling 12 month period)** – The trust is reporting a slight improvement in March 2011 at 26.67% and has continued to improve month on month since December, however the figure is still significantly over the target figure of 10%. Once allegations are identified that may result in a disciplinary investigation being instigated, a preliminary investigation is undertaken to establish the basic facts to inform whether an investigation is required. It is difficult to pre empt whether an allegation will ultimately result in a decision that there is no case to answer; this only comes to light as the investigation progresses. A case management review of all disciplinary investigations is held by the head of operational HR services every two weeks to review how cases are progressing.

- **Percentage of disciplinary cases completed (including the disciplinary hearing but excluding the appeal hearing stage) within 3 months (rolling 12 month period)** - performance against the target over the last 12 months has improved from 29.27% in April 2010 to the figure of 41.67% reported this month. A number of initiatives to improve the performance have been implemented following an rapid process improvement workshop last year, these included provisionally scheduling hearing dates into the diary to ensure hearings were taking place in a timely manner. The executive management team receives a monthly update detailing progress made in relation to disciplinary investigations and hearings against the target of three months. The head of operational human resources services regularly attends the operational management team to discuss employee relations issues. There are a number of reasons that impact upon whether a disciplinary case is concluded within the three month time frame, such as the sickness absence of the individual or key witnesses. A review of the cases over the last 12 months is to be undertaken to identify where delays of over four weeks have occurred due to either the absence of the employee or key witnesses, along with cases that have been delayed due to outside influences such as a police investigation. The outcome of the review along with recommendations will be submitted for the attention of the board in April.

- **% of CQUIN indicators achieved** – The trust set itself a stretch target of 100% of CQUIN indicators to be achieved during 2010/2011 and has achieved most of the indicators.

Contractual relationships

The following significant contractual relationships are essential to the delivery of our services:

Our services are commissioned by:

- The Ministry of Defence
- The Ministry of Justice
- The Department of Health
- NHS County Durham and Darlington
- NHS Tees
- NHS North Yorkshire and York
- Darlington Borough Council
- Durham County Council
- Hartlepool Borough Council
- Middlesbrough Borough Council
- Stockton-on-Tees Borough Council
- Redcar and Cleveland Borough Council
- North Yorkshire County Council
- The Northern Specialist Commissioning Group
- Yorkshire and the Humber Specialised Commissioning Group

We provide integrated services in partnership with the following local authorities:

- Darlington Borough Council
- Durham County Council
- Hartlepool Borough Council
- Middlesbrough Borough Council
- Stockton-on-Tees Borough Council
- Redcar and Cleveland Borough Council
- North Yorkshire County Council

We act as a sub-contractor to Mental Health Matters for the provision of Improving Access to Psychological Therapies (IAPT) Services in Teesside.

We are part of a joint venture arrangement for the provision of IAPT Services in County Durham and Darlington with Mental Health Matters and County Durham and Darlington NHS Foundation Trust.

We are part of consortium led by South Staffordshire and Shropshire NHS Foundation Trust to inpatient mental health services to serving armed forces personnel.

We have a contract to provide children and young people mental health research capacity with the University of Durham.

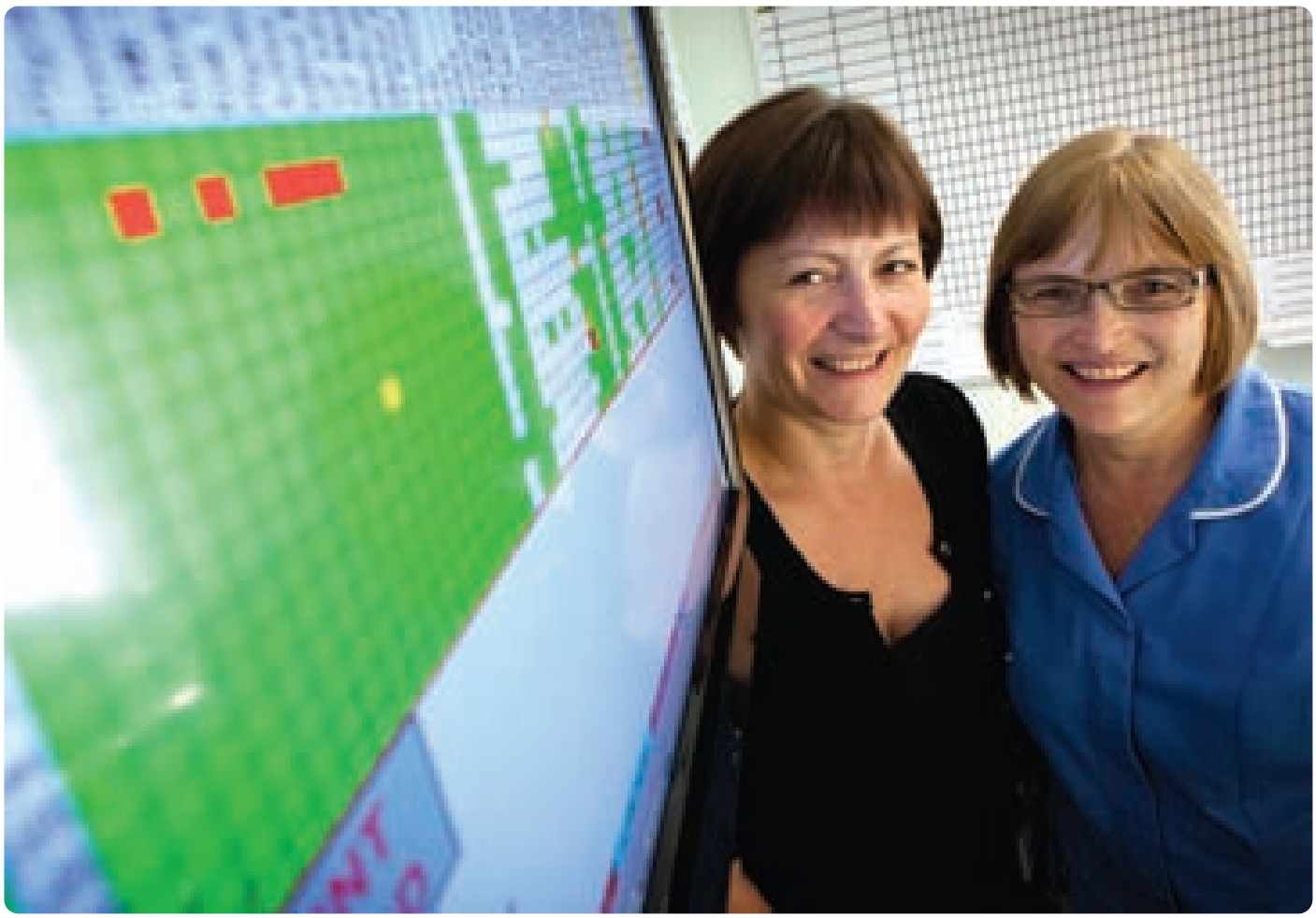
We have contracts with the following companies to provide hard facilities management services:

- John Laing Integrated Services Ltd (Roseberry Park Hospital)
- The Grosvenor House Group (Lanchester Road Hospital)
- Integral Ltd (West Park Hospital)

The project companies for our PFI Contracts are Governor House Lanchester Road Ltd and Three Valleys Healthcare Ltd.

The main contractor for the redevelopment of Cross Land Hospital, Scarborough is Kier Northern.

We have an agreement with Care UK Ltd to provide offender mental health services under a sub-contracting arrangement within the North East Region.



Quality assurance

The trust is committed to providing safe and high quality services. To support this we have developed a quality assurance strategy, which outlines the framework for assuring high quality care, through robust clinical governance and performance systems.

The strategy is built upon the Essential Standards of Quality and Safety as defined by the Care Quality Commission and embodies the trust's vision (see page 11). The strategy reflects the ten key statements of the Monitor quality governance framework.

Our aim is to develop and implement this framework throughout the trust, from ward to board level. This will ensure that all staff are aware of and involved in the management of clinical quality and safety risks within their own areas. The strategy is an integral part of the overall trust integrated governance and risk management strategy.

As part of the strategy the board of directors established a non- executive sub-committee, the quality assurance committee (QAC) (see page 68).

Improving quality governance

We are carrying out a number of actions to improve quality governance:

- We have established an annual programme of service inspections and validation of compliance evidence to check that clinical care meets the CQC Essential Standards of Quality and Safety. This project includes gathering evidence of best practice that can be shared and used for benchmarking and quality control.
- Following the successful piloting of standardised patient surveys in in-patient areas we are extending this into community services. These surveys rate experience against a 'top ten' of quality indicators developed by service users and we use the feedback gathered to identify any areas for improvement and development.
- We have redesigned and improved the processes for investigating incidents so that recommendations are more timely and focused. The next step is to establish systems for monitoring the implementation of the recommendations and for evaluating their impact on services. This will give us more assurance that lessons are being learned from incidents.
- The clinical assurance framework has improved the systems for collecting data on service performance, such as complaints, incidents, safeguarding and patient experience. Data is regularly collected, analysed and reported but all at present as separate feedback streams. An 'early warning system' is to be tested that integrates a number of key quality, safety and staffing indicators into a risk related performance report. This will highlight any areas of concern that can then be escalated for action.
- Further to a review of the trust's clinical audit processes we have developed a plan to improve the links between the annual clinical audit programme and the services risk registers, clinical incidents, complaints and clinical outcomes. This will ensure that audits are being used as an integral part of the quality assurance framework.
- The director of nursing and governance as Senior Information Risk Owner implemented an information security risk management system (ISRMS) to improve information governance. Further to the external audit of the ISRMS an action plan will further improve the system by embedding both the IG staff roles and processes of asset management and risk monitoring.
- We have identified a number of new quality indicators in relation to national standards, such as the eliminating mixed sex accommodation, hospital care acquired infection and safeguarding children. We have improved systems for monitoring and reporting on these indicators.

Quality Account (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 accounts which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual. The quality account reviews the processes and key actions being taken to manage and improve the quality of the clinical care and services provided by the trust. A number of improvement priorities are identified and outputs are reported on through the quality account each year (see page 41 for the trust's quality account/ report). The report can also be downloaded from the trust's website www.tewv.nhs.uk

"Thank you to all staff who have helped and supported our child through a sensitive, traumatic and hard time over the last couple of years."

The family of a service user

Research and development

Our aim is to improve the quality of care through research and we have seen a continued and rapid increase in the level of participation in large scale clinical research over the last year.

We are now participating in a significant portfolio of large scale research, a large proportion of which is run by the Mental Health Research Network (MHRN). This is clear evidence of our commitment to contributing to the evidence base for improving outcomes for the people who use our services.

National Institute for Health Research (NIHR) research studies currently active within the trust range from psychosis and attention deficit hyperactivity disorder (ADHD) to addictions, drug safety and forensic mental health, with a substantial involvement in affective disorder and mental health services research.

Over 400 participants from the trust have been engaged in national research this year across 27 large scale multi-site studies, more than double the number of participants reported for the preceding year.

Having successfully become a research partner of choice in important mental health research, we are now in a favourable position to undertake a more ambitious research challenge. Progress has been made this year towards developing a reputation as a leader in mental health research with a major impact on the NHS and last year we made nine major research grant applications.

As a current example of the research being shaped by the trust, one of the largest personality disorder trials ever conducted, funded in 2009 by NIHR's Health Technology Assessment programme, has run for the first of three years. The PEPS (psychoeducation and problem solving) trial, run in partnership with Nottingham University, is testing the effectiveness of a therapeutic intervention in a priority clinical area of unmet need.

Also, in partnership with Durham University we are conducting a comprehensive evaluation of staff, user and carer experience and clinical outcomes at Roseberry Park in Middlesbrough, funded by the NIHR Physical Environment Programme.

The trust has worked with the MHRN and broader clinical research networks to encourage its service users and carers to participate in multicentre studies. Our aim is to have active involvement in all areas of research from design through to results communication. Innovative user engagement approaches employed in a study of the role of occupational therapists in assertive outreach teams has been presented at the national INVOLVE conference.

We launched a major new collaborative partnership with Durham University to expand the research centre to focus on the needs of young people with severe mental illness. The main themes of the collaborative research will be the evaluation of psychological interventions in young people and exploration of prescribing quality and safety.

Our clinicians have published articles this year in a range of high quality journals, including Schizophrenia Research, Nature Genetics and the Lancet. The results of a national study of intravenous heroin treatment have been disseminated, including publication in the Lancet. This research, in which the trust has been a key collaborator, has provided new evidence for the effective treatment of heroin addiction. A British Journal of Psychiatry publication on the evidence of therapy for depression as delivered effectively by non-specialists may have potentially far-reaching implications for NHS Increasing Access to Psychological Therapies (IAPT) services.

There is more detail about our research activities in our quality report on page 54.

Serious untoward incidents (SUIs) involving data loss or confidentiality breach

There were no reportable SUIs involving data loss or confidentiality breach's in 2010/11 (categories 3-5).

The table opposite shows a summary of other personal data related incidents in 2010/11 at category 1-2

Category	Nature of Incident	Total
I	Loss/theft of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	2
II	Loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	1
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	
IV	Unauthorised disclosure (fax sent to incorrect address)	1
V	Other	1

Quality report

Part 1:
Chief Executive's report

I am pleased to be able to present the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) quality report for 2010/11. This is our third quality report and it tells you what standards of quality we have provided in 2010/11 and how we intend to improve the quality of our services in 2011/12 and beyond.

At TEWV we are fully committed to continually improving the quality of the services we provide and to be:

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

This means that we are always trying to ensure that the services and care that we deliver:

- meet the needs of each individual service user and are based on best practice
- are effective so that they make a positive difference to people's lives
- provide a good experience for people
- reduce waste so that everything we do adds value to our service users and commissioners

During 2010/11 we have continued to make good progress on improving the quality of services that we provided. Some of our key achievements during the year were:

- We continued to implement the TEWV quality improvement system throughout the organisation. Our progress has been recognised by Sir John Oldham, national director of quality and productivity at the Department of Health, who said on a recent visit to the trust:

  "Today's visit has been inspiring. I know of no other organisation in the UK or Europe that is so comprehensively implementing kaizen[1] in a health care setting to the obvious benefit of patients, staff, and use of resources. The whole of the NHS needs to follow where this trust has led".

  Some of the key improvements we have made as a result of the further implementation in 2010/11 include:

  - improving our prescribing practices of lithium and high dose antipsychotics
  - working with health and social care colleagues to improve the care provided to service users on ward 51 in Darlington Memorial Hospital who have dementia as well as a physical illness. (For example we have improved by 250% the involvement of our liaison services with these service users which means they get the specialist mental health input they need and that staff on the ward are supported. This has helped reduce the average length of stay from 16 days to 11 days, reduced the number of times someone is readmitted within 30 days of discharge from 35% to 16% and dramatically reduced the time taken for service users' referrals from ward 51 receiving social care packages from 54 days to 15 days.)
  - improving how our Easington CAMHS team work which has reduced the time between receiving a referral to the first appointment from 162 days to 35 days and reducing the time taken from referral to the assessment being completed from 92 days to 28 days
  - improving how our adult inpatient ward in Scarborough works which has reduced the average length of stay from 64 days to 34 days, reduced bed occupancy from 99% to 86% and reduced the number of days that people from North East Yorkshire have had to spend in beds outside the local areas (due to unavailability of beds)
  - improving our community adult mental health services in North East Yorkshire which has resulted in the number of admissions from the crisis teams reducing from 17 to 6 per month and the percentage of service users discharged from the ward where there was involvement of the crisis resolution and home treatment team in discharge planning increasing from 40% to 100%

- We opened our new inpatient facility at Roseberry Park in Middlesbrough in May 2010 which means that we now have some of the best inpatient accommodation in the country. 97% of our inpatient accommodation is provided in single rooms (with 80% being ensuite).

- Our board committee responsible for quality, the quality and assurance committee (QuAC) has started for the first time inviting service users or their carers to come and tell their story of what it's like to get services from us and how we could improve their experience.

- We have piloted some new ways to get service user feedback on a regular basis. Initial feedback has been positive on the whole but where service users have said they have not had a good experience we have made changes. For example on the forensic wards in response to direct service user feedback we have:
  - introduced more choice of menus and day-before ordering of food
  - changed ward routines to give better access to the gym
  - changed the ward round and Care Programme Approach (CPA) processes to improve user involvement

- We received some extremely positive external reports including:
  - the annual Mental Health Act report from the CQC
  - the annual patient survey
  - the annual staff survey and
  - a number of positive compliance reports on planned reviews and unannounced inspections undertaken by the CQC

[1]Kaizen is the Japanese term used within the Toyota production system for continuous quality improvement

However we know we do not always get it right and that this is not good enough. That is why we continue to focus on what more we can do to make sure that everyone who uses our services receives high quality care all of the time.

The structure of this quality report is in line with guidance that has been published by both the Department of Health (DH) and the foundation trust regulator Monitor and contains the following information:

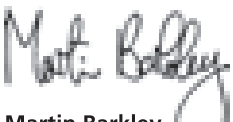
- part 2 – information on how we have improved in the areas of quality we identified as important for 2010/11, what we plan to improve in 2011/12 and the required statements of assurance from the board
- part 3 – further information on how we have performed in 2010/11 against our key quality metrics and national targets.

In drawing together the quality report for this year we have tried to improve on how we involved our wider stakeholders in its development. To do this we held two stakeholder workshops which involved service users, carers, LINKs, overview and scrutiny committees, governors, GPs and our commissioners. These workshops have allowed people to be involved in helping us to identify what we should concentrate on in 2011/12 and what we should do to improve the quality in those areas. We have also produced regular performance reports for the board of directors and the council of governors on how we are doing to address the things we said were important for 2010/11.

In addition we have also shared the draft quality report with our seven local PCTs, the seven overview and scrutiny committees and the seven LINKs which we cover to give them the opportunity to comment on its content. This is described in more detail in part 3.

can confirm that the information contained within this report is accurate, to the best of my knowledge. A full statement of directors' responsibilities in respect of the quality report is included on page 59. This is further supported by the signed limited assurance report provided by our external auditors on the content of the 2010/11 quality report which is included on page 60.

I hope you find this report interesting and informative. If you have any feedback or suggestions on how we could improve our quality report please do let us know by emailing sharon.pickering@tewv.nhs.uk.



Martin Barkley
Chief Executive

Part 2:
Priorities for improvement and statements of assurance from the board

2010/11 priorities for improvement – how did we do?

As part of our 2009/10 quality report the board of directors agreed five quality priorities to be addressed in 2010/11. Good progress has been made against these five priorities as follows:

Priority 1: improve how we learn lessons from serious untoward incidents

We know that serious untoward incidents (SUIs) have a major impact on patients, staff and the organisation as a whole. We therefore identified work to prevent their occurrence by learning lessons from them and taking steps to prevent recurrence as one of our key priorities. In order to monitor our progress we agreed to monitor the percentage of SUI recommendations implemented within the agreed deadline and set ourselves a target of 70%.

The table opposite shows our performance in 2010/11 and 2009/10 for comparison

It can be seen from the table that we did not achieve the target we set ourselves however we did improve our performance by a third in 2010/11 compared to the position in 2009/10.

To support the delivery of this priority we identified nine actions to implement in 2010/11 which had all been implemented by 31 March 2011:

- We have developed a team of 20 specially trained SUI investigators.
- We have improved how we share the recommendations that arise from investigating incidents.
- We have supported our services to develop ways of sharing lessons learnt from SUIs and how they then implement those lessons effectively.
- We have developed a communication tool to be used when there needs to be an immediate alert communicated to services regarding an issue of immediate patient safety.
- We have identified themes from SUIs that have occurred and built in related questions to patient safety walkrounds.
- We have further developed the system for ensuring safety alert broadcasts (SABs) are actioned, including a response process to provide assurance that SAB recommendations have been implemented trust wide.
- We have established systems to ensure the implementation of actions from SUI investigations is monitored and reported
- We have improved the process for producing and approving the reports provided following a SUI.
- We have developed a mechanism for capturing any emerging themes from SUIs and ensuring these are reported within the organisation as soon as they have been recognised.

Whilst all the actions were delivered by 31 March 2011 some of them were implemented part way through the year and are still being embedded across all services. It is believed that once these processes are further embedded the percentage of SUI recommendations delivered within the agreed timescales will improve further.

The board of directors recognise that we still need to undertake further work to ensure that we learn lessons from SUIs and have therefore identified this as a priority for 2011/12 and expanded it to include learning lessons from complaints as well.

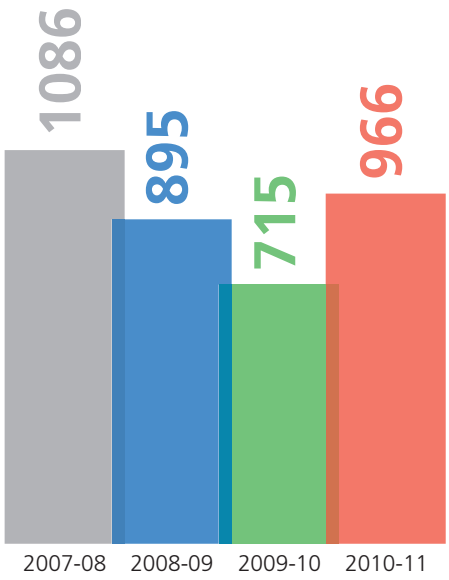
Indicator	2010/11 Actual	2010/11 Target	2009/10 Actual
Percentage of SUIs recommendations implemented within the agreed deadline	60% (95 of 160 recommendations complete.)	70%	45%

Priority 2: reduce the amount of violence and aggression

During 2008/09 we identified that the number of incidents of violence and aggression was higher than we thought was acceptable across the trust. We therefore started to address this as part of the Leading Improvement in Patient Safety (LIPS) work we had commenced with the NHS Institute of Improvement and Innovation. Whilst we saw a reduction in the number during 2009/10 the board of directors agreed to continue this work as one of the key quality priorities in 2010/11 because of the impact it has on both service users and staff.

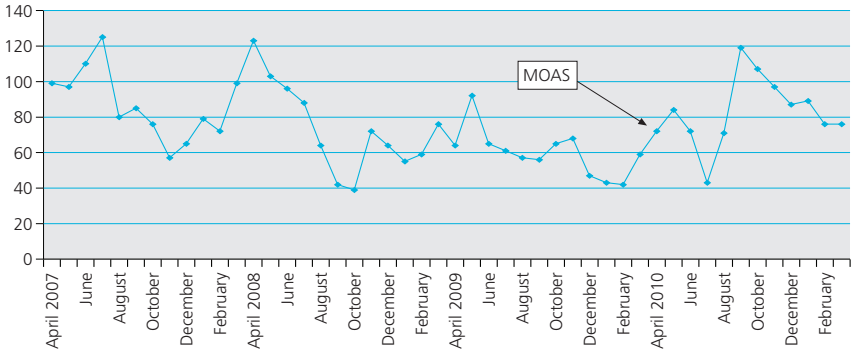
We therefore set a very ambitious target of reducing physical assaults in inpatient settings by 50% each year until 2012. The following graph shows the number of physical assaults leading to harm in inpatient settings from 2007/08.

Number of reported physical assaults leading to harm



It can be seen from the graph that from 2007/08 to 2009/10 the number of physical assaults leading to harm has indeed reduced by a total of 34%. However this trend reversed in 2010/11 when the number of physical assaults leading to harm increased. The graph at the top of the page shows the trend over the three years:

Number of physical assaults that led to harm since April 2007



MOAS is the new classification of incidents based on the level of harm which was introduced in April 2010 (see table on the following page)

Whilst this position appears at odds with the work that has taken place during the year (see previous page) it is important to recognise that 2010/11 was a year of significant change within the trust which included:

- The opening of a large number of additional beds (59) within forensic mental health and forensic learning disability services at Roseberry Park. This increase was in two main stages, the first being at the time of the opening of Roseberry Park in May 2010 and the second with the opening of an additional female secure ward in September 2010 at Roseberry Park. Clearly the extra beds have resulted in a higher number of service users within these services which has contributed to the increase in physical assaults. This can be seen in the graph above where the numbers peaked in May 2010, then started to reduce but peaked again in September 2010. When the two years figures (for number of physical assaults) are adjusted to take into account the increase in occupied bed days (OBDs) the percentage increase is in fact 18% rather than the 35% shown above.
- With the opening of the new beds a significant number of new service users transferred into the forensic beds from out of area placements. In total 45 new patients came into the new beds from other providers. Of these, 21 were in forensic mental health and 24 were in forensic learning disabilities. The environment and routine within Roseberry Park tends to be less restrictive and more therapeutic compared to the locations where these people were previously. We believe that the change in environment and routine for these individuals has also contributed to the increase in assaults as the individuals have needed to adapt to the changes. This has been compounded by the fact that the existing service users were also moved from a 'familiar' setting in St Luke's Hospital to the new wards within Roseberry Park, which in a number of cases resulted in them being moved to wards with other service users that were 'new' to our service.
- Of the 59 additional secure beds 20 of these have been female, 14 in forensic mental health and six in forensic learning disabilities. It is recognised that women in secure settings are a particularly challenging group. It can be seen from the trend graph above that there was an increase in incidents in September 2010 when the additional female ward was opened. Indeed the absolute increase between 2010/11 and 2009/10 in the number of physical assaults leading to harm on the female secure wards was 211% (compared to the average annual increase across all wards of 35%). Even when this is adjusted to take into account the increase in beds the increase is still 130% (compared to 18% across the trust as a whole)
- There have also been changes in other services such as adult mental health and mental health services for older people with the opening of the new wards at both Lanchester Road Hospital and Roseberry Park which again leads to a level of disruption for service users as they become acclimatised to their new environment. In addition there have been changes in the way we provide inpatient access and treatment services on the wards to ensure that people do not stay on the ward longer than is needed. This has resulted in a greater number of service users on the ward at any one time being in a more acute stage of their illness. Again we believe this has contributed to the increased number of incidents of violence and aggression.
- In addition the introduction of the new classification of types of physical assaults, known as MOAS, on 1 April 2010 and the work that has taken place in communicating this to services is believed to have increased the level of reporting in 2010/11. The introduction of the MOAS tool now allows us to monitor the different 'levels' of physical assaults and this has demonstrated that whilst the total numbers have increased at points during 2010/11 the numbers resulting in serious harm have not.

MOAS v9 - Violence and aggression categories

1. Makes threatening gestures, swings, grabs at clothes (No damage)	MDT, PARIS **and** complete incident form if appropriate *(see note 1. below)*	No injury
2. Strikes, kicks, pushes, pulls hair (without injury to them), grabs at clothes and damages them	Report incident, describe care in PARIS *(see notes below)*	Low
3. Attacks other or throws objects causing mild-moderate physical injury (bruises, sprains, welts), Spitting, Grabs in sexual manner		Moderate
4. Attacks others, causing severe physical injury (e.g. broken bones, deep lacerations, internal injury)		Severe
5. Homicide		Death

For 2010/11 we identified six actions to address this priority all of which had been implemented by 31 March 2011 as follows:

- We have introduced standard patient safety questions within safety walkrounds which are an integral part of the regular structured board visits and executive management team visits to services.
- We have tested the inclusion of aspects of care relating to the reduction of violence in the visual control boards in the adult mental health directorate. In addition the use of monitoring charts for assaults has been built in to the roll out of the Productive Mental Health Wards work we have implemented.
- We have developed and implemented standard working practices for the management of violence and aggression across the trust. This includes the testing of a robust standardised approach in handovers, on-call arrangements, medical escalation and safety alerts.
- We have continued 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. This includes all outcomes from the patient experience reflection tool (a questionnaire completed after incidents to help staff learn from them).
- We have developed standard work processes for the post-incident debrief.
- We have improved our approach to training in the management of violence and aggression including ensuring it is available via e-learning (computer based training).

Significant developmental work has been undertaken in 2010/11 on this priority which will be implemented across the trust during 2011/12. This will be coordinated by the LIPS Violence and Aggression group and will be monitored via the patient safety group by the QuAC. Given that the work in 2011/12 is about mainstreaming the work that has occurred in 2010/11 the board of directors has not identified this as a key quality priority in 2011/12.

"The staff we have come into contact with have been professional, dedicated and informative whilst maintaining an air of caring and understanding that has been a great comfort and support to our family."

A service user's husband

Priority 3: implementation of the Care Programme Approach (CPA)

The board of directors recognise the importance of the CPA to the delivery of safe and effective care and therefore identified that one of the quality priorities for 2010/11 should be to expand on the work to improve the use of the CPA in inpatient areas undertaken in 2009/10 into community services.

The table opposite shows how we have performed against the four targets we identified for 2010/11.

It can be seen from the table that we did not meet two of the targets we set. The reasons for this are as follows:

Indicator 1 – There was a delay in ensuring that all staff were trained to the appropriate levels (see explanation for Indicator 4), and whilst the standard communication tool for record keeping and the visual control boards have been implemented they are still being embedded across the community teams.

Indicator 4 – There was a delay in implementing the action required to meet this target as the national competency assessment had several technical problems and the transfer to the trust e-learning programme was problematic. The CD Rom training programmes have therefore only been available since mid January 2011. As these continue to be used in 2011/12 it is expected that the percentage of care coordinators reaching the required standard will increase further.

In order to deliver this priority we identified seven actions to undertake in the year all of which had been implemented by 31 March 2011 including:

- We have improved the delivery of care coordinator training to the crisis, early intervention psychosis and access teams across the trust. As described above this was delayed due to issues with the national competency assessment.
- We have distributed the e-learning care coordinator competencies assessment tool. Assessments are being completed and results are being returned to the training department and recorded against staff records. Training is being provided where the assessment indicates this is necessary.
- We have undertaken a quantitative CPA audit via the PARIS system and the results were analysed by the audit department and a report completed in November. We have also developed a tool to provide intermittent checking of compliance with the standards of CPA.
- We have collected data on the targets above in the relevant teams.
- We have established standard processes for implementing the CPA within the community teams.
- We have implemented a standard communication tool for record keeping in the relevant community teams in AMH, MHSOP and North East Yorkshire. However we need to undertake further work to embed it across all clinical services.
- We have started to implement visual control boards in the community teams.

Indicator		2010/11 Actual*	2010/11 Target
1)	The percentage of patients seen by the adult access teams, crisis teams and early intervention teams having a risk assessment within 72 hours of contact with the service.	79%	100%
2)	The percentage of patients seen by the adult access teams, crisis teams and early intervention teams with a risk assessment within 72 hours that have an intervention plan, based on that risk assessment, within 72 hours of contact with the service.	100%	100%
3)	The percentage of patients seen by the adult access teams, crisis teams and early intervention teams having risk assessments and intervention plans that meets the quality standards identified in the LIPS initiative.	78%**	50%
4)	The percentage of care coordinators having reached the required standard in terms of undertaking robust risk assessments and developing intervention plans based on those assessments	66%	100%

** Comparable figures for 2009/10 are not available*

*** Data from the quantitative CPA Audit*

It is recognised that we need to continue to embed the systems and processes we have put in place during 2010/11 to ensure the implementation of the CPA consistently across the trust. However it is believed that the development work has been completed and as such this priority has not been carried forward into 2011/12. However, the work will still continue and will be monitored by the CPA steering group and reported via the patient safety group to the QuAC.

Priority 4: transfers of care

A transfer of care is any situation in the patient's journey where they move between services. This can be a change from one therapist to another eg from a nurse to a social worker or a move from one care setting to another eg from inpatient care to the community.

It is recognised that discharge from an inpatient ward to a community setting is an area of high risk. The board of directors

Indicator	2010/11 Actual*	2010/11 Target	2009/10 Actual	2008/09 Actual
1) Percentage of users discharged from AMH inpatient areas with a risk assessment, an identified care coordinator and a discharge plan	27%	N/A*	Not collected	Not collected
2) Percentage of users in AMH on CPA followed up in the community within 7 days of discharge from an inpatient ward (known as 7 day follow ups)	98.5%	95%	97.5%	97.3%
3) Percentage of all 7 day follow ups completed in the community that were carried out in person	95.4%	90%	Not collected	Not collected

** We did not set a target as we wished to identify the baseline level during 2010/11*

therefore identified improving the discharge process from inpatient care to community services as one of our quality priorities for 2010/11.

The table above shows the progress we have made in the year against the key targets we set for 2010/11.

It would appear from the above table that the percentage of users discharged from inpatient areas with a risk assessment, identified care coordinator and a discharge plan is low. This is because the percentage is of all discharges from inpatient care. However some of these would not require all elements of the standard discharge process because the service users were discharged directly back to their GP on standard care not on CPA. (In future years this percentage will only be calculated from those service users discharged on CPA).

In order to deliver this priority we identified eight key actions to be implemented in 2010/11. As at 31 March 2011 six of these had been implemented as follows:

- We have undertaken an improvement event on the discharge process and implemented standard documentation to ensure that all discharges follow the same process.
- We have implemented a training and development programme to ensure staff have the skills necessary to complete discharge planning safely. This was delayed internally due to problems with the national tool.
- We have further developed the skills and competencies in the CPA within inpatient and community staff.
- We have undertaken a quantitative and qualitative audit of the application of the CPA focusing on care planning and risk assessment on discharge which will inform an action plan to make further improvements in 2011/12.
- We have developed a GP discharge document which has been piloted in adult mental health services. It will be made available on PARIS following the system upgrade planned for 2011/12.
- We have developed standard work for discharges from inpatient to community services within the adult mental health services.

We could not complete two of the actions identified for 2010/11 as they depend on the upgrading of the electronic patient record system (PARIS) which has been delayed and is not now due to take place until 2011/12. We have completed the preparatory work that is needed and once the PARIS upgrade has taken place these actions will be completed.

The board of directors are keen that we build on the work completed on improving discharges from inpatient wards in order to improve other transfers of care, for example from one community team to another. Transfers of care will therefore remain as one of our five quality priorities for 2011/12.

Priority 5: development of ways to collect information on patient experience

A key element of our quality definition is whether our service users feel that the experience they had whilst using our services was a positive one. We recognised that we did not have a robust framework to collect real time patient experience feedback. Therefore, the board of directors identified the development of ways to gather this information as the fifth of our key quality indicators for 2010/11.

To improve how we collect information on patient experience we identified seven key actions to undertake in 2010/11 and as at 31 March 2011 we have implemented six of these as follows:

- We have identified all the methods that were being used across the trust to gather service user experience. There was a wide range of methods in use and these have helped inform the patient experience strategy which has been developed and will be published in early 2011/12.
- We have developed a framework for the collection of service user views across the trust which recognises that there will need to be different approaches for different services.
- We have developed the top ten quality themes using a patient led approach. These themes have been the basis of the questions we have asked our service users in terms of their experience. They included for example attitudes of staff, respect and dignity, safety, activities and access and appointments.
- We have run pilots on different methods of collecting information from our service users on their experience.
- We have piloted the use of the 'Dr Foster Patient Experience Tracker' (a hand held electronic system to collect service user views) in ten assessment and treatment inpatient wards within adult mental health services and mental health services for older people. Following an evaluation of the pilot a full business case is to be developed in 2011/12 to agree how systems to monitor service users' experience will be rolled out across the trust.
- We have developed a draft patient experience strategy that brings together the different ways in which we will capture service user experience and how services will use that feedback to improve the experience of our service users in the future. This strategy was being consulted on as at 31 March 2011 and will be published in mid 2011/12 following that consultation.

There was one action around gathering views on 'same sex accommodation' which we planned to undertake in 2010/11 which we subsequently decided not to pursue given the high percentage of single rooms in the trust following the opening of the new Lanchester Road and Roseberry Park Hospitals. We have however published our declaration that we meet the mixed sex accommodation requirements and we continue to collect data and report on any breaches of sleeping accommodation in line with the guidance. The declaration can be found at www.tewv.nhs.uk/samesexaccommodation.

Again the board of directors is keen to ensure we continue to make progress in this area. It has therefore agreed that seeking views from our service users and their carers will continue to be a priority in 2011/12.

2011/12 priorities for improvement

Within the trust the QuAC 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 for any given year to ensure that we continue to improve the quality of services we deliver.

The process of identifying the key priorities for 2011/12 involved a number of stakeholders such as LINks, overview and scrutiny committees, governors, PCTs and so forth. The process was as follows:

- A review was undertaken on the findings of SUIs, other incidents, complaints, patient advice and liaison services (PALS) contacts and audit findings to identify common themes in terms of where quality needs to be improved.
- A stakeholder event was held in September 2010 to share these issues with a wide range of stakeholders and to get feedback from them on where they think the quality of the services needs to be improved. From this workshop six key quality priorities were identified and these were submitted to the board of directors in October 2010.
- At its formal meeting in October the board of directors agreed the five quality priorities (from the six identified at the stakeholder workshop) for 2011/12 to be included in the quality report. The remaining priority identified by the stakeholders was included in the business plan 2011/14 to prevent it from being lost.
- Key responsible leads within the trust were identified for each priority and an overarching target and detailed actions were then developed for each priority.
- A further stakeholder workshop was held in February 2011 where the proposed indicators and actions were shared. The stakeholders were asked for comments on these which were captured and taken into account in identifying the final action plans for each priority as described below.

A key enabler to us delivering the priorities identified will be use of the various tools within the TEWV quality improvement system which is our internal processes for ensuring we have a robust process for improving quality.

Priority 1: to proactively seek feedback from service users and carers on a day to day basis and act on this

Our aim
To increase the number of service users who are asked about their experience by 50% by 31 March 2012.

Why this is important
A key element of our approach to quality is that the experience of those people who use our services is good. However at present we do not have a consistent system for collecting service user views on their experience of the care we have provided. If we do not know what our service users think needs to improve we cannot make the changes to make the experience better.

What we will do
We will:

- identify and publish a baseline of all service user numbers who were asked about their experience and the methodologies used in 2010/11 by 30 April 2011
- identify and agree the methodologies to be piloted to capture service user experience in community services by 30 June 2011
- begin to pilot the agreed methodologies in community services as per project plan by 30 June 2011
- develop a menu of all the different ways used to capture service user experience appropriate for use with different groups of service users and clinical services by 30 September 2011
- develop a regular reporting structure at corporate level to ensure survey rates and results of service user experience are being monitored by 30 September 2011
- Ensure the service user views that are gathered are fed back to staff in a timely way so that they can address any issues that have been raised by 31 December 2011
- Produce regular quarterly reports of service users surveyed and results by 31 December 2011
- Complete the roll out of the electronic system used to collect service user experience across all adult mental health inpatient areas in Durham, Darlington and Teesside by 31 March 2012
- Produce an annual evaluation report on the findings from the service user experience surveys and uptake numbers by 31 March 2012
- Evaluate the community pilot project and make recommendations for next steps by 31 March 2012

Priority 2: improving transfers of care, including improving communication between professionals

Our aim
To improve transfers of care by at least 10% against an agreed set of standards by 31 March 2012.

Why this is important
We know that when someone is transferred from one service to another or from one team to another there is a greater risk to the service user. This is because it is a time of change; more people are involved and new relationships need to be built. In 2010/11 we identified that we should concentrate on improving the discharge process from our inpatient wards as this is the transfer with the highest risk. We want to build on what we did in 2010/11 and expand this to all transfers of care not just inpatient discharge. This ensures service users can be transferred to the most appropriate service and team in a safe and effective way.

What we will do
We will:
- develop a regular reporting mechanism to report on the number of Care Programme Approach (CPA) reviews held prior to transfer and use this to identify a baseline by 30 June 2011
- agree a set of quality standards to apply to CPA reviews and care plans completed when there is a transfer of care by 30 June 2011
- check the baseline quality of CPA reviews and care plans at transfer by undertaking an audit of reviews and care plans against the agreed quality standards by 30 September 2011. This will include the involvement of service users, carers and all relevant professionals
- in response to the results of the audit we will develop an action plan to address key findings of the audit by 31 October 2011 and start to implement that action plan from that date
- evaluate the impact of the implementation of the action plan by further spot checks during February 2012

Priority 3: implementing lessons learnt from SUIs and complaints

Our aim
To ensure 90% of the actions agreed in response to the reviews of SUIs and complaints are implemented on time by 31 March 2012.

Why this is important
We know we do not always reach the high standards we aim to achieve and when we get it wrong this can have serious consequences for service users, carers and staff. Therefore, we need to ensure that when we do get it wrong we learn from that and ensure we do not make the same mistake again. We know that by learning from investigations or from complaints that we receive we can continue to improve our services.

What we will do
We will:
- test the safety systems developed in 2010/11 for the most serious incident reporting, investigations and complaints in Teesside, Durham and Darlington by 30 June 2011. This will include incidents such as:
  - SUIs, eg deaths or permanent damage or significant near misses
  - near misses and reversible harm
- identify what would be required to extend the implementation of safety systems for less serious incidents by 30 June 2011
- implement the agreed safety systems in Teesside, Durham and Darlington by 30 September 2011
- develop a system where we can analyse the issues being highlighted in complaints, claims and incidents and identify common themes that need to be addressed by 30 September 2011
- explore existing patient safety systems in North Yorkshire and identify the work required to ensure consistency with existing arrangements in Durham, Darlington and Teesside by 30 September 2011
- explore the actions required to implement the Leading Improvement in Patient Safety (LIPS) objectives (reduction in the number of incidents of physical assaults and increase the quality and use of care plans) across the North Yorkshire localities by 31 December 2011
- implement safety systems to North Yorkshire services by 31 December 2011
- develop and test a system for monthly lessons learnt together with 'stories' and scenarios about incidents and complaints
- audit or review outcomes using a consistent model which will be included in the audit forward programme by 31 December 2011
- establish a quarterly patient safety team report to the QuAC with feedback provided to clinical services from 31 March 2012

Priority 4: improving the quality of the crisis services including service user satisfaction

Our aim
To improve the experience of service users and carers by a minimum of 10% against agreed criteria by 31 March 2012.

Why this is important
Our review of SUIs, complaints and feedback from service users, carers, GPs and LINKs has indicated that we do not have consistent quality across our crisis services. As access to and response from the crisis team is central to the safety and effectiveness of the care received by service users ensuring consistent quality of that care is essential.

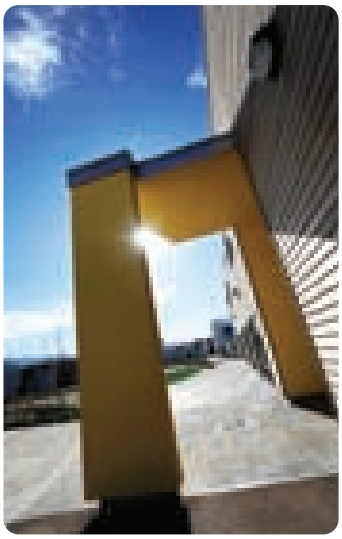
What we will do
We will:
- establish baseline satisfaction levels using a service user and carer survey, the GP survey, focus groups, Mind review, and reports by LINKs by 31 August 2011
- carry out a review of the current ways our crisis services operate by 31 August 2011. It is planned that the review will involve service users, carers, LINKs and other key stakeholders
- produce and agree an action plan to address the findings from the review by November 2011
- begin the implementation of the action plan in December 2011
- undertake further survey of satisfaction of service users and carers by 31 March 2012

Priority 5: review and monitor clinical risk assessments to ensure they comply with expected standards and outcomes

Our aim
All clinical risk assessments undertaken will comply with expected standards and outcomes by 31 March 2012.

Why this is important
Clinical risk assessments are critical if we are to support our service users to recover safely. They help us understand what factors are increasing the risk to the individual, and others, and also the things that may be in place to help to reduce or manage those risks. It is only by having a good understanding of these through a thorough clinical risk assessment that we can, jointly with the service user, develop an appropriate plan to support recovery.

What we will do
We will:
- agree acceptable standards for the completion of clinical risk assessments, to include quality and timescales for completion by 30 June 2011
- undertake an audit to establish a baseline position against those standards and identify issues which require action by 30 September 2011
- establish a monthly monitoring process to check completion within the agreed timescales by 30 September 2011
- develop and implement an action plan to address any areas of non compliance by 31 December 2011 (the action plan will include addressing any training requirements identified)
- carry out an audit to ensure 100% compliance against agreed standards by 31 March 2012



"inspirational artwork", the "fantastic facilities" and "beautiful courtyard areas" – Roseberry Park

Monitoring progress

Progress against all of the above priorities both in terms of performance against the overall indicator/target and the agreed actions will be as follows:
- delivery of performance of each of the indicators compared to the targets set above will be measured
- progress against the actions identified for each priority will be monitored

The progress in terms of both the actions and achievement of the targets will be collected and reported formally in the quarterly quality performance report to the following:
- QuAC
- board of directors
- council of governors

The formal report submitted will outline the progress made together with any corrective action that may be required. The submission of the quarterly quality performance report will ensure accountability for the delivery of the agreed key quality priorities through the key governance mechanisms of the trust.

Finally the quarterly report that is submitted to the board of directors will be available on the trust website and therefore available to all stakeholders and the general public. These can be found at www.tewv.nhs.uk/boardpapers.

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 in this section. In some cases additional information has been provided over and above that required by the guidance.

Review of services

During 2010/11 TEWV provided and/or subcontracted seven NHS services.

TEWV has reviewed all the data available to them on the quality of care in seven of these NHS services.

The income generated by the NHS services reviewed in 2010/11 represents 96% of the total income generated from the provision of NHS services by TEWV for 2010/11.

The review of services is undertaken by the QuAC and includes a quarterly report from each service. This report includes information on:

- patient safety – including information on SUIs, levels of violence and aggression, medication incidents, use of control and restraint, implementation of safety alerts
- clinical and cost effectiveness – including information on the implementation of NICE guidance and the results of clinical audits
- experience – including information on complaints, claims, and PALS contacts

In addition to the formal report the service gives a presentation on particular areas of work that they have been undertaking to improve quality or invites a service user to talk to the QuAC on the experience they have had and what they think we could do to improve further.

The data reviewed as described above covers the three areas of patient safety, clinical effectiveness and patient experience. However the QuAC recognises that some of the data is more available and robust than others. The data on clinical outcomes in mental health is still limited and, as has been described earlier, whilst there is a range of data available on patient experience we are trying to improve this so that we have regular real time collection of the views of our service users.

In addition to the detailed QuAC quarterly review each service also has a 'service performance dashboard' which contains a 'balanced' overview of the performance of the service which is reviewed monthly by the executive management team and the board of directors with actions being agreed as appropriate. The board of directors also undertakes monthly visits to different services. 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.

Participation in clinical audits

During 2010/11, eight national clinical audits and one national confidential inquiry covered NHS services that TEWV provides.

During that period TEWV participated in 100% of 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 were eligible to participate in during 2010/11 were as follows:

- Royal College of Psychiatrists (RCP) continence care audit
- Prescribing Observatory for Mental Health (POMH) UK Topic 7- monitoring of patients prescribed lithium
- POMH UK Topic 8 - medicines reconciliation
- POMH UK Topic 9 - antipsychotics in people with LD
- POMH UK Topic 10 - use of antipsychotic medicine in CAMHS
- POMH UK Topic 11 - prescribing antipsychotic medication for people with dementia
- National Audit of Psychological Therapies (NAPT)
- National Audit of Schizophrenia (NAS) formerly National Audit of Prescribing Practice for Treatment Resistant Schizophrenia
- 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 participated in during 2010/11 are as follows:

- Royal College of Psychiatrists (RCP) continence care audit
- Prescribing Observatory for Mental Health (POMH) UK Topic 7- monitoring of patients prescribed lithium
- POMH UK Topic 8 - medicines reconciliation
- POMH UK Topic 9 - antipsychotics in people with LD
- POMH UK Topic 10 - use of antipsychotic medicine in CAMHS

Audit Title	Cases Submitted	% of the number of registered cases required
POMH UK Topic 7 Monitoring of Patients Prescribed Lithium	83	100%
POMH UK Topic 8 Medicines Reconciliation	86	100%
POMH UK Topic 9 Antipsychotics in People with LD	183	100%
POMH UK Topic 10 Use of Antipsychotic Medicine in CAMHS	44	100%
National Audit of Psychological Therapies (NAPT)	*	*
National Confidential Inquiry into Suicide & Homicide by People with Mental Illness (NCI/NCISH)	-	97.1% = national % returns)

** Data collection return due 31 March 2011.*

- POMH UK Topic 11 - prescribing antipsychotic medication for people with dementia
- National Audit of Psychological Therapies (NAPT)
- National Audit of Schizophrenia (NAS) formerly National Audit of Prescribing Practice for Treatment Resistant Schizophrenia
- 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 participated in, and for which data collection was completed during 2010/11 are listed below. Alongside are 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.

The reports of three national clinical audits have been formally reviewed by the provider in 2010/11 and TEVW intends to take the following actions to improve the quality of healthcare provided:-

- POMH UK Topic 7 monitoring of patients prescribed lithium
  Actions:
  - roll out lithium RPIW to all community teams
  - 12 month audit of Lakeside CMHT lithium RPIW.
  - repeat POMH Topic 7 audit

- POMH UK Topic 8 medicines reconciliation
  Actions:
  - circulate results to pharmacists
  - develop guidance for non-pharmacy staff performing medicines reconciliation

- POMH UK Topic 10 use of antipsychotic medicine in CAMHS
  Actions:
  - action plan developed for monitoring recommendations to be achieved
  - participate in POMH UK re-audit

The reports of 31 local clinical audits were reviewed by the provider in 2010/11 and TEWV intends to take actions to improve the quality of healthcare provided. The actions are included in appendix 1. (It should be noted that 180 local clinical audits were undertaken in 2010/11)

Research

The number of patients receiving NHS services provided or subcontracted by TEWV in 2010/11 that were recruited during the period to participate in research approved by a Research Ethics Committee was 491. Of these, 374 were recruited to National Institute for Health Research (NIHR) portfolio studies. Taking this as a key indicator of trust involvement with large scale NIHR research this compares with 106 participants reported for the previous year. The rapidly increasing level of participation in clinical research through 2010/11 and in particular in multi-site large scale trials, shows that we are committed to improving the quality of care we provide as well as to contributing to the broader goals of mental health research.

We were involved in conducting 59 clinical research studies in total during 2010/11, completing 15 within the agreed time and to the agreed recruitment targets. The NIHR supported 23 of these studies through its research networks and NIHR coordinated system for gaining NHS permission was employed in managing approvals for 13 new studies.

In addition to the above in order to embed a research culture within TEWV in 2010/11 120 members of clinical staff participated as researchers in studies approved by a research ethics committee, with 59 of these in the role of principal investigator. NIHR research studies currently active within the trust cover medical specialties ranging from psychosis and attention deficit hyperactivity disorder (ADHD) to addictions, drug safety and forensic mental health, with a substantial involvement in affective disorder and mental health services research. In addition, several new research studies are currently in set-up for trust participation including industry sponsored clinical trials, which address key areas of unmet need for our service users.

Of the 32 studies permitted to start in the reporting period, 24 were given permission by an authorised person less than 30 days from receipt of a valid and complete application, including favourable opinion from an ethics committee. 13 researchers from outside the organisation have been granted access under the national research passport scheme.

We have also worked with the Mental Health Research Network and other clinical research networks to establish innovative approaches, including training and awareness programmes, to encourage our service users and carers to participate in multicentre studies. Active user and carer involvement spanning the research process from design through to results communication is a major goal of the trust's new research and development strategy approved by the board in March 2011.

In addition we have launched a major new collaborative partnership with Durham University for an expanded research centre focussed on the needs of young people with severe mental illness. The main themes will be the evaluation of psychological interventions in young people, and prescribing quality and safety.

Finally our clinical staff have published articles this year in a range of high quality journals, including Schizophrenia Research and Nature Genetics. The results of a national study of intravenous heroin treatment (RIOTT) have been disseminated; as well as publication in the Lancet, service users have given their personal accounts to both the trust's QuAC and local criminal justice services. This research, in which we have been a key collaborator, has provided new evidence for the effective treatment of heroin addiction with resulting positive impact on the users of addiction services and their families. A British Journal of Psychiatry publication on the evidence of therapy for depression as delivered effectively by non-specialists may have potentially far-reaching implications for NHS Increasing Access to Psychological Therapies (IAPT) services.

Goals agreed with commissioners

Use of the Commissioning for Quality and Innovation Payment Framework (CQUIN)

A proportion of TEWV's income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between TEWV and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2010/11 and for the following 12 month period are available online at www.tewv.nhs.uk/qualitypayments

As part of the development and agreement of the 2010/11 mental health contract, discussions were held between TEWV and each of its commissioners to agree a set of goals and indicators that both parties felt were appropriate and relevant to local and national strategies. Indicators linked to patient experience, patient safety and clinical effectiveness were key to both provider and commissioner.

An overall total of £3,254,877 was available for CQUIN to Tees, Esk and Wear Valleys NHS Foundation Trust in 2010/11 conditional upon achieving quality improvement and innovation goals across all of its CQUINs, and a total of £3,069,478 was received for the associated payment on 2010/11.

What others say about the provider

Statements from Care Quality Commission (CQC)

TEWV is required to register with the Care Quality Commission and its current registration status is licensed to provide services with no conditions attached. The Care Quality Commission has not taken enforcement action against TEWV during 1 April 2010 to 31 March 2011.

TEWV has not participated in any special reviews or investigations by the CQC during the reporting period. However the CQC has carried out four planned reviews during December 2010 and January 2011, which were then followed by unannounced visits to two of the locations from the planned reviews (Bankfields Court on 3 February 2011 and Park House on 3 March 2011). In all four cases the CQC agreed that we were fully compliant with the required standards. They did however make some suggestions on how we could improve further and we will take the following action to address these requirements/recommendations:

Church View – learning disability rehabilitation service

- An action plan relating to the recording of patient activities will be implemented at Church View by May 2011.
- The way Church View seeks views on their service from people who use the service and their relatives will be improved by the end of April 2011.
- Staff at Church View will receive training in safeguarding vulnerable adults by 31May 2011.
- All staff at Church View will have an appraisal by 31 May 2011.

Bankfields Court – learning disability Inpatient service.

- Service users will have more involvement in making choices regarding meals by April 2011.
- The re-design of Bankfields Court Home will be delivered according to the current project plan.
- Access to audit reports will be available to all staff within the service by March 2011.

West Lane Hospital – children and young people's inpatient service

- A review of access to dentistry will be undertaken to take into account the specialist inpatient eating disorder service by May/June 2011.
- Staff will receive training in dual diagnosis with a focus on young people by July 2011.
- Westwood and Newberry wards need enhancements to their physical environment which have been identified and addressed in the children and young people's 2010/2014 business case.
- The security review has highlighted site problems and is currently on the trust risk register.
- The CQC found that people are not at risk of harm from unsafe or unsuitable equipment but to maintain this age appropriate information will be provided to those who use equipment in the service by June 2011.

Park House – adult mental health rehabilitation service

- By the end of January 2011 Park House will implement a monthly audit to ensure the responsible consultant documents discussions regarding medication. The audit will also look at whether the responsible consultant ensures that discussions regarding medication use on-line information to aid the consent process. This audit will be undertaken alongside the existing audit of rights under section 132.
- Audits of compliance with relevant HR policies and procedures will be completed by March 2011.

Data quality

TEWV NHS FT submitted records during 2010/11 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 94.93% for admitted patient care; 98.2% 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 accurate 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 which meets on a monthly basis and addresses data quality issues in terms of patient information, staff information and financial information.
- We have established regular reports on key elements of data which show how well data is being recorded on the various information systems, particularly the patient information system and the staff information system.
- The regular reports above are available to all services so that they can target improvement work on areas where problems occur. Data quality is a key item for discussion in the monthly performance meetings that are held with the services and include the chief operating officer, the director of finance and information and the director of planning and performance.
- Data quality is discussed each month at the executive management team meeting dedicated to performance.

Information Governance Toolkit attainment levels

TEWV Information Governance Assessment Report overall score for 2010/11 was 81% and was graded red.

The red grading is due to us not being able to meet the required levels for 2 of the elements of the information governance assessment. These were as follows:

Element 8-112 - Information governance awareness and mandatory training procedures are in place and all staff are appropriately trained. Whilst we did not achieve the required 95% of staff having taken and passed the information governance toolkit training module we have this year had the information governance campaign team who have raised awareness at team level and addressed any weaknesses at that level. Work will continue in 2011/12 to increase the percentage of staff that are appropriately trained.

Element 8-324 - the confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate. The implementation of the information strategy has meant that we will be changing a key system in 2011/12 and therefore we decided to invest resources into ensuring we can implement pseudonymisation on the new system rather than the current one which has meant that we have not achieved level 2 in 2010/11.

Clinical coding error rate

TEWV was not subject to the payment by results clinical coding audit during the reporting period by the Audit Commission.

Part 3:
Other information on quality performance 2010/11

Our performance against our quality metrics

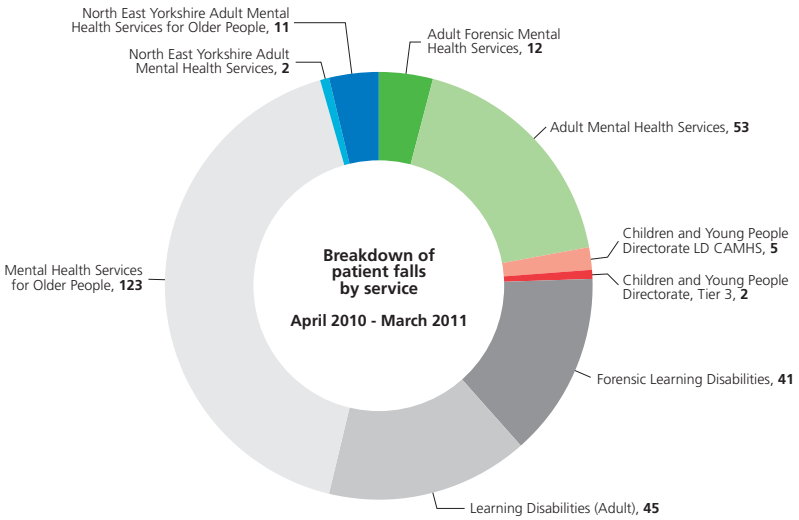
The following table provides details of our performance against a set of agreed quality metrics in 2010/11. We agreed to continue with the same metric as in previous quality reports so that we can monitor progress.

	2010-11		2009-10	2008-09	2007-08
	Indicative level/Target	Actual	for comparative purposes		
Patient safety measures					
1 Number of unexpected deaths	36*	**28**	32	40	38
2 Number of outbreaks of Healthcare Associated Infections	0	**0**	0	0	0
3 Number of Patient Falls	244	**294**	244	284	442
Clinical effectiveness measures					
4 CPA 7 day follow up	95.0%	**98.5%**	97.5%	97.3%	99.0%
5 Implementation of NICE Guidance	100.0%	**66.7%**	75.0%	75.0%	26.5%
6 Average length of stay for patients in AMH & MHSOP Assessment and Treatment Wards	<47	**39**	47	47	45
Patient experience measures					
7 Delayed Transfers of Care	7.5%	**1.6%**	2.9%	4.8%	N/A
8 Complaints	<111	**125**	111	104	96
9 National Patient Survey	**Actual**				
Number of questions where our score was within the top 20% of trusts	18 (47%)		16 (42%)	18 (49%)	7 (19%)
Number of questions where our score was within the middle 60% of trusts	14 (37%)		22 (58%)	17 (46%)	30 (81%)
Number of questions where our score was within the lowest 20% of trusts	6 (16%)		0 (0%)	2 (5%)	1 (3%)

* The number here is the maximum level of unexpected deaths that we would expect to see rather than a target number we are trying to achieve.

Notes on selected metrics

1. *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. It should be noted that there is a reduction of one for the 2009/10 figure shown above when compared to the figure in the 2009/10 quality report due to a reclassification of one incident within the adult learning disability service.*
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 have completed so far this financial year. 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 the other years.*



Comments on performance

Metric 3 – The majority of patient falls occur within the older people's service (see chart above) therefore extra support in managing falls has been made available to them and is proving to be beneficial. The annual position remains high at 294 against a target of 242, which is an increase on the previous year; however the increase in falls within MHSOP is linked to increased admissions and more complex patients with associated age related illnesses.

The following work has been undertaken during 2010/11 within MHSOP:

- A MHSOP falls strategy has been developed and approved.
- A standard process for preventing and managing falls, known as the falls pathway, has been piloted.
- Audits have been undertaken against NICE Guideline 21 falls and the fracture neck of femur audit and action plans produced.
- All wards undertake initial falls assessments on admission which is monitored via electronic visual display boards.
- The initiative to identify people at risk of falling on admission, known as the falling stars initiative, is being extended as an alert on the patient information system PARIS.
- Work has also been undertaken around unobserved falls and the use of CCTV at Roseberry Park.
- The service has identified link people from each ward and work has been undertaken to ensure access to supervision around this aspect of care.
- Finally on a positive note the National Patient Safety Agency (NPSA) are using the trust as the main example of good practice in their new 'how to' guide for mental health.

It has not been possible to include any benchmark information with other organisations due to the unavailability of such information. The trust does participate in the Audit Commission Benchmarking Club but due to changes in the Audit Commission the more recent information refers to 09/10.

Metric 4 – The trust has met the nationally set target for CPA seven day follow up; however we have also focused on the number of follow ups which are face to face with the patient as opposed to a telephone call. Priority 4 (transfers of care) includes the performance for both seven day follow up and those that were followed up face to face. The trust's performance for the latter metric is 95.4% at year end, against a target of 90%.

Metric 5 – There were 63 NICE Audits on the programme for 2010/11, of which 42 have been completed at year end. The main reasons for completion rates being below the target are the natural reporting lag and several projects being expanded in scope during 2010/11.

Metric 8 –The trust received 125 complaints in 2010/11 which means the annual target of 111 has been exceeded. This trust also monitors the percentage of complaints 'satisfactorily resolved' as it is important that when people do complain that they are comfortable with the response we provide. In 2010/11 86.0% of complaints were satisfactorily resolved compared to our target of 90.0%. Complaints continue to be monitored by the QuAC 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.

Metric 9 – The trust performed well in the 2010 National NHS community mental health services users survey management report from the Care Quality Commission, achieving the same number of questions (18) that scored within the top 20% of trusts as in the 2008 community survey. The number of questions where our scores were within the middle 60% of trusts are slightly lower than 2008 whilst the number of questions where our scores were within the lowest 20% of trusts are slightly higher.

- The trust scored in the highest performing 20% of trusts in relation to all the questions about health and social care workers (for example, 'Did this person listen carefully to you'?) and also the two overall questions ('Overall, how would you rate the care you have received from mental health services in the last 12 months?' and 'Have mental health services involved a member of your family or someone else close to you, as much as you would like?')

- The trust also received the highest score achieved of all trusts for the question 'If you had any talking therapy from NHS mental health services in the last 12 months, did you find it helpful?'

- The trust performed less well in a number of questions relating to care plans; however an action plan has been developed to improve on the areas identified in the lowest 20% of 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.

	2010-11		2009-10	2008-09	2007-08
	Target	Actual	for comparative purposes		
a The trust has registered with the CQC with no conditions	Yes	**Yes**	Fully met	Fully met	Fully met
b Number of occupied bed days of under 18s admitted to adult wards	0	**70**	173	104	79
c Retention Rate: Substance Missuse (rolling 12 month and 3 months behind)*	89.7%	**86.6%**	89.7%	87.8%	82.6%
d Number of Early Intervention in Psychosis New Cases (cumulative position)	230	**455**	407	301	236
e Number of Crisis Resolution Home Treatment Episodes	2978	**5751**	5191	3944	3865
f Percentage of admissions to inpatient services that had access to Crisis Resolution Home Treatment Teams	90.0%	**97.0%**	97.2%	94.5%	N/A
g CPA 7 day follow up	95.0%	**98.5%**	97.5%	97.3%	99.0%
h Maintain level of Crisis Resolution Teams set out in 03/06 planning round	Maintain	**Maintained**	Maintained	Maintained	Maintained

** Data is for the period January to December 2010 as this is the latest available*

Notes on national targets and regulatory requirements

a. Information shown between 2007-08 and 2009-10 is compliance with HCC core standards; however these are no longer applicable and have been replaced by registration with the CQC from 2010-11. The line for registration re: health care associated infections has been removed from the table as this is now within the overall registration requirements.

b. The target for this is 0 unless clinically appropriate.

c. Retention rate - the information shown for 2009/10 has been updated since the annual account was published, this is due to the delay in reporting three months behind which meant the final out-turn position was not available at the time.

f. This target did not exist in 2007/08 and so no data is available for that period.

Comments on performance

Indicator b – There were 70 occupied bed days for under 18s admitted to adult wards during 2010/11 which is an improvement on the previous year and all of the admissions were deemed as clinically appropriate. All these admissions were of children aged 16-18 and there were no admissions onto adult wards of under 16s

Indicator c – The trust's latest performance for this metric remains slightly below target, however this continues to be addressed through the performance management fora.

Our stakeholders' views

Last year when we shared our draft quality report with our stakeholders we received a number of comments which fell broadly into two key themes:

- Our stakeholders wanted greater involvement in the process of developing the quality report and in particular to have the opportunity to influence the quality priorities agreed by the board of directors
- Our stakeholders wanted all the comments they submitted published as opposed to only those received from the organisations that were coterminous with the locality where the trust headquarters is.

In response to this we have taken the following action:

- We held two stakeholder workshops to provide the opportunity to gather views and comments on what the quality priorities should be for 2011/12 and action we should take to address those priorities. We invited a wide range of stakeholders including LINks, OSCs, PCTs, local authority directors of adult social care, local authority directors of children's services, practice based commissioning chairs and governors. The views expressed were fed into the board of directors' discussion on what the quality priorities should be and significantly influenced the final priorities agreed.
- We also shared drafts of the quality report with the council of governors working group for comment and amended the draft in light of those comments.
- We shared the final draft of our quality report with our three main commissioners, our seven Overview and Scrutiny Committees and our seven LINks organisations and asked them for comments.

All the comments we have received from our stakeholders are included verbatim in appendix 2.

2010/11 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 Reports) Regulations 2010 to prepare quality reports 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 content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2010 to June 2011
  - papers relating to quality reported to the board over the period April 2010 to June 2011
  - feedback from the commissioners dated May 2011
  - feedback from governors dated 19 May 2011
  - feedback from LINks dated May 2011
  - feedback from OSCs dated May 2011
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 5 May 2011
  - the [latest] national patient survey published on 14/09/2010
  - the [latest] national staff survey published on 16/03/2011
  - the head of internal audit's annual opinion over the trust's control environment dated 17 May 2011
  - care Quality Commission quality and risk profiles dated 16/03/2011
- the quality report presents a balanced picture of the NHS 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; and
- 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 reports regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (available at 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

Jo Turnbull
Chairman

Martin Barkley
Chief Executive

2nd June 2011

Independent assurance report to the Council of Governors of Tees, Esk and Wear Valleys NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Tees, Esk and Wear Valleys NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Tees, Esk and Wear Valleys NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the "Quality Report").

This report, including the conclusion, has been prepared solely for the Council of Governors of Tees, Esk and Wear Valleys NHS Foundation Trust as a body, to assist the Council of Governors in reporting Tees, Esk and Wear Valleys NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Tees, Esk and Wear Valleys NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter
We read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for our report if we became aware of any material omissions.

Respective responsibilities of the Directors and auditors
The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

We read the other information contained in the Quality Report and considered whether it is inconsistent with the specified documents in the Monitor guidance.

We considered the implications for our report if we became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Making enquiries of management;
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report and;
- Reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

Deloitte LLP
Chartered Accountants
Newcastle
June 2011

Governance review

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 67).

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 and
- 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 Foundation Trust Code of Governance

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

The Code, published by Monitor, the independent regulator of foundation trusts, brings 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.

In 2010/11 we complied with all the provisions of the code of governance with the exception of provision C.2.2 which states that:

"Non-executive directors, including the chairman, should be appointed by the council of governors for specified terms subject to re-appointment thereafter at intervals of no more than three years …"

The following non-executives have terms of office of over 3 years:

- Jim Tucker (4 years)
- Andrew Lombard (3 years and 2 months)
- Mrs. Barbara Matthews (3 years and 2 months)
- Douglas Taylor (3 years and 6 months)

In making the appointments the council of governors was mindful of the need to maintain a balance of skills and experience on the board of directors and the benefits of ensuring that vacancies are evenly spread between years.

The latest version of the code of governance, published in 2010, is available on Monitor's website: www.monitor-nhsft.gov.uk

"I was always impressed by the dedication of the nurses and carers. A very challenging and demanding job was met with care and consideration for both the patients and families."

A service user's granddaughter

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 and 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 2010 there has been only one change to the membership of the board with the appointment of Mrs Barbara Matthews who succeeded Mr Paul Briggs as a non-executive director on 1st July 2010.

The chairman has no other significant commitments than shown overleaf.

Membership of the board
as at 31 March 2011

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:
1 April 2010 to 31 March 2013*

Mr John Robinson
Deputy chairman and chairman of the quality and assurance 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:
1 July 2010 – 31 August 2012*

Mr Andrew Lombard
Non-executive director, senior independent director and chairman of the Mental Health Act 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:
1 July 2010 – 31 August 2013*

Mrs Barbara Matthews
Non-executive director

Barbara is an international lawyer specialising in the oil and gas industry but currently works as a political assistant for the City of York Council.

Qualifications:
BA hons, JD (law)

Term of office:
1 July 2010 to 31 August 2013

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 and chairs the Northern School of Psychiatry's workforce sub-committee.

Qualifications:
MA, MBBS, FRCPsych

Appointed:
January 2010

Mr Colin Martin
Director of finance and deputy chief executive

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 Payment by Results 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 and deputy chief executive

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

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:
1 July 2010 to 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 (the council of governors has appointed Graham for a further term of office to run consecutively until 31 August 2014)

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:
1 March 2011 to 31 August 2014*

Mr Jim Tucker
Non-executive director and chairman of the investment committee

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 was 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

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.

*indicates that the individual has been reappointed as a board member of the foundation trust)

Board Meetings

The board formally meets at least ten times a year. Special meetings are held in June, to approve the annual report, financial statements and quality report, August and December. Further special meetings are held as and when necessary to discuss significant issues.

At each ordinary meeting, the board receives certain reports, for example on financial and operational performance and risks.

The board meets in public once each quarter with at least one of these meetings being held each year in Durham, Stockton on Tees, Middlesbrough and North East Yorkshire. The remaining meetings are held in private, usually at West Park Hospital in Darlington.

The chairman holds meetings with the non-executive directors without the executive directors present each month.

The attendance of directors at meetings during 2010/11 is set out in the table below:

Attendance at board meetings

The board met 14 times during 2010/11. The number of these meetings attended by individual directors was as follows:

	No. of Board Meetings attended
Mrs Jo Turnbull	12
Mr Paul Briggs	4 (5)
Mr Andrew Lombard	13
Mrs Barbara Matthews	8 (9)*
Mr Graham Neave	8*
Mr Michael Newell	13
Mr John Robinson	13
Mr Douglas Taylor	13
Mr Jim Tucker	14
Mr Martin Barkley	13
Mr Colin Martin	11
Dr Nick Land	12
Mr Les Morgan	13
Mrs Chris Stanbury	11
Mr David Levy	13
Mrs Sharon Pickering	11
Mr Chris Parsons	12

Notes: *Maximum possible number of meetings to be attended shown in brackets*
(*) Although Mr Neave and Mrs Matthews were unable to attend a meeting on 21st December 2010 due to severe inclement weather they were able to contribute to discussions by way of a teleconferencing facility

The trust secretary attends 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 business plan
- non-executive directors and executive directors have been aligned to each of the public constituencies and attend both formal and informal meetings
- updates provided by the chairman at board meetings
- attendance by governors at monthly structured board visits to services
- governors are encouraged to attend public meetings of the board of directors

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.

Attendance by board members at meetings of the council of governors is based on the following principles:

- The chairman attends all meetings.
- Attendance at meetings by non-executive directors is not compulsory; however, there is a standing invitation for them to attend as observers.
- Executive and corporate directors attend meetings if required, for example Colin Martin attends meetings to deliver the finance report, or as observers.

Attendance by the members of the board of directors at the five meetings of the council of governors during 2010/11, including the Annual General Meeting was as follows:

Mrs Jo Turnbull	5
Mr Paul Briggs	0 (1)
Mr Andrew Lombard	4
Mrs Barbara Matthews	4(4)
Mr Graham Neave	3
Mr Michael Newell	4
Mr John Robinson	5
Mr Douglas Taylor	5
Mr Jim Tucker	4
Mr Martin Barkley	4
Mr Colin Martin	4
Dr Nick Land	0
Mr Les Morgan	3
Mrs Chris Stanbury	3
Mr David Levy	3
Mrs Sharon Pickering	5
Mr Chris Parsons	4

Note: *Maximum possible number of meetings to be attended shown in brackets*

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 3600 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. Peer assessments may also be sought from the trust's partners.
- 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 is carried out by the chief executive, whose performance is 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 evaluated by self assessment. The results are considered by each committee and the board.

Committees of the board

The board has standing audit, investment, quality and assurance (formerly the clinical governance and clinical risk), mental health act and remuneration committees.

Each committee has terms of reference which have been approved by the board and includes its reporting arrangements. Details of the terms of reference are included in the trust's integrated governance strategy which is available on our website.

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

The audit committee

Role and Responsibilities

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 organisation (eg the Care Quality Commission, Monitor, etc) and considering their implications for the governance of the trust
- reviewing and monitoring the integrity of any financial statements including any financial judgements contained in them and ensuring the completeness and accuracy of information provided to the board
- reviewing arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters (the whistleblowing policy)

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

Membership of the Committee

The committee comprises a maximum of five members all of whom must be independent non-executive directors. There is also a standing invitation for all other non-executive directors to attend meetings of the committee and participate in discussions but not to vote.

Douglas Taylor, a qualified accountant, brings a high level of recent relevant financial experience in his capacity as chairman of the committee.

The committee held seven meetings during the year. Attendance by each member was as follows:

Mr Douglas Taylor *(chairman)*	7
Mr Paul Briggs	2 (2)
Mr Andrew Lombard	6
Mr Michael Newell	5
Mr Jim Tucker	4 (4)
Mrs Barbara Matthews	3 (3)

Note: *Maximum possible number of meetings to be attended shown in brackets*

The director of finance, head of internal audit and the audit partner, Deloitte LLP generally attend all meetings of the committee. The trust secretary is the secretary to the committee.

At least once a year the committee meets privately with the external and internal auditors.

Main activities during the year

During 2010/11, in addition to maintaining an overview of the work of the internal and external auditors, the audit committee has undertaken the following key activities:

- provided assurance to the board on the fairness and accuracy of the 2009/10 annual report including the annual financial statements and quality report based on the findings of the external auditors' report to those charged with governance (ISA 260) and "dry run" review of the quality account
- reviewed and being assured on the trust's project management framework
- monitored and being assured of progress of the reforming community teams project which was introduced following a report commissioned by the committee from Deloitte LLP in 2009
- oversaw the development of a three year strategic audit plan which is aligned to the principal risks identified by the trust
- supported the review of the provision of external audit services (see following page)
- developed and agreed key performance indicators for external audit services
- reviewed and recommended improvements to clinical audit activity including ensuring coverage of principal risks and the development of processes to confirm progress on the implementation of agreed actions
- reviewed the trust's arrangements for staff to raise concerns in confidence (the whistleblowing policy)

Safeguarding Auditor Independence

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

- external audit does not audit its own

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

During 2010/11 Deloitte LLP, the external auditors, was not commissioned by the trust to provide non-audit services.

In 2010 the internal and external auditors entered into a strategic partnership. Under the partnership agreement any work undertaken by the external auditors must be approved by the audit committee and meet the internal ethical standards of the external audit firm.

The External Auditors
In 2010 the council of governors, in partnership with the audit committee, reviewed the provision of external audit services.

The review was undertaken by a working group comprising members of the audit committee and representatives of the council of governors under the chairmanship of Douglas Taylor.

In undertaking the review the group considered the requirements of the audit code, particularly with regard to the appointment and rotation of auditors, the quality of the work of the present auditors, the costs of external audit services to other foundation trusts and an appraisal of the market.

The group's recommendation that Deloitte LLP should be reappointed as the trust's external auditors until the completion of the 2012/13 audit was subsequently confirmed by the council of governors.

The cost of providing external audit services during 2010/11 was £84,000 including VAT. This includes the cost of the statutory audit and the review of the quality account required by Monitor, the independent regulator of foundation trusts.

Investment committee

The principal role of the investment committee is to review and provide assurance to the board 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 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

In 2010 the terms of reference of the committee were amended to include reviewing progress on the "upside" scenarios included in the business plan.

The committee comprises a non-executive chairman, three other non-executive directors, the chief executive, finance director, chief operating officer and director of planning and performance.

Jim Tucker succeeded Paul Briggs as chairman of the committee in September 2010. As at 31st March 2011 the following non-executive directors were members of the committee, in addition to Mr. Tucker:
- Andrew Lombard
- Michael Newell
- Douglas Taylor

During 2010/11 the committee reviewed and recommended to the board:
- the termination of the PFI contract for West Park Hospital
- the development of a young people's mental health academic collaboration between the trust and the University of Durham
- the outline business cases for the following developments:
  - The expansion of forensic services at Roseberry Park
  - The West Lane Hospital site development control plan (Phase 2)
  - A 6 bed forensic learning disability low secure extended treatment facility at Lanchester Road Hospital (Langley Ward)

The quality assurance committee (QuAC)

The QuAC oversees the quality assurance processes and clinical performance systems in place to govern service quality. The committee reports to the board of directors monthly and monitors regulatory compliance, service and clinical outcomes, quality performance and risk together with quality improvement processes. This is achieved through the collection of quality indicator performance data, which is reviewed and analysed by a network of assurance working groups and service governance teams.

This committee replaced the clinical governance and clinical risk committee, refocusing on the assurance of quality performance and management of the risks to service quality. Membership includes executive, non executive, corporate, service and clinical directors. As a minimum the panel must have the committee chairman (or deputy), a medical representative, a non executive director, a director and a member of the senior team from the nursing and governance directorate.

This year the QuAC has undertaken a planned programme of reviews as well as presented patient experience stories, both 'live' and through story telling.

The committee manages the development and production of the annual quality account (see page 41) and monitors performance against the annual quality improvement priorities identified in the quality account. The committee also provides a forum to review any national inquiries, safety alerts, service and internal reviews to identify lessons to be learned by the trust, actions required and progress of implementation of actions.

Membership
- Non-executive director lead for quality and assurance (Chairman) – Mr John Robinson
- Non-executive directors – Mr Jim Tucker, Mr Graeme Neave , Mr Michael Newell
- Mrs Chris Stanbury, director of nursing and governance
- Dr Nick Land, medical director
- Mr Les Morgan, chief operating officer
- Mrs Sharon Pickering, director of planning and performance
- Mrs Christine McCann, acting associate director of assurance and registration
- Service directors – Mr Paul Newton, Mrs Lesley Crawford, Mr David Brown
- Clinical directors – Dr Angus Bell, Dr Ingrid Whitton, Dr Soraya Mayat, Dr Kasi Prasad, Dr Ahmad Khouja, Dr Ruth Briel, Prof. Joe Reilly
- Mrs Wendy Broderick, chief pharmacist

Mental Health Act committee

This committee's responsibilities are:

- to appoint associate managers and oversee managers' 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 reports and the management responses including the implementation of action plans
- 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

Membership

This committee comprises:

- Mr Andrew Lombard, non-executive director and chairman
- Mrs Barbara Matthews, non-executive director
- Mrs Lesley Mawson, associate director of nursing and governance
- Mr Chris Parsons, director of estates and facilities
- Mrs Chris Stanbury, director of nursing and governance
- Dr Nick Land, medical director
- Ms Mel Wilkinson, MHA project manager
- Mr Paul Newton, service director
- Service user and carer representatives

Remuneration committee

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

Three remuneration committees were held during 2010/11 and attendance was as follows:

Mrs Jo Turnbull	3
Mr Jim Tucker	3
Mr John Robinson	3
Mr Douglas Taylor	3
Mr Michael Newell	2
Mr Andrew Lombard	3
Mr Graeme Neave	2
Mrs Barbara Matthews	3
Mr Martin Barkley (by invitation)	3

"I now have the tools to deal with my condition and always know that support is there. Thank you to your organisation for giving me a second chance"

A service user

The council of governors

For 2010/11 our council of governors comprised:

- 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, mental health services for older people, substance misuse and North East Yorkshire (CYPs, MHSOP, SMS and NEY)
  - corporate
  - learning disability and forensic services
  - 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 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 appointed Cllr Ann McCoy (Stockton Borough Council) as its lead governor.

The terms of office of governors and their attendance at the five meetings of the council of governors held during 2010/11 were as follows:

Public Governors (Elected)

Name	Constituency	Term of Office		No. of Council of Governor meetings attended (inc the AGM)
		From	To	
Dr David Hall	Darlington	1/7/08	30/6/11	4 (5)
Mr Dennis Haithwaite	Darlington	18/12/08	17/12/11	5 (5)
Mrs Betty Gibson	Durham	1/7/08	30/6/11	5 (5)
Mr Christopher Wheeler	Durham	1/7/08	30/6/11	4 (5)
Mr Roger Humphries	Durham	1/7/08	30/6/10	0(1)
Mrs Maggie Bosanquet	Durham	29/10/09	30/6/11	2 (5)
Mr Andrew Everett	Durham	1/7/10 (re-elected)	30/6/13	3 (5)
Mr Vince Crosby	Durham	1/7/10 *(re-elected)*	30/6/13	4 (5)
Dr Rachel Mitchell	Durham	1/7/08	30/6/11	1(5)
Dr Nadja Reissland	Durham	1/7/10	30/6/13	3 (4)
Mr John Doyle	Durham	1/7/10 *(re-elected)*	30/6/13	4 (4) *(inc authorised sabbatical)*
Mr Simon Carey	Durham	18/12/08	17/12/11	2 (5)
Mrs Christine Jeffreys	Hartlepool	8/4/09	6/10/10	2 (3)
Mr Paul Williams	Hartlepool	1/7/10 *(re-elected)*	30/6/13	3 (5)
Mrs Ann Tucker	Middlesbrough	29/10/09	30/6/11	5 (5)
Ms Catherine Haigh	Middlesbrough	29/10/09	30/6/11	5 (5)
Mr Michael Taylor	Middlesbrough	1/7/10 *(re-elected)*	30/6/13	5 (5)
Mr Paul Hyde	North East Yorkshire	1/7/08	30/6/10	1 (1)
Mr Richard Thompson	North East Yorkshire	1/7/08	30/6/11	5 (5)
Mr Keith Marsden	North East Yorkshire	1/7/10 (re-elected)	30/6/13	5 (5)
Mrs Andrea Darrington	North East Yorkshire	17/2/09	16/2/12	5 (5)
Mrs Vivienne Trenchard	Redcar and Cleveland	1/7/10 *(re-elected)*	30/6/13	3 (5)
Miss Jayne Mitchell	Redcar and Cleveland	1/7/08	30/6/11	5 (5)
Mrs Caroline Parnell	Redcar and Cleveland	18/12/08	17/12/11	3 (5)
Ms Susan Keith	Stockton	1/7/08	30/6/10	0 (1)
Mr Gareth Rees	Stockton	1/7/08	30/6/11	3 (5)
Mrs Rita Clark	Stockton	1/7/08	30/6/11	1 (2) *(inc authorised sabbatical)*
Mr Ray McCall	Stockton	18/12/08	17/12/11	5 (5)
Mr Paul Emerson	Stockton	1/7/10	30/6/13	4 (4)

Note: *Maximum possible number of meetings to be attended shown in brackets*

Staff Governors (Elected)

Name	Constituency	Term of Office		No. of Council of Governor meetings attended (inc the AGM)
		From	To	
Dr Richard Pyatt	Medical	1/7/08	21/2/11	3 (5)
Mr Simon Hughes	Allied Health Professionals	1/7/08	30/6/11	4 (5)
Mr Giles Hallam	Nursing	1/7/08	30/6/11	4 (5)
Dr Judith Hurst	Corporate	25/1/10	30/6/11	5 (5)
Mr Nigel Cooke	LD & Forensic	1/7/08	30/6/11	4 (5)
Mrs Jill Jefferson	MHSOP, C&YP, SM, NEY	1/7/08	30/6/11	5 (5)
Mrs Clare Beighton	Adult Mental Health	16/7/08	30/6/11	5 (5)

Note: *Maximum possible number of meetings to be attended shown in brackets*

Appointed Governors

Name	Appointing	Term of Office		No. of Council of Governor Organisation(s) meetings attended (inc the AGM)
		From	To	
Ms Cath Siddle	North Tees & Hartlepool NHS/ South Tees Hospitals NHS Trust/ County Durham and Darlington NHS Foundation Trust/ Scarborough & North East Yorkshire Healthcare NHS Trust	1/7/08	30/6/11	0 (5)
Mr Alan Tallentire	North East Prisons Directorate	1/7/08	17/9/10	0 (3)
Mr Matt Spencer	North East Prisons Directorate	17/9/10	30/6/11	0 (2)
Mrs Pauline Mitchell	Darlington Borough Council	8/1/10	30/6/11	2 (5)
Mrs Lesley Jeavons	Durham County Council	1/7/08	30/6/11	2 (5)
Mrs Jill Harrison	Hartlepool Borough Council	23/7/09	30/6/11	1 (5)
Mrs Ruth Hicks	Middlesbrough Borough Council	1/7/08	30/6/11	3 (5)
Cllr Herbert Tindall	North Yorkshire County Council	14/1/10	17/2/11	2 (5)
Mr Mike Dillon	Redcar and Cleveland Borough Council	1/7/08	7/9/10	1 (2)
Cllr Ann McCoy	Stockton Borough Council	1/7/08	30/6/11	4 (5)
Mr Malcolm Cook	NHS County Durham & Darlington	15/4/09	30/6/11	1 (5)
Mr Brian Key	North East Mental Health & Learning Disability Commissioning Directorate	1/3/09	22/12/10	1 (4)
Mr Paddy Pearce	NHS North Yorkshire and York	1/7/08	15/2/11	5 (5)
Mrs Melanie Bradbury	NHS North Yorkshire and York	16/2/11	30/6/11	0 (0)
Mrs Clare Hunter	NHS Tees	1/7/08	30/6/11	5 (5)
Prof Pali Hungin	University of Durham	1/7/08	30/6/11	4 (5)
Prof Cliff Hardcastle	University of Teesside	26/11/09	30/6/11	1 (5)
Mr Mike Hill	Voluntary Organisations Network North East	1/7/08	30/6/11	5 (5)
Mr Robert Salkeld	Ryedale Voluntary Action	1/7/08	7/6/10	1 (1)

Details of company directorships or other material interests in companies held by governors where those companies or related parties are likely to do business, or are 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.

Elections held during 2010/11

Constituency	Date	Seats	No. of Candidates	No. of eligible voters	Turnout (%)
Stockton	23/6/10	1	2	867	10.7
Durham	23/6/10	4	6	1213	13.3
Hartlepool	23/6/10	1	2	661	9.4
Middlesbrough	23/6/10	1	2	787	13.2
Redcar & Cleveland	23/6/10	1	1	-	-
North East Yorkshire	23/6/10	2	1	-	-

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

Work of the Council of Governors during 2010/11

During 2010/11 the council of governors:

- held its annual general meeting based on the theme of carers
- further developed its arrangements for engaging with members (see opposite page)
- approved the carers' standards for the trust
- approved standards for the use of feedback received from service users
- assured itself of our financial and operational performance
- assisted with the development of the trust's business plan
- assisted with the development of our quality report
- approved the re-appointment of five non-executive directors and the appointment of a new non-executive director
- considered and was assured on the performance of the board, the chairman and the non-executive directors
- reviewed our constitution
- contributed to a review and approved the re-appointment of the trust's external auditors
- approved the training and development plan for governors
- received briefings on significant issues affecting the trust including the outcomes of the national patients survey and staff survey

Committees of the council of governors

The council of governors has established four thematic committees and a nomination and remuneration committee to support its work.

The following issues were progressed by the **four thematic committees** during 2010/11:

Improving the Experience of Carers Committee
- developed standards for the involvement of carers which were subsequently agreed by the board and launched at the AGM
- established a working group and kept an overview of the development of a carers' strategy.
- contributed to the development of a carers' satisfaction survey

Improving the Experience of Service Users Committee
- developed standards for service user feedback
- reviewed learning disability move on accommodation
- undertook an assurance review of the trust's complaints procedures
- reviewed how service user feedback is collated within the children and young people directorate
- at the request of the council of governors commenced reviews of cash availability in the trust's hospitals and delays in the reinstatement of benefit payments to service users
- reviewed and commented upon the draft patient experience strategy

Promoting Social Inclusion Committee
- received presentations on developing vocational interventions
- supported and contributed to the Social Inclusion Institutes project in Easington
- progressed the development of the trust's social inclusion strategy
- agreed the winner of the trust's "making a difference award" for promoting social inclusion

Making the Most of Membership Committee
- monitored progress on the implementation of the membership plan
- agreed the format of the annual general meeting
- supported the development of an art competition to develop a trust calendar.
- oversaw the further development of communications with members
- agreed the membership strategy and plan for 2011 taking into account the expansion of the trust in North Yorkshire.

The nomination and remuneration committee

The nomination and remuneration committee supports the council of governors undertake its duties regarding the appointment and setting the remuneration and terms of service of the chairman and non-executive directors.

During 2010/11 the committee:
- assured the council of governors regarding the performance of the chairman and non-executive directors
- recommended the re-appointment of the following non-executive directors:
  - Mr Andrew Lombard
  - Mr Graham Neave
  - Mr Michael Newell
  - Mr John Robinson
  - Mr Douglas Taylor
- Recruited a new non-executive director (Mrs Barbara Matthews) following open advertisement

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 membership of the committee and attendance at its 4 meetings during 2010/11 was as follows:

Mrs Jo Turnbull	Chairman of the Trust	4
Mr Martin Barkley	Chief Executive	2
Mrs Clare Hunter	Appointed Governor	3
Mr Mike Hill	Appointed Governor	4
Mr Roger Humphries	Public Governor	2 (2)
Mr Paddy Pearce	Appointed Governor	3
Dr Nadja Reissland	Public Governor	2 (2)

Note: *Maximum possible number of meetings to be attended shown in brackets*

Andrew Lombard, the senior independent director attended one meeting of the committee for discussions on the appraisal of the chairman under the board performance evaluation scheme.

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

Carers strategy Group
This group has been established by the improving the experience of carers committee to research the development and draft a carers' strategy for the trust.

Quality task group
This task group of governors has assisted with the development of the quality report (see page 41).

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.

External audit review group
Representatives of the council of governors supported the review of external audit services in conjunction with the audit committee (see page 68).

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.

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.

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.

Based on the requirements of our authorisation as a foundation trust we aim to have a growing, representative and engaged membership.

Our membership strategy and plan for 2010/11 was developed and monitored by the "making the most of membership" committee and was approved by the council of governors following consultation with the board.

We consider that our membership is broadly representative in terms of age, gender and ethnicity; however, as well as seeking the continued growth in the number of members throughout our catchment area, within the strategy we recognised the need to focus on the following key areas of under-representation:
- males
- North East Yorkshire
- Durham
- Redcar and Cleveland

We achieved our target of recruiting 500 (net) new members during 2010/11.

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.

Membership recruitment

Activities to support member recruitment during 2010/11 were as follows:
- promotion of membership on the trust's website
- attendance at public meetings and events held by the trust
- attendance at public events held by other organisations eg "Help for Heroes" and SuperGay in Middlesbrough, the Durham Miners' Gala and Great Aycliffe Show.
- joint recruitment activities with other foundation trusts
- 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 and 'be a friend' calendar competition
- 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 and learning disability field
- greater involvement of governors in recruitment activity

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 2010/11 the size and movements in public membership were as follows:

Public members as at 1/4/10	4870
New members during 2010/11	819
Members leaving during 2010/11	378
Public members as at 31/3/11	5311

The number of members for each of the public constituencies on 31st March 2011 was as follows:

Public constituencies	Total
Darlington	595
Durham	1361
Hartlepool	709
Middlesbrough	983
North East Yorkshire	258
Redcar & Cleveland	461
Stockton	944

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 up to 31 March 2011 was as follows:

Staff constituencies	
Corporate	965
Nursing	1565
Learning disability and forensic services	829
Psychology	142
Medical	171
Adult mental health	710
Allied health professionals	199
MHSOP, CYP, NEY*	711

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

Member Engagement

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

All members receive a welcome pack, with personalised membership card, on joining the trust.

Members are kept up to date with developments at the trust by:

- receiving copies of our bi-monthly publication 'Insight' which includes a dedicated members' page
- visiting the member pages on our website, becoming a friend on facebook or following the trust on twitter
- attending:
  - our annual general meeting (in July each year) including a national guest speaker
  - public meetings in our constituencies
  - the official opening of new premises
- visiting promotional stands at a variety of events

Our public meetings are usually held in partnership with partner organisations based on topics of interest to our local communities. We seek to ensure that all meetings are highly participative and members are able to influence the trust through the attendance of governors and members of the board of directors.

During 2010/11 we held the following public meetings for our members:

Date	Constituency	In Partnership with	Focus	Number of attendees
28/04/2010	Redcar & Cleveland	Redcar & Cleveland Mind and Redcar & Cleveland Borough Council	• discharge arrangements • care plans • self directed support	30
12/05/2010	Darlington	Darlington Mind	• care planning • crisis services	39
09/06/2010	Stockton on Tees	Alzheimer's Society	• services for older people in Stockton	26
12/07/2010	Hartlepool	Hartlepool LINk and Hearing Voices Support Group	• crisis services • the hearing voices support group	18
24/09/2010	Durham	-	Positive practice in County Durham including: • pharmacy • crisis services • service user feedback • community services • older people's services • patient advice and liaison service (PALS) • carers strategy workshop	68
30/09/2010	North East Yorkshire	Alzheimer's Society	Improvements to older people's services in North East Yorkshire	39
13/01/11	Durham and Darlington	-	• proposed changes to inpatient services for older people in Darlington and South Durham • the development of dementia services	41
09/03/11	Middlesbrough and Redcar and Cleveland	Middlesbrough MIND & Middlesbrough LINk	• crisis services	83

Changes to our governance arrangements and our membership strategy for 2011/12

During 2010/11 we undertook a consultation exercise on our governance arrangements due to:

- concerns regarding the size of our council of governors
- our ambition to become the main provider of mental health, learning disability and substance misuse services in North Yorkshire

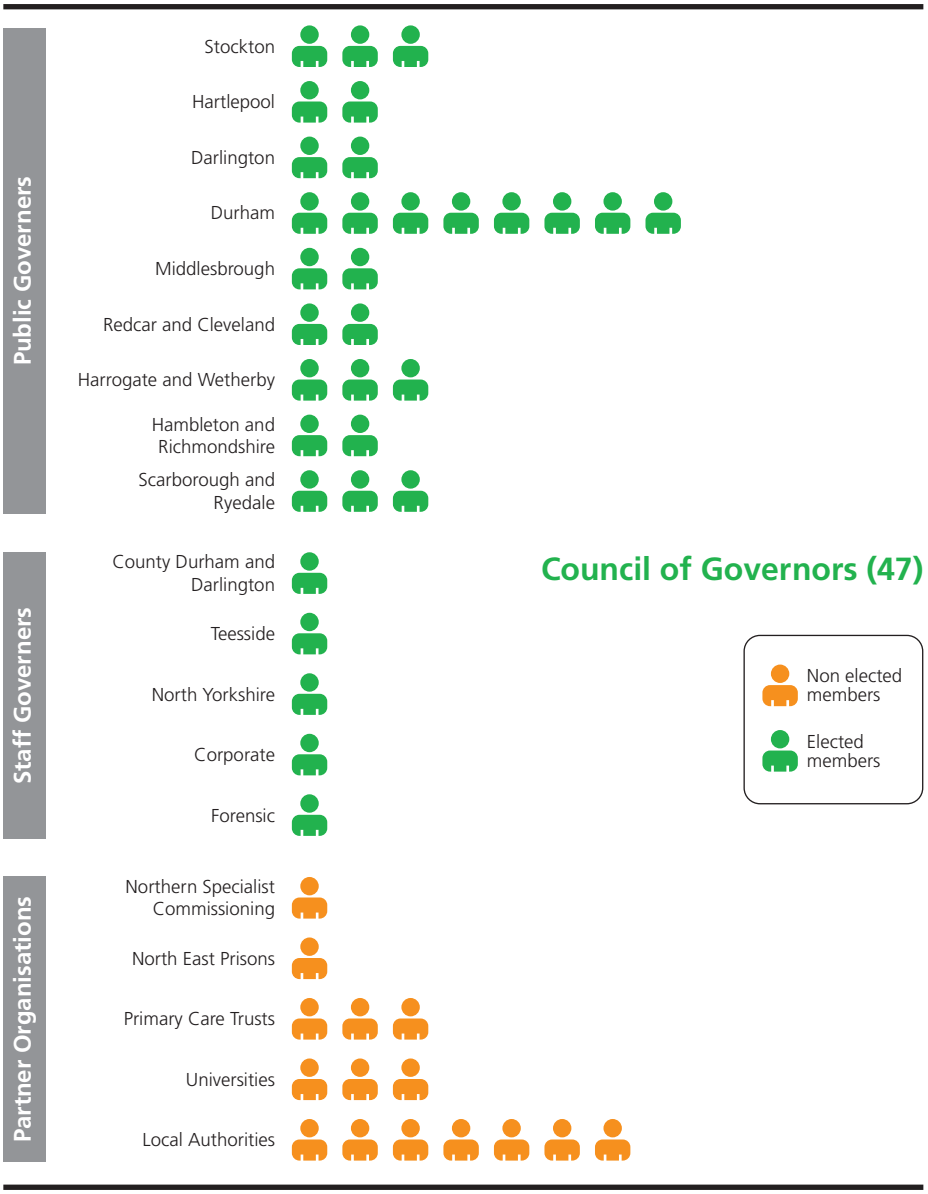
We received over 120 responses to our consultation.

Following discussions with the council of governors we decided to make the following changes to our governance arrangements to reflect our success in becoming the provider of services in Hambleton, Richmondshire and Harrogate (see page 27).

The changes include:

- an increase in the number of our public constituencies from 7 to 9 with the inclusion of two new constituencies: Hambleton and Richmondshire and Harrogate and Wetherby
- changing the ratio of governors to population from 1:50,000 to 1:60,000. (this has reduced the number of public governors for some of our constituencies; however, a minimum of two governors per constituency was set to ensure representation is maintained)
- revising our staff classes so they are aligned with the new management and leadership arrangements for the trust
- changing the partner organisations which may appoint governors

The chart opposite reflects the revised composition of the council of governors:



The changes came into effect on 7 April 2011. However, we have introduced transitional arrangements to ensure:

- governors were able to see out their terms of office
- elections to the new public constituencies would not take place until October 2011 to enable the recruitment of sufficient members in those areas
- the election of the governor for the North Yorkshire staff class would not commence until after the commencement of the contract to enable staff transferring to the trust's employment to be able to participate

The expansion of the trust has had implications for our membership strategy and plans for 2011/12. During the year we will aim to:

- recruit 350 members in our new constituencies
- at least maintain the number of members in our original constituencies and further improve representation
- continue with our member engagement activities

Financial report

Financial review 2010/11

Summary of financial performance

In 2010-11 the trust continued to build on the strong underlying financial position from previous years. This position allowed new investments in services and improvements in quality to take place against a background of low levels of financial risk.

The 2010-11 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. Our objectives are shown in the table opposite.

The trust planned an operating surplus of £5.7m for the financial year and achieved £6.4m. This was mainly due to the phased appointments to posts within Roseberry Park Hospital in the first half of the year and higher than anticipated bed occupancy within forensic services.

Total CRES achieved at 31 March 2011 was £9.3million and was marginally ahead of plan, mainly as a result of the early implementation of schemes identified for 2011/12. Total CRES achieved was recurrent and the trust is making good progress with future years plans.

Income and surplus growth
The trust experienced a further year of income growth mainly due to the expansion of services with Roseberry Park which consolidated the underlying position and now provides 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	10.9%	4
EBIDTA % achieved	111.4%	5
Return on assets	10.5%	5
I & E surplus margin	3.6%	5
Liquid rate	46.3 days	4
Overall rating		5

2010/11 objectives

Objectives	Outcomes
Delivering a £5.7m operating surplus	**Operating surplus of £6.4m achieved**
Achieving a Monitor risk rating of 4	**Calculated risk rating of 5 achieved**
Delivery of £8.9m cost reductions	**£9.3m saving**
EBITDA margin of 9.9%	**EBITDA margin of 10.9% achieved**

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, £9.3m or 4.1% of our cost base was saved through a variety of ongoing and one off schemes.

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 2010-11, £12.3m was invested in capital assets.

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

	2010 -11 £
Investment in fixed assets	12.3m
Disposal of unprotected asset	0.6m

In December 2010 the trust voluntarily terminated the PFI contract agreement at West Park Hospital removing long term liabilities from the statement of financial position and reducing its operating costs.

The trust has a borrowing limit of £106.1m 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 £18m 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 (2010-11) as directed by Monitor, 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.

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

The 2011-12 annual plan provides for a surplus of £5.5m (2% of turnover).The financial plans for 2012-13 and 2013-14 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".

Accounting Information
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 that no relevant audit information has been withheld or made unavailable. Nor have any undisclosed post balance sheet events occurred.

No political or charitable donations were made by the trust during 2010-11.

Accounting policies for pensions and other retirement benefits are set out in pages 89 and 101 in the accounts and details of senior employees' remuneration can be found in page 103.

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

Better Payment Practice Code

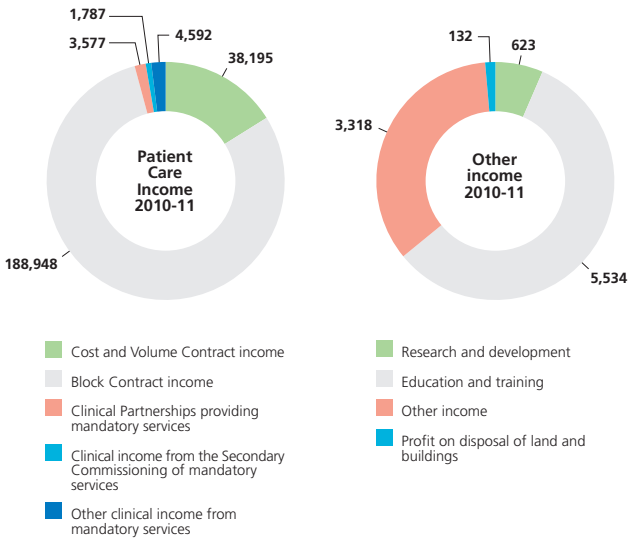
The Better Payment Practice code requires the trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. Performance for the financial year 2010-11 is as follows:

	Year to date	
	Number of invoices	Value of invoices £000s
NHS creditors		
Total bills paid	978	12,829
Total bills paid within target	689	10,965
Percentage of bills paid within target	70.45%	85.47%
Non-NHS Creditors		
Total bills paid	48,553	83,370
Total bills paid within target	46,562	80,424
Percentage of bills paid within target	95.90%	96.47%

Income generation

During 2010-11, income generated was £246.7m from a range of activities; 96.1% from direct patient care.

There is a further £9.6m from education and other non-patient care services.



Senior managers' remuneration and pension
Details of senior managers remuneration and pensions can be found in the remuneration report on page 103.

Management costs
In line with best practice the trust continues to monitor expenditure on management costs in accordance with Department of Health definitions. In 2010-11, 4.74% of our total income was incurred on management costs.

Martin Barkley
Chief Executive

2nd June 2011

Statement on internal control 2010-11

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 2011 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 quality assurance 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, 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 took steps to ensure the trust was 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 2011 and remains in place up to the date of approval of the annual report and accounts.

The main risks to the trust meeting its principal objectives have been identified within the framework together with the key controls in place to manage these risks. Although the trust has not identified any significant control issues, it has recognised that there are some gaps in the control of managing some of the risks in the following areas:
- A considerable amount of work has been undertaken to strengthen clinical audit arrangements. Improvements have been made to processes for planning and management of the programme, however further developments are needed, particularly with respect to the identification and management of capacity. Action plans are in place to further strengthen and embed clinical audit procedures.
- Actions are in place to strengthen training provision and monitoring controls of the trust's devolved information risk management framework with the intention of further embedding the process, at local level, in 2011-12.
- An action plan is being agreed to further embed a project management framework for all (non IT) projects which will support effective project management across the trust.
- Further work has been carried out continuing the improvements put in place in 2009-10 in the development of a robust workforce performance management framework and the further development of the trust's IT systems to

support the organisations objectives including data quality, the lack of agreed currencies, and quality and outcome measures for the trust's patient care contracts.

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 third 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 third 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 commitment to ensure ongoing compliance with the requirements of the Department of Health Information Governance Assurance Programme. The trust achieved an overall score of 81% against the Information Governance Toolkit requirement in 2010/11 but this will be noted as not satisfactory as 2 sequences did not reach level 2. An improvement plan has been implemented to rectify this position in 2011/12. 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.

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 3 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 quality assurance committee is responsible for producing the quality accounts with the director of nursing and governance and the director of planning and performance being lead directors. The quality assurance committee has received reports throughout the year regarding the development of the quality accounts, including an early draft of the accounts.
- Priorities for improvement have been identified from an analysis of serious untoward incidents, complaints, as well as feedback from users and other stakeholders. Theses priorities have been shared with wider stakeholders for comment and were approved by the quality assurance committee before final sign off by the board of directors.
- 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, 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 is provided to support staff using the electronic patient record (PARIS) and to ensure compliance with CPA. Training is provided where issues around data quality have been identified.
- As part of performance reporting to the board actual data is used to forecast future positions thus improving the decision making process.
- All data returns are submitted in line with agreed timescales.

Review of effectiveness
As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors 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, quality assurance 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 quality assurance 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

2nd June 2011

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

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed 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 Annual 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 Annual 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

2nd June 2011

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 requirement in preparing the Accounts.

Jo Turnbull
Chairman on behalf of the Board of Directors

2nd June 2011

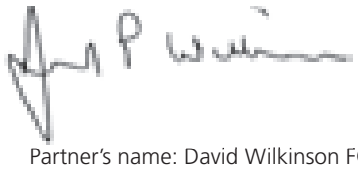
Independent Auditor's report to the Council of Governors and Board of Directors of Tees, Esk and Wear Valleys NHS Foundation Trust on the NHS foundation trust summarisation schedules

We have examined the summarisation schedules designated FTC 1 to FTC 39 of Tees, Esk and Wear Valleys NHS Foundation Trust for the year ended 31 March 2011, which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This report is made solely to the Council 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.

In our opinion these summarisation schedules are consistent with the statutory financial statements on which we have issued an unqualified opinion

Partner's signature:



Partner's name: David Wilkinson FCA (Senior Statutory Auditor)

For and on behalf of Deloitte LLP

Address: Newcastle upon Tyne, UK

Date: 02/06/2011

Independent Auditor's Report to the Council 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 2011 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers Equity and the related notes 1 to 44. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

This report is made solely to the Council 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 auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the accounting officer and auditor
As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code of NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements
An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements
In our opinion the financial statements:
- give a true and fair view of the state of the Trust's affairs as at 31 March 2011 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Opinion on other matters prescribed by the National Health Service Act 2006
In our opinion:
- the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception
We have nothing to report in respect of the following matters where the National Health Service Act 2006 requires us to report to you if, in our opinion:
- proper practices have not been observed in the compilation of the financial statements; or
- the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources

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
(Senior Statutory Auditor)
For and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Newcastle upon Tyne, UK
2nd June 2011

Statement of comprehensive income for 12 months ended 31 March 2011

	Note	12 months ended 31 March 2011 Including WPH vol termination of PFI £000	WPH voluntary termination of PFI £000	Excluding WPH vol termination of PFI £000	12 months ended 31 March 2010 Including impairments £000	impairments £000	Excluding impairments £000
Revenue							
Income from activities	2	237,099	0	237,099	221,845	0	221,845
Other operating income	2	9,607	0	9,607	10,460	0	10,460
Total operating income		**246,706**	**0**	**246,706**	**232,305**	**0**	**232,305**
Operating expenses	3	(227,946)	(224)	(227,722)	(287,927)	(58,681)	(229,246)
Operating surplus/(deficit)		**18,760**	**(224)**	**18,984**	**(55,622)**	**(58,681)**	**3,059**
Finance costs:							
Finance income	8	387	0	387	208	0	208
Finance expense - financial liabilities	9	(10,233)	(5,709)	(4,524)	(1,408)	0	(1,408)
Finance expense - unwinding of discount on provisions		(24)	0	(24)	(21)	0	(21)
PDC dividends payable		(2,518)	0	(2,518)	(3,546)	0	(3,546)
Net Finance Costs		**(12,388)**	**(5,709)**	**(6,679)**	**(4,767)**	**0**	**(4,767)**
surplus/(deficit) for the year		**6,372**	**(5,933)**	**12,305**	**(60,389)**	**(58,681)**	**(1,708)**
Other comprehensive income							
Impairments - property, plant and equipment		0	0	0	(8,624)	0	(8,624)
Revaluation gains - property, plant and equipment		68	0	68	8,806	182	8,624
Other reserve movements		(10)	0	(10)	(17)	0	(17)
Total comprehensive income/(expense) for the year		**6,430**	**(5,933)**	**12,363**	**(60,224)**	**(58,499)**	**(1,725)**

In December 2010 the trust voluntarily terminated the PFI contract agreement at West Park Hospital. The analysis above identifies the finance expenses attributable to West Park Hospital in 2010-11.

Statement of financial position as at 31 March 2011

	Note	31 March 2011 £000	31 March 2010 £000
Non-current assets			
Property, plant and equipment	12	183,698	179,151
Trade and other receivables	22	61	369
Total non-current assets		**183,759**	**179,520**
Current assets			
Inventories	21	223	223
Trade and other receivables	22	4,354	5,670
Non current assets for sale and assets in disposal groups	18	4,225	5,055
Cash and cash equivalents	25	31,578	41,594
Total current assets		**40,380**	**52,542**
Current liabilities			
Trade and other payables	26	(14,756)	(14,744)
Borrowings	27	(2,085)	(1,992)
Provisions	31	(623)	(667)
Tax payable	26	(3,613)	(3,388)
Other liabilities	29	(4,632)	(2,348)
Total current liabilities		**(25,709)**	**(23,139)**
Total assets less current liabilities		**198,430**	**208,923**
Non-current liabilities			
Borrowings	27	(85,555)	(102,309)
Provisions	31	(851)	(1,020)
Total non-current liabilities		**(86,406)**	**(103,329)**
Total assets employed		**112,024**	**105,594**
Financed by taxpayers' equity			
Public dividend capital		143,821	143,821
Revaluation reserve	33	11,787	12,382
Donated asset reserve		272	282
Statement of comprehensive income reserve		(43,856)	(50,891)
Total Taxpayers' Equity		**112,024**	**105,594**

The notes 1-44 form part of these financial statements.
The financial statements on pages 86 - 104 were approved by the Board and signed on its behalf by:

Signed:  (Chief Executive) Date: 2nd June 2011

Statement of changes in taxpayers' equity

	Total	Public Dividend Capital (PDC)	Revaluation Reserve	Donated Assets Reserve	Statement of Comprehensive Income Reserve
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2010	**105,594**	**143,821**	**12,382**	**282**	**(50,891)**
Surplus for the year	**6,372**	0	0	0	6,372
Revaluations	**68**	0	68	0	0
Other reserve movements	**(10)**	0	(663)	(10)	663
Taxpayers' Equity at 31 March 2011	**112,024**	**143,821**	**11,787**	**272**	**(43,856)**
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)
Impairments	**(8,624)**	0	(8,624)	0	0
Revaluations	**8,806**	0	8,806	0	0
Other reserve movements	**(17)**	0	(2,823)	(218)	3,024
Taxpayers' Equity at 31 March 2010	**105,594**	**143,821**	**12,382**	**282**	**(50,891)**

Statement of cash flows for 12 months ended 31 March 2011

	Note	12 months ended 31 March 2011 £000	12 months ended 31 March 2010 £000
Cash flows from operating activities			
Operating surplus/(deficit) from continuing operations		18,760	(55,622)
Operating surplus/(deficit)		**18,760**	**(55,622)**
Non-cash income and expense:			
Depreciation and amortisation		5,518	16,411
Impairments		2,496	58,681
Reversal of impairments		0	(30)
Transfer from donated asset reserve		(10)	(17)
Loss on disposal of PPE		200	
Profit on sale of assets held for sale		(132)	
Decrease in trade and other receivables		1,563	3,276
Increase in inventories		0	(20)
(Decrease)/increase in trade and other payables		(341)	4,765
Increase in other liabilities		2,509	531
Decrease in provisions		(213)	(497)
Decrease in Tax Payable		0	0
Other movements in operating cash flows - non cash provisions		119	(17)
Net cash generated from operations		**30,469**	**27,461**
Cash flows from investing activities			
Interest received		387	208
Purchase of financial assets		0	0
Sales of financial assets		0	0
Purchase of intangible assets		0	0
Sales of intangible assets		0	0
Purchase of property, plant and equipment		(12,144)	(7,255)
Sales of property, plant and equipment		532	68
Net cash generated used in investing activities		**(11,225)**	**(6,979)**
Cash flows from financing activities			
Public dividend capital received		0	0
Public dividend capital repaid		0	0
Loans received		0	0
Loans repaid		0	0
Capital element of finance lease rental payments		0	0
Capital element of Private Finance Initiative obligations		(16,682)	(510)
Interest paid		0	0
Interest element of finance lease		0	0
Interest element of Private Finance Initiative obligations		(5,215)	(1,408)
PDC dividend paid		(2,457)	(3,645)
Cash flows from other financing activities		(4,927)	0
Net cash generated used in financing activities		**(29,281)**	**(5,563)**
(Decrease)/increase in cash and cash equivalents	25	**(10,037)**	**14,919**
Cash and cash equivalents at 1 April	25	**41,579**	**26,660**
Cash and cash equivalents at 31 March	25	**31,542**	**41,579**

Notes to the 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 2010-11 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.

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

Accounting standards issued that have been adopted early
The following standards and updates have been published by the International Accounting Standards Board as adopted but are not required to be followed until after the current reporting period.

IAS 24 (amended)	Related party disclosures
IAS 27	Separate financial statements
IAS 28	Associates
IAS 32 (amended)	Classification of rights issues
IFRIC 14 (amended)	Prepayments of a minimum funding requirement
IFRIC 19	Extinguishing financial liabilities with equity instruments
IFRS 10	Consolidation
IFRS 11	Joint ventures
IFRS 12	Disclosure on interest in other entities
IFRS 13	Fair value measurement
IFRS 9	Financial instruments

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
- it forms part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost
- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably

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

Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value. Depreciated replacement cost has been applied for assets with a short life and/or low values.

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

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

- land and non-specialised buildings – market value for existing use
- specialised buildings – depreciated replacement cost

In line with HM Treasury guidance with effect from 31 March 2010, trust owned assets have been valued on modern equivalent asset (MEA) valuations, based on an alternative site valuation where the location meets the requirements of service provision. Owned assets lives were assessed as part of the MEA valuation exercise at 31 March 2010. The MEA value and assessed asset life are the basis for the depreciation charge. The depreciation charge for non-owned assets is based on the capital expenditure being depreciated over the remaining lease license life of the asset.

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 ceased. At that date it was decided that the carrying value of existing assets at that date would be written off over their remaining useful lives. 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 impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the statement of comprehensive income.

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

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 the statement of comprehensive income reserve.

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 the statement of comprehensive income reserve. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then transferred to the statement of comprehensive income reserve.

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

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:

a) payment for the fair value of services received
b) payment for the PFI asset, including finance costs and
c) payment for the replacement of components of the asset during the contract 'lifecycle replacement'

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

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

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the statement of comprehensive income.

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

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

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

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

Assets contributed by the trust to the operator for use in the scheme
Assests 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. The discount rate has increased from 2.2% to 2.9% in real terms resulting in a reduction in the amount of provision made.

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 31.3.

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

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

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

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 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 2011. 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 43 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. The dividend payable is based on the average relevant net assets for the year.

Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

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

Joint operations
Joint operations are activities undertaken by the trust in conjunction with one or more other parties but which are not performed through a separate entity. The trust 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 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 2011. 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 2011	12 months ended 31 March 2010
Income from activities	**£000**	**£000**
Cost and volume contract income	38,195	27,091
Block contract income	188,948	184,489
Clinical partnerships providing mandatory services (including S31 agreements)	3,577	3,579
Clinical income for the secondary commissioning of mandatory services	1,787	2,356
Other clinical income from mandatory services	4,592	4,330
Total income from activities	**237,099**	**221,845**
Other operating income		
Research and development	623	321
Education and training	5,534	5,658
Transfers from donated asset reserve in respect of depreciation on donated assets	10	17
Non patient care services to other bodies	2,751	3,278
Other revenue	557	1,156
Profit on disposal of land and buildings	132	0
Reversal of impairments of assets held for sale	0	30
Total other operating income	**9,607**	**10,460**
Total operating income	**246,706**	**232,305**

Note 2.2
Private patient income
The trust has no private patient income (2009-10, £nil)

Note 2.3
Operating lease income
The trust has no operating lease income (2009-10, £nil)

Note 2.4
Operating income (by type)

	12 months ended 31 March 2011 £000	12 months ended 31 March 2010 £000
Income from activities		
NHS Foundation Trusts	807	780
NHS Trusts	132	4
Strategic Health Authorities	59	46
Primary Care Trusts	230,508	215,836
Local Authorities	3,578	3,567
Department of Health – other	132	0
NHS Other	236	0
Non NHS Other	1,647	1,612
Total income from activities	**237,099**	**221,845**
Other operating income		
Research and development	623	321
Education and training	5,534	5,658
Transfers from donated asset reserve	10	17
Non-patient care services to other bodies	2,751	3,278
Profit on disposal of land & buildings	132	0
Reversal of impairments of assets held for sale	0	30
Other	557	1,156
Total other operating income	**9,607**	**10,460**
Total operating income	**246,706**	**232,305**
Analysis of income from activities - non NHS other		
Other government departments and agencies	598	1,472
Other	1,049	140
	1,647	**1,612**
Analysis of other operating income - other		
Estates recharges	89	692
Catering	242	366
Rental income	101	7
Other	125	91
	557	**1,156**

Revenue is mainly from the supply of services. Revenue from the sale of goods is not material.

Note 3
Operating expenses (by type)

	12 months ended 31 March 2011 £000	12 months ended 31 March 2010 £000
Services from NHS Foundation Trusts	1,065	1,485
Services from NHS Trusts	423	602
Services from other NHS Bodies	121	499
Purchase of healthcare from non NHS bodies	1,736	1,770
Executive directors costs	1,434	1,422
Non-executive directors costs	153	152
Staff costs	175,995	168,358
Drug costs	3,676	3,599
Supplies and services - clinical (excluding drug costs)	1,314	1,668
Supplies and services - general	4,095	5,252
Establishment	6,278	5,348
Research and development	274	0
Transport	3,513	3,469
Premises	15,092	14,836
Increase in bad debt provision	189	149
Depreciation on property, plant and equipment	5,518	16,411
Impairments of property, plant and equipment	1,166	58,479
Audit fees		
audit services - statutory audit	66	83
audit services - regulatory reporting	18	89
Other auditors remuneration		
further assurance services	218	218
Clinical negligence	390	502
Loss on disposal of other property, plant and equipment	200	0
Impairments of assets held for sale	1,330	202
Legal fees	287	165
Consultancy costs	866	614
Training courses and conferences	1,215	1,413
Patient travel	61	60
Redundancy	177	89
Hospitality	148	186
Insurance	38	56
Losses, ex-gratia & special payments	12	5
Other	878	746
Total operating expenses	**227,946**	**287,927**

Other audit remuneration
Other audit remuneration in 2010-11 for £218,000 (2009-10, £218,000) is for internal audit services.

Note 4.1
Employee expenses

	12 months ended 31 March 2011			12 months ended 31 March 2010		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	144,705	138,182	6,523	137,484	134,255	3,229
Social security costs	10,349	9,633	716	9,740	9,135	605
Pension costs - defined contribution plans						
Employers contributions to NHS Pensions	17,467	16,464	1,003	16,632	15,784	848
Termination benefits	177	177	0	89	89	0
Agency/contract staff	4,908	0	4,908	5,924	0	5,924
Employee expenses	**177,606**	**164,456**	**13,150**	**169,869**	**159,263**	**10,606**

Note 4.2
Average number of employees (WTE Basis)

	12 months ended 31 March 2011			12 months ended 31 March 2010		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	238	223	15	237	233	4
Administration and estates	872	831	41	842	822	20
Healthcare assistants and other support staff	293	288	5	320	315	5
Nursing, midwifery and health visiting staff	2,857	2,809	48	2,739	2,719	20
Scientific, therapeutic and technical staff	457	388	69	417	388	29
Social care staff	40	0	40	37	0	37
Bank and agency staff	231	0	231	238	0	238
Total	**4,988**	**4,539**	**449**	**4,830**	**4,477**	**353**

Note 4.3
Employee benefits
There were no employee benefits paid in the twelve months ended 31 March 2011 (twelve months to 31 March 2010, nil).

Note 4.4
Early retirements due to ill health
During the pertod to 31 March 2011 there were 9 (2009-10,6) early retirements from the trust on the grounds of ill-health. The estimated additional pension liabilities of the ill-health retirement will be £642,757 (2009-10, £444,547). These retirements represented £1.80 per 1,000 active scheme members. The cost of this ill-health retirement will be borne by the NHS Business Services Authority - Pension Division.

Note 5.1
Operating leases

	12 months ended 31 March 2011 £000	12 months ended 31 March 2010 £000
Minimum lease payments	4,599	3,934
Total	**4,599**	**3,934**

Note 5.2
Arrangements containing an operating lease

	12 months ended 31 March 2011 £000	12 months ended 31 March 2010 £000
Future minimum lease payments due:		
not later than one year	1,002	870
later than one year and not later than five years	2,458	2,086
later than five years	883	790
Total	**4,343**	**3,746**

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

Note 5.3
Limitation on auditor's liability
There is no specified limitation stated in the engagement letter of the trust's auditors.

Note 5.4
The late payment of commercial debts (interest) Act 1998
The trust did not pay any interest payable arising from claims or pay compensation to cover debt recovery costs under this legislation.

Note 6
Discontinued operations
The trust has no discontinued operations at 31 March 2011 (31 March 2010, £nil).

Note 7
Corporation tax
The trust has no Corporation Tax liability or asset at 31 March 2011 (31 March 2010, £nil).

Note 8
Finance income

	12 months ended 31 March 2011 £000	12 months ended 31 March 2010 £000
Bank deposits	387	208
Total	**387**	**208**

Note 9
Finance costs - interest expense

	12 months ended 31 March 2011 £000	12 months ended 31 March 2010 £000
Other	4,784	0
Finance costs in PFI obligations		
Main finance cost	5,449	1,408
Total	**10,233**	**1,408**

Other finance costs are the finance charge attributable to the voluntary termination of the PFI contract at West Park Hospital (£4,927,000) offset by the change in discount rate of provisions (£143,000).
£5,709,000 is included within £10,233,000 finance costs relating to West Park Hospital PFI costs which will not re-occur next year.

Note 10
Impairment of assets

	12 months ended 31 March 2011 £000	12 months ended 31 March 2010 £000
Re-statement of assets to open market value of assets held for sale	456	0
Impairment of completed assets (previously classified as assets under construction)	710	0
Other - adjustment for the change in modern equivalent assets base	0	67,103
Total impairments	**1,166**	**67,103**

Note 11
Intangible assets financing
The trust has no intangible assets financing as at 31 March 2011 (31 March 2010, £nil).

Note 12.1
Property, plant and equipment 2010-11

	Total	Land	Buildings exc. Dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2010	278,764	49,827	214,005	196	3,152	2,614	293	6,380	2,297
Additions purchased	12,263	0	3,059	0	8,894	82	0	209	19
Reclassifications	0	0	1,246	0	(1,246)	0	0	0	0
Revaluations	68	0	68	0	0	0	0	0	0
Transferred to disposal group as asset held for sale	(1,176)	0	(1,176)	0	0	0	0	0	0
Cost or valuation at 31 March 2011	**289,919**	**49,827**	**217,202**	**196**	**10,800**	**2,696**	**293**	**6,589**	**2,316**
Accumulated depreciation at 1 April 2010	99,613	35,457	53,905	196	0	2,348	243	5,848	1,616
Provided during year	4,997	0	4,997	0	0	0	0	0	0
Impairments	1,166	540	626	0	0	0	0	0	0
Transferred to disposal group as asset held for sale	(76)	0	(76)	0	0	0	0	0	0
Accumulated depreciation at 31 March 2011	**107,700**	**35,997**	**59,452**	**196**	**0**	**2,348**	**243**	**5,848**	**1,616**

Note 12.2
Property, plant and equipment 2009-10

	Total	Land	Buildings exc. Dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	190,617	57,726	120,814	196	518	2,532	243	6,291	2,297
Additions purchased	97,531	0	94,294	0	3,016	82	50	89	0
Impairments	(8,624)	(5,105)	(3,519)	0	0	0	0	0	0
Reclassifications	0	0	382	0	(382)	0	0	0	0
Revaluations	8,806	716	8,090	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
Cost or valuation at 31 March 2010	**278,764**	**49,827**	**214,005**	**196**	**3,152**	**2,614**	**293**	**6,380**	**2,297**
Accumulated depreciation at 1 April 2009	30,389	910	19,967	3	0	2,275	241	5,560	1,433
Provided during year	16,411	0	15,672	193	0	73	2	288	183
Impairments	58,479	34,547	23,932	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
Accumulated depreciation at 31 March 2010	**99,613**	**35,457**	**53,905**	**196**	**0**	**2,348**	**243**	**5,848**	**1,616**

Note 12.3
Property, plant and equipment financing

	Total	Land	Buildings exc. Dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value - 31 March 2011									
Owned	101,956	13,830	76,012	0	10,800	255	43	493	523
PFI	81,470	0	81,470	0	0	0	0	0	0
Donated	272	0	268	0	0	4	0	0	0
Net book value total at 31 March 2011	**183,698**	**13,830**	**157,750**	**0**	**10,800**	**259**	**43**	**493**	**523**
Net book value - 31 March 2010									
Owned	75,786	14,370	56,741	0	3,152	260	50	532	681
PFI	103,083	0	103,083	0	0	0	0	0	0
Donated	282	0	276	0	0	6	0	0	0
Net book value total at 31 March 2010	**179,151**	**14,370**	**160,100**	**0**	**3,152**	**266**	**50**	**532**	**681**

In December 2010 the trust voluntarily terminated the PFI contract agreement at West Park Hospital removing long term liabilities from the statement of financial position.

Note 13
Intangible assets acquired by government grant
The trust has no assets acquired by government grant.

Note 14
Economic life of property, plant and equipment

	Min Life Years	Max Life Years
Land	n/a	n/a
Buildings excluding dwellings	1	89
Dwellings	0	0
Assets under Construction & POA	10	90
Plant & Machinery	1	9
Transport Equipment	1	6
Information Technology	1	5
Furniture & Fittings	1	7

Note 15.1
Analysis of property, plant and equipment - 31 March 2011

	Total	Land	Buildings exc. Dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
NBV - Protected assets	166,527	13,790	152,737	0	0	0	0	0	0
NBV - Unprotected assets	17,171	40	5,013	0	10,800	259	43	493	523
Total at 31 March 2011	**183,698**	**13,830**	**157,750**	**0**	**10,800**	**259**	**43**	**493**	**523**

Note 15.2
Analysis of property, plant and equipment - 31 March 2010

	Total	Land	Buildings exc. Dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
NBV - Protected assets	165,681	14,230	151,451	0	0	0	0	0	0
NBV - Unprotected assets	13,470	140	8,649	0	3,152	266	50	532	681
Total at 31 March 2010	**179,151**	**14,370**	**160,100**	**0**	**3,152**	**266**	**50**	**532**	**681**

Note 16
Investments
The trust holds no investments as at 31 March 2011 (31 March 2010, £nil).

Note 17
Associate and jointly controlled operations
The trust has no investments in associate (and joined controlled operations) as at 31 March 2011 (31 March 2010, £nil).

Note 18.1
Non current assets for sale and assets in disposal groups 2010-11

	Total	Property, Plant & Equipment
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2010	5,055	5,055
Plus assets classified as available for sale in the year	1,100	1,100
Less assets sold in year	(600)	(600)
Less impairment of assets held for sale	(1,330)	(1,330)
NBV of non-current assets for sale and assets in disposal groups at 31 March 2011	**4,225**	**4,225**

Note 18.2
Non current assets for sale and assets in disposal groups 2009-10

	Total	Property, Plant & Equipment
	£000	£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**

Note 18.3
Liabilities disposal groups
The trust has no liabilities in disposal groups as at 31 March 2011 (31 March 2010, £nil).

Note 19
Other assets
The trust has no other assets as at 31 March 2011 (31 March 2010, £nil).

Note 20
Other financial assets
The trust has no other financial assets as at 31 March 2011 (31 March 2010, £nil).

Note 21
Inventories

	31 March 2011 £000	31 March 2010 £000
Materials	223	223
Total Inventories	**223**	**223**

Note 22
Trade receivables and other receivables

	31 March 2011 £000	31 March 2010 £000
Current		
NHS receivables	2,123	1,687
Other receivables with related parties	298	242
Provision for impaired receivables	(339)	(149)
Prepayments	1,553	1,775
PFI Prepayments		
Prepayments - lifecycle replacements	25	1,179
Accrued income	19	54
PDC receivable	38	99
Other trade receivables	637	783
Total current trade and other receivables	**4,354**	**5,670**
Non Current		
NHS receivables	0	305
Other trade receivables	61	64
Total non current trade and other receivables	**61**	**369**

Non current NHS receivables were back to back arrangements with PCTs for the payment of injury benefits relating to ex PCT staff. The PCTs settled this debt in 2010-11.

Note 23.1
Provision for impairment of receivables

	31 March 2011 £000	31 March 2010 £000
At 1 April	149	177
Increase in provision	244	149
Amounts utilised	0	0
Unused amounts reversed	(54)	(177)
At 31 March	**339**	**149**

Note 23.2
Analysis of impaired receivables

	31 March 2011 £000	31 March 2010 £000
Ageing of impaired receivables		
Up to three months	129	63
In three to six months	18	18
Over six months	192	68
Total	**339**	**149**
Ageing of non-impaired receivables past their due date		
Up to three months	1,294	974
In three to six months	169	106
Over six months	230	177
Total	**1,693**	**1,257**

Note 24
Finance leases
The trust does not have any finance lease obligations other than PFI commitments.

Note 25
Cash and cash equivalents

	31 March 2011 £000	31 March 2010 £000
At 1 April	41,579	26,660
Net change in year	(10,037)	14,919
At 31 March	**31,542**	**41,579**
Broken down into:		
Commercial banks and cash in hand	34	47
Cash with Government Banking Service	31,544	41,547
Cash and cash equivalents as in SoFP	**31,578**	**41,594**
Bank overdraft	(36)	(15)
Cash and cash equivalents as in SoCF	**31,542**	**41,579**

Note 26.1
Trade and other payables

	31 March 2011 £000	31 March 2010 £000
NHS payables	413	1,006
Amounts due to other government bodies	2,224	2,571
Trade payables - capital	1,506	1,387
Other trade payables	3,213	3,742
Taxes payable	3,613	3,388
Other payables	30	36
Accruals	7,370	6,002
Total current trade and other payables	**18,369**	**18,132**

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

Note 26.2
Early retirements detail included in NHS payables above

There were no early retirement costs in the twelve months ended 31 March 2011 (2009-10, £nil).

Note 27
Borrowings

	31 March 2011 £000	31 March 2010 £000
Current		
Bank overdrafts	36	15
Obligations under Private Finance Initiative contracts	2,049	1,977
Total current borrowings	**2,085**	**1,992**
Non current		
Obligations under Private Finance Initiative contracts	85,555	102,309
Total other non-current liabilities	**85,555**	**102,309**

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

In December 2010 the trust voluntarily terminated the PFI contract agreement at West Park Hospital removing long term liabilities from the statement of financial position.

Note 28.1
Prudential borrowing limit

	31 March 2011 £000	31 March 2010 £000
Total long term borrowing limit set by Monitor	106,100	107,100
Working capital facility agreed by Monitor	18,000	17,000
Total prudential borrowing limit	**124,100**	**124,100**
Long term borrowing available at 1 April	107,100	48,600
Net actual borrowing in year - long term	-1,000	58,500
Long term borrowing available at 31 March	**106,100**	**107,100**
Working capital borrowing available at 1 April	17,000	17,000
Net actual borrowing in year - working capital	1,000	0
Working capital borrowing available at 31 March	**18,000**	**17,000**

Note 28.2
Prudential borrowing limit ratios

	Threshold	31 March 2010
Minimum dividend cover	>1x	8.5x
Minimum interest cover	>2x	4.9x
Minimum debt service cover	>1.5x	3.1x
Maximum debt service to revenue	<10%	3.50%

Note 29
Other liabilities

	31 March 2011 £000	31 March 2010 £000
Current		
Deferred income	4,632	2,348
Total other current liabilities	**4,632**	**2,348**

Note 30
Other financial liabilities

The trust has no other financial liabilities at 31 March 2011 (31 March 2009-10, £nil).

Note 31.1
Provisions for liabilities and charges - 2010-11

	Total £000	Pensions - other staff £000	Legal claims £000	Other £000
At 1 April 2010	1,687	1,087	510	90
Change in the discount rate	(143)	(143)	0	0
Arising during the year	765	107	364	294
Utilised during the year	(726)	(112)	(392)	(222)
Reversed unused	(133)	0	(133)	0
Unwinding of discount	24	24	0	0
At 31 March 2011	**1,474**	**963**	**349**	**162**
Expected timing of cash flows:				
not later than one year	556	45	349	162
Current	**556**	**45**	**349**	**162**
later than one year and not later than five years	180	180	0	0
later than five years	738	738	0	0
Non Current	**918**	**918**	**0**	**0**
TOTAL	**1,474**	**963**	**349**	**162**

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 - £131,000 (2009-10, £171,000), employer/public liability claims notified by the NHS Litigation Authority £154,000 (2009-10, £155,000), and the provision for employment law £64,000 (2009-10, £184,000).

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

Note 31.2
Provisions for liabilities and charges - 2009-10

	Total £000	Pensions - other staff £000	Legal claims £000	Other £000
At 1 April 2009 - current	1,246	80	1089	77
At 1 April 2009 - non current	938	938	0	0
At 1 April 2009	2,184	1,018	1,089	77
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 2010	**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 31.3
NHSLA provisions for liabilities and charges

£1,724,000 (2009-10, £1,853,000) is included in the provisions of the NHS Litigation Authority at 31 March 2011 in respect of clinical negligence liabilities of the NHS foundation trust.

Note 32.1
Contingent liabilities

	31 March 2011 £000	31 March 2010 £000
Gross value of contingent liabilities	120	187
Net value of contingent liabilities	**120**	**187**

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 trusts accounts.

Note 32.2
Contingent assets

The trust has no contingent assets at 31 March 2011 (31 March 2010, £nil).

Note 33
Revaluation reserve

	31 March 2011 £000	31 March 2010 £000
Revaluation reserve at 1 April	12,382	15,023
Impairments	0	(8,624)
Revaluations	68	8,806
Other reserve movements	(663)	(2,823)
Revaluation reserve at 31 March	**11,787**	**12,382**

Note 34.1
Related Party Transactions

	Income £000	Expenditure £000
2010-2011		
Department of Health	195	4
Other NHS Bodies	239,748	7,235
Other	489	3,427
Total	240,432	10,666
2009-10		
Department of Health	0	0
Other NHS Bodies	225,313	7,925
Other	4,295	2,526
NHS Shared Business Services	0	16,631
Total	229,608	27,082

Note 34.2
Related Party Balances

	Receivables £000	Payables £000
2010-2011		
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2011	(320)	0
Department of Health	3	0
Other NHS Bodies	2,123	2,555
Other	299	659
Total	2,105	3,214
2009-10		
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2010	(149)	0
Department of Health	52	0
Other NHS Bodies	1,635	3,034
Other	242	542
Total	1,780	3,576

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

Note 34.3
Related Party Organisations

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:

County Durham and Darlington NHS Foundation Trust
North Tees & Hartlepool NHS Foundation Trust
Northumberland, Tyne & Wear NHS Foundation Trust
South London and Maudsley NHS Foundation Trust
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
South Tees NHS Foundation Trust
Leicester Partnership NHS Trust
NE Ambulance Service NHS Trust
Nottinghamshire Healthcare NHS Trust
Scarborough and North Yorkshire Healthcare NHS Trust
North East Strategic Health Authority
Barnsley PCT
County Durham PCT
Cumbria PCT
Darlington PCT
Ealing PCT
East Riding of Yorkshire PCT
Gateshead PCT
Hartlepool PCT
Lambeth PCT
Middlesbrough PCT
North Tees PCT
North Tyneside PCT
North Yorkshire & York PCT
Northumberland Care Trust
Nottinghamshire County Teaching PCT
Redcar & Cleveland PCT
Sheffield PCT
South Tyneside PCT
Suffolk PCT
NHS Business Services Authority
NHS Institute for Innovation and Improvement
Welsh Government
National Heath Service Pension Scheme

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:

County Durham Unitary Authority
Darlington Borough Council
Gateshead Council
Hartlepool Borough Council
Middlesbrough Council
North Yorkshire County Council
Redcar and Cleveland Borough Council
Sheffield City Council
Stockton-on-Tees Borough Council
Sunderland City Metropolitan Borough Council

Note 35
Contractual capital commitments

	31 March 2011 £000	31 March 2010 £000
Property, plant and equipment	8,290	13,500
Total as at 31 March	**8,290**	**13,500**

The reduction in 2010-11 relates to payments made to Morgan Sindall for the Bankfields Court scheme and Kier for the Cross Lane Hospital scheme.

Note 36
Finance lease obligations
The trust has no finance obligations as at 31 March 2011 (31 March 2010, £nil).

Note 37.1
PFI obligations (on Statement of Financial Position)

	31 March 2011 £000	31 March 2010 £000
Gross PFI liabilities	251,100	301,630
of which liabilities are due		
not later than one year	8,513	9,255
later than one year and not than five years	34,016	40,123
later than five years	208,571	252,252
Finance charges allocated to future periods	(163,496)	(197,344)
Net PFI liabilities	**87,604**	**104,286**
not later than one year	2,049	1,976
later than one year and not later than five years	8,691	9,899
later than five years	76,864	92,411
	87,604	**104,286**

Note 37.2
On SoFP PFI commitments

	31 March 2011 Total £000	31 March 2011 Lanchester Rd PFI £000	31 March 2011 Roseberry Park PFI £000	31 March 2010 Total £000
Commitments				
Within one year	8,513	1,643	6,870	9,255
2nd to 5th years (inclusive)	34,016	6,764	27,252	40,123
Later than 5 years	208,571	39,185	169,386	252,252
Total	251,100	47,592	203,508	301,630
Present value of commitments				
Within one year	2,049	414	1,635	1,976
2nd to 5th years (inclusive)	8,691	1,854	6,837	9,899
Later than 5 years	76,864	15,120	61,744	92,411
Total	87,604	17,388	70,216	104,286

The trust has two operational PFI schemes relating to Lanchester Road Hospital and Roseberry Park Hospital.

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 38
PFI schemes off-Statement of Financial Position
The trust has no off-statement of financial position PFI schemes.

Note 39
Events after the reporting period
In 2010-11 the trust was also awarded the contract to provide mental health, learning disability and substance misuse services in Harrogate, Hambleton and Richmondshire. The service will move to TEWV from North Yorkshire and York PCT in June 2011.

Note 40.1
Financial assets by category

	Total £000	Loans and receivables £000
Trade and other receivables excluding non financial assets at 31 March 2011	2,799	2,799
Cash and cash equivalents (at bank and in hand at 31 March 2011)	31,578	31,578
Total at 31 March 2011	**34,377**	**34,377**
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**

Note 40.2
Financial liabilities by category

	Total £000	Other financial liabilities £000
Trade and other payables excluding non financial assets at 31 March 2011	14,756	14,756
Provisions under contract at 31 March 2011	1,474	1,474
Total at 31 March 2011	**16,230**	**16,230**
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**

Note 40.3
Fair values of financial assets at 31 March 2011

	Book Value £000	Fair Value £000
Non current trade and other receivables excluding non financial assets	61	61
Other	31,578	31,578
Total	**31,639**	**31,639**

Note 40.4
Fair values of financial liabilities at 31 March 2011

	Book Value £000	Fair Value £000
Provisions under contract	1,474	1,474
Other	36	36
Total	**1,510**	**1,510**

Note 41
On SoFP pension schemes
The trust does not operate an on-statement of financial position pension scheme. Refer to note 1 for details.

Note 42

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 59 cases in the twelve months to the 31 March 2011 at a value of £12,000 (2009-10, 60 cases, value £10,000).

Note 43

Third party assets and liabilities

The trust held £141,000 cash at bank and in hand at 31 March 2011(31 March 2010, £216,000) 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 £4,000 at 31 March 2011 (31 March 2010, £10,000) relating to patients monies held within the trust bank account.

The trust held £239,000 cash at bank and in hand at 31 March 2011 (31 March 2010, £186,000) 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 44

Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the NHS 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 £18,000,000, unused at 31 March 2011.

Remuneration Report

Senior manager's remuneration

Name and Title	2010-11 Salary (bands of £5000) £000	2010-11 Other Remuneration (bands of £5000) £000	2010-11 Benefits in Kind Rounded to the nearest £100	2010-11 Total Remuneration (bands of £5000) £000	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 Remuneration (bands of £5000) £000
Mr Martin Barkley, *chief executive*	145-150	0	0	145-150	145-150	0	**28,000	170-175
Mr Colin Martin, *director of finance and information*	110-115	0	*7,600	120-125	110-115	0	*7,600	120-125
Dr Nick Land, *medical director*	30-35	***155-160	*3,100	190-195	5-10	***40-45	*900	45-50
Mr David Levy, *director of human resources and organisational development*	100-105	0	0	100-105	95-100	0	0	95-100
Mrs Chris Stanbury, *director of nursing and governance*	95-100	0	*1,900	95-100	95-100	0	*2,000	100-105
Mr Chris Parsons, *director of estates and facilities management*	85-90	0	*3,200	85-90	90-95	0	*2,800	90-95
Mrs Sharon Pickering, *director of planning and performance*	90-95	0	*3,600	90-95	85-90	0	*2,200	85-90
Mr Les Morgan, *chief operating officer*	100-105	0	*5,600	105-110	95-100	0	*6,100	105-110
Mr Paul Newton, *service director – LD and forensic services*	75-80	0	*6,800	85-90	75-80	0	*8,900	85-90
Mr David Brown, *service director - MHSOP/C&YP's/Sub Misuse/NEY*	80-85	0	*4,000	80-85	80-85	0	*3,800	80-85
Mrs Lesley Crawford, *service director – adult mental health services*	80-85	0	*1,600	80-85	75-80	0	*2,500	80-85
Mrs Jo Turnbull, *chairman*	40-45	0	0	40-45	40-45	0	0	40-45
Mr Andrew Lombard, *non-executive director*	15-20	0	0	15-20	15-20	0	0	15-20
Mr Paul Briggs, *non-executive director (Apr - Jun)*	00-05	0	0	00-05	10-15	0	0	10-15
Mrs Barbara Matthews, *non- executive director (Jul - Mar)*	05-10	0	0	05-10	0	0	0	0
Mr Michael Newell, *non-executive director*	10-15	0	0	10-15	10-15	0	0	10-15
Mr John Robinson, *non-executive director*	10-15	0	0	10-15	10-15	0	0	10-15
Mr Graeme Neave, *non-executive director*	10-15	0	0	10-15	10-15	0	0	10-15
Mr Jim Tucker, *non-executive director*	10-15	0	0	10-15	10-15	0	0	10-15
Mr Douglas Taylor, *non-executive director*	15-20	0	0	15-20	15-20	0	0	15-20

Benefits in kind are the provision of lease cars (*)

2009-10 - reimbursement of actual expenses incurred through relocation (**)

Other remuneration includes the full time salary for the role as a consultant psychiatrist plus an additional two additional clinical programmed activities worked during the reported period, for which £26,000 was paid 2010-11 (£6,500, 2009-10) (***)

The directors remuneration is determined by the remuneration committee. All executive directors are on a permanent contract and have a notice period of 6 months.

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
The remuneration committee is responsible for executive directors pay.

Membership:
Mrs Jo Turnbull – Chairman
All Non-Executive Directors of the Trust Board

Signed:  Chief Executive Date: 2nd June 2011

Senior manager's pensions 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 2011 (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2011 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Mr Martin Barkley, *chief executive*	2.5-5.0	7.5-10.0	70-75	210-215	1,507	1,564	(57)	-
Mr Colin Martin, *director of finance and information*	0.0-2.5	5.0-7.5	35-40	105-110	527	579	(52)	-
Dr Nick Land, *medical director*	5.0-7.5	55.0-60.0	170-175	150-155	931	949	(18)	-
Mr Les Morgan, *chief operating officer*	0.0-2.5	7.5-10.0	40-45	140-145	789	813	(24)	-
Mrs Chris Stanbury, *director of nursing and governance*	2.5-5.0	12.5-15.0	45-50	140-145	826	832	(6)	-
Mr David Levy, *director of human resources and organisational development*	0.0-2.5	2.5-5.0	15-20	50-55	314	323	(9)	-
Mrs Sharon Pickering, *director of planning and performance*	2.5-5.0	10.0-12.5	20-25	70-75	314	314	0	-
Mr Chris Parsons, *director of estates and facilities management*	0.0-2.5	5.0-7.5	15-20	50-55	386	368	18	-
Mr Paul Newton, *service director – LD and forensic services*	0.0-2.5	0.0-2.5	35-40	115-120	673	756	(83)	-
Mrs Lesley Crawford, *service director – adult mental health services*	0.0-2.5	5.0-7.5	30-35	90-95	556	573	(17)	-
Mr David Brown, *service director - MHSOP/C&YP's/Sub Misuse/NEY*	0.0-2.5	5.0-7.5	25-30	75-80	447	454	(7)	-

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.

In the budget of 22nd July 2010 the Chancellor announced that the uprating (annual increase) of public sector pensions would change from the Retail Price Index (RPI) to the Consumer Prices Index (CPI). As a result the Government Actuaries Department undertook a review of all transfer factors. The new CETV factors have been used in our calculations and are lower than the previous factors we used therefore you will find that the value of the CETV's for some members has fallen since 31 March 2010.

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.

Appendices

Apendix 1
Summary of the actions in response to 31 clinical audits reviewed in 2010/11

1 Clinical Audit of the Family Interventions Service – Staff Training Questionnaire

Action Plan
- Agree allocated time (half day per month) for staff to receive monthly family intervention supervision and to work on skill development.
- Look at appropriate paperwork to support supervision and use a model to audit/evaluate staff skills acquisition within the service.
- Develop the service by working with a service user and carer focus group and developing a questionnaire to audit experience of families who have been involved with the service.

2 Information Sharing Audit

Action Plan
- Staff should be reminded that all patients must be given an approved Trust leaflet explaining the uses of the patient's information, and this should be documented in the patient's records.
- Consideration to be given to having an application on PARIS to capture that the patient has been given a copy of the leaflet and had it explained to them. PARIS change request initiated.
- Staff should be reminded that all patients need to give consent for their information to be used in the following ways:
  - The main use of the patient's information is to manage their care and treatment
  - The information will be used to check the quality of care they and other patients receive – anonymously
  - Information about the patient will be shared with the team if it is necessary to provide the best care for them
  - The patient has a right of access to their health records
  - Anonymous information is sent to the Department of Health

  This information should be documented in the care record.
- The audit findings are to be shared at Adult DMT and via the Directorate Governance Meetings.
- Re-audit in 2010/2011

3 Audit against the recommendations relating to the care of a particular individual service user

Action Plan
Recommendations included:-
- Teams need to ensure that FACE risk assessments are fully completed for all patients and that narrative of historical risk is included on PARIS where appropriate.
- Planning meetings should document frequency of contact with care coordinator/lead professional following discharge. The need for 7 day follow up should be highlighted, and the date and time of the 7 day follow up must be documented.
- Arrangements made in South of Tees teams around future contact and 7 day follow up visits need to be adhered to and monitored.
- A standardised protocol across South of Tees should be agreed regarding the covering of pre discharge meetings. All teams across the Trust must ensure that these meetings are covered in the event of planned or unplanned leave of the care coordinator/lead professional.

Action Plan
- Findings to be shared through Governance Meetings

4 Clinical Audit of Young Carers

Action Plan
- All young carers must be offered a carer's assessment and this must be documented on PARIS; safeguarding issues must be taken into consideration.
- Whether the carer's assessment is accepted or declined the appropriate field in PARIS must be completed.
- If a young carer accepts a care plan it must be formulated within the care records section on PARIS and a copy given to the carer.
- All young carers who decline an assessment should be offered an advice plan.
- A re audit should be undertaken in 2010/2011.

5 Clinical Audit of Standards for Drug Administration Recording (Omissions) December 2009.

Trust-wide recommendations included:-

- All nursing staff involved in administering medicines need to be made aware of the results of this audit.
- 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. Explore ways to remedy this in order to continually improve the standards of recording and ultimately patient care.

Action Plan
- To support further improvements in practice by adopting Trust-wide recommendations.

6 Clinical Audit of NICE Clinical Guideline 22 – Anxiety: Management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care

Action Plan
- 100% of patients to be involved in decision making in all phases of their care.
- 100% of patients/carers/family to be given information on the nature of their condition and the likely course of their condition. This to be documented in the PARIS/IAPTUS record.
- Patient preferences must have been taken into account when deciding on interventions and evidenced within the care record.
- Within the patient's care records there must be evidence that patient recorded outcomes (PROMS) are being monitored using short, self-complete questionnaires.
- Following the completion of the RPIW re: access to psychological therapies within both primary and secondary care, review current practice to ensure greater and speedier access to therapies.
- 100% of patients to be given information on the nature of the use of medication and side-effect profile. This to be documented in the PARIS/IAPTUS record.

7 Clinical Audit to Identify Level of Compliance with FACE Risk Assessments in Adult Mental Health Services

Action Plan
- All Service users must have a FACE Risk Assessment completed by the care coordinator/lead professional.
- Team Managers must routinely run CRS reports for their areas of responsibility and ensure compliance with the standard that all service users will have an up-to-date FACE Risk Assessment.
- Team managers to ensure that those clients not currently in service have their PARIS referral closed to their team
- The Information Department to re-run the report taking into account the issues highlighted in the audit findings
- The findings of the report to be discussed with the Performance Team

8 Clinical Audit of NICE CG25 – Violence

Action Plan
- Service users' care plans/intervention plans will have documented evidence that they have been involved in identifying preferred strategies in the event of a disturbed/violent incident.
- Modern Matrons/Ward Managers ensure 100% of service users have a comprehensive FACE Risk Assessment completed on admission.
- Assurance Team to speak to ward manager to gain assurance that information is being given to clients on admission.
- Aide Memoire to be developed to remind staff of what they should be documenting in PARIS notes with respect to NICE best practice
- Re-audit of Elm Ward PARIS entries on admission
- Identification within the PARIS record must include a record of named nurse allocation and reason for admission.

9 CPA/ Formulation Documentation for Patients Admitted to Inpatient Adult Units

Action plan
- Ensure standard work is operated by all disciplines.
- All registered nurses receive professional supervision relating to their standard work
- All registered nursing staff to receive teaching sessions on formulation (5 P's and SVM)
- All medics to receive professional supervision relating to their standard work on induction during the initial supervision with Consultant Psychiatrist. Standard work to be reiterated via ward managers during induction. Induction package provided
- Change the form to ensure the headings/prompts run vertically and incorporate standard work to ensure a universal approach and identify any omissions in standard work at a glance
- Completed CPA/Formulation documentation to be put on PARIS by administration staff
- Community staff/care coordinators to re visit Standard work Regarding "Formulation Meetings" (Chairing the process)
- Observe practice and re-audit

10 Health, Safety and Security Workbook Self Assessment Returns

Trust-wide action plan.
- Health and Safety Team to remind responsible person that the self audit must be returned to the department within 7 days
- Monitoring of self audits returned for completion of action plans
- Reporting on monthly basis to General Managers for information and action
- Provide further sessions for teams who have not yet received the workbook
- Team Managers to ensure a workbook is available for their team

11 Clinical Audit of NICE Clinical Guideline 31 – Obsessive-Compulsive Disorder: Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder

Action Plan
- Information about disorder, treatments and current guidance should be offered to all patients and carers (where appropriate). Staff should check understanding and then record that information has been given and understood on PARIS.
- Identify a member of each team considered to have specialist skills at secondary care level to treat moderate to severe OCD/BDD to whom referrals can be made. Adult directorate clinical governance and risk meeting to confirm how to integrate this with reforming community teams process.
- Use of IAPT Low Intensity and High Intensity must be made appropriately so that secondary teams are not taking on Low Intensity work unless there are particular issues within the case, e.g. risk factors, multiple diagnosis, that warrant secondary care interventions. Remind teams of importance - send out via CG&R meeting.
- The audit results and action plan should be issued to all teams within the adult directorate following agreement of actions by the Directorate Governance and Risk meeting.
- Re-audit 2011.

12 Clinical Audit of NICE CG38 Bipolar Disorder: The management of bipolar disorder in adults, children and adolescents, in primary and secondary care.

Action Plan
- All female patients of child-bearing potential where no effective alternative to valproate has been identified should receive an explanation regarding the need for adequate contraception and the risks of taking valproate during pregnancy.
- All clients must have an annual health check which is documented fully in the care records.
- Take these actions to the Risk meeting to decide on best action and remind teams of importance.
- Serum levels must be monitored in accordance with NICE guidance following initiation of lithium. Achieved by lithium RPIW.
- The audit results and action plan to be agreed by Adult Clinical Governance and Risk Meeting with subsequent issue/ briefing of all teams within the adult directorate.

13 Person Centred Pathway of Care for Electro Convulsive Therapy (ECT)

Action Plan -
- ECT staff to continue to monitor any variances from the pathway and ensure these continue to be documented and communicated to the consultant in charge.
- Report to be disseminated to relevant staff via DMT to the Directorate Governance Meetings.

14 Service-wide Baseline Audit on Client's Non-Prescribed Drug Use

Action Plan
- All service users entering EIP services should be routinely assessed for past and present drug use in order to inform clinical care and possible treatment options.
- Findings to be disseminated to service manager and locality team managers for discussion.

15 Clinical Audit of Deliberate Self Harm (DSH) Training Needs

Action Plan
- Establish working group to be tasked with implementing recommendations by reviewing audit findings and improving training and support; designing and rolling out a training process for CAMHS staff who are expected to carry out self harm assessments throughout the CAMHS teams. The working group should also be tasked with the design of an academic course for all CAMHS staff that should be mandatory.
- Each CAMHS team should ensure that appropriate supervision is made available to all staff that carry out self harm assessments.
- Re-audit 2011/12 in order to ensure that the recommendations have been implemented. It is noted that the audit instrument requires some re-design.
- The working group should review the deliberate self harm protocol to ensure that it is suitable for purpose and up to date.

16 Clinical Audit of Suicide Prevention

Action Plan
- Staff will record documented evidence of the information and guidance families and carers have received in how to assist the patient in engaging in their treatment plan in patient records.
- Staff will record that patients have given consent to contact with relatives and carers in the patient's records. This will also include when permission has been withheld.
- Consideration given to 48 hour follow up following discharge of patients at risk of Suicide or self harm.
- Staff will document that leaflets, cards and information for families and carers informing them of contact numbers to access services has been provided.
- Direction and Leadership in dealing with relatives /carers and sharing the content of completed reports where appropriate using Being Open Principles.

17 Trainee Doctor Audit: Monitoring Following Drug Treatment for ADHD

Action Plan
- A form containing key points for elicitation of appropriate medical history including family cardiac history may be used.
- Centile charts and growth charts must be part of all case notes and must be filled in for all patients.
- Physical examination forms must be completed. To have forms in the PARIS system for medical, family history and physical examination.
- Re-audit. By May 2011.

18 Clinical Audit of NICE CG43: Obesity

Action Plan
- The results of this audit should be shared with all staff in Forensic Services.
- Staff should be reminded of the importance of assessing Body Mass Index (BMI) on admission and recording this on the physical examination form.
- All service users should have a current intervention plan, and should have their BMI monitored regularly in line with this.
- Clinical assessment of the service user must include an assessment of the presence or risk of diabetes, hypertension, cardiovascular disease and osteoarthritis.
- Staff should continue to offer the wide range of interventions regarding obesity to service users.
- Staff should be offered training in weight management/nutrition to at least a level 1.
- Staff should be trained in motivational interviewing and the process of change.
- A re-audit should be conducted in January 2011 to continue to monitor compliance with Trust policy 'Weight Management in Inpatient Units, Part 1, Obesity'.
- All patients should be referred to the fitness suite for body analysis and physical development plans.
- Service users should continue to have access to healthy food, e.g. fresh fruit, at any time.
- All wards should adopt the flexible breakfast scheme proposed by the Physical Wellbeing Forum.

19 Clinical Audit of NICE Clinical Guideline 31 – Obsessive-Compulsive Disorder (OCD) : Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder (BDD)

Action Plan
- Teams need to ensure the patient's needs and preferences have been taken into account when deciding on the individual's care, and ensure evidence of this process is documented within the patient's notes.
- Teams need to ensure that all patients with a diagnosis of OCD/BDD are provided with information of the disorder in an appropriate, accessible format (consistent with the patient's needs), and ensure evidence of this process is documented in the patient's notes.
- Teams need to ensure that where carers and/or family are involved with a patient's care, and the patient has given consent, carers and/or family have been provided with information of the disorder, and evidence of this process is documented within the patient's notes.
- Teams need to ensure that where the patient's care is shared between primary and secondary care, there is a clear written agreement between healthcare professionals identifying responsibility for monitoring and treatment.
- Teams need to ensure that they refer patients with OCD/BDD to a team or individual with the relevant expertise, and that they are offered the appropriate, evidence based interventions in accordance with NICE Guideline 31: Core interventions in the treatment of OCD and BDD.

20 Clinical Audit of Obesity

Action Plan
- The results of this audit should be shared with all staff in Forensic Services.
- Staff should continue to offer the wide range of interventions regarding obesity to service users.
- A re-audit should be conducted in September 2011 to continue to monitor compliance with Trust policy 'Weight Management in Inpatient Units, Part 1, Obesity'.
- Service users should continue to have access to healthy food, e.g. fresh fruit, at any time.
- Review of menus and food provision.
- All staff should be offered training in nutrition and weight management.
- All staff should be trained in nutritional screening.

21 Clinical Audit of Side Effects of Antidepressants

Action Plan
- To provide reminder for monitoring side effects in Out Patient Discharges.
- Change Outpatient Patient Discharge letter format to include section on capacity.

22 Clinical Audit of NICE CG25 – Violence

Action Plan
- Post incident review following disturbed/Violent incident to be performed within 72 hours of the incident.
- Document within the Patient's PARIS record that the review includes:
  - account of the incident techniques attempted prior to physical intervention.
  - trigger factors.
  - Individual staff member's role within the incident.
- Staff involved within the incident to be provided with the opportunity to discuss their feelings with regard to the incident.
- Review process will be specific to individual clinical areas needs (supervision, group discussion, utilise allied healthcare professionals).
- To ensure that following the incident that the review includes service user's feelings during and after the incident and this is recorded within the Patient's PARIS record.
- Following an incident review care plan to be reviewed and intervention plan.
- Service user's care plans/Intervention plans will have documented evidence that they have been involved in identifying preferred strategies in the event of a disturbed/violent incident.
- Patient Risk Assessment that has identified factors associated with violent behaviour ensure that the following risk assessments have been completed.
  - General risk assessment
  - Management of violence and aggression risk assessment
  - Suicide prevention risk assessment
  - Environmental risk assessment

23 Clinical Audit of Delays in Discharging Patients in MHSOP

Action Plan
- The Directorate identified that there was good practice in Stockton from last year's audit. Agreed to provide a process map of current processes for information.
- The Directorate to discuss at Trust level the feasibility of a timescale or number of family choices with regard to delayed discharges.
- The Directorate to continue to monitor the reason for delayed discharges at local Governance Groups.
- The results to be discussed at Locality Governance Groups and Mental Health Services for Older People Directorate Management Team meetings.
- The audit should be repeated in 2011 - the re-audit should take account of all delayed discharges within the given financial year.

24 Clinical Audit of NICE Clinical Guideline 50 Acutely Ill Patients in Hospital, Physiological Observations Including MHSOP in North East Yorkshire.

Action Plan
- Mandatory training carried out for Early Warning Score (EWS) for all staff in MHSOP.
- Identify EWS champion on each ward whose responsibility it will be to maintain skill level of staff in use of EWS and physiological check skills and also to complete reaudits.
- Band 6 and 7 nurses to ensure the admission and annual standards flow charts are adhered to.
- Yearly reaudit of completion of early warning score charts, monitoring of admission practices and monitoring of training records that will be presented at Quality Assurance Group (QAG).
- Carry out unannounced visits to wards to assess staff skills in taking of physiological observations and the use of the EWS chart.

25 Clinical Audit of NICE CG 38 -The Management of Bipolar Disorder in Adults, Children and Adolescents, in Primary and Secondary Care.

Action Plan
- All patients will have an annual physical review and this must be documented in PARIS.
- Ensure that all patients were encouraged to make an advanced decision and this will be recorded within the PARIS care record.
- Changes to be made to the audit tool to take into account the Lithium shared care guideline recommendations.
- The results of this audit be shared with the medical staff and discussed within the MHSOP Governance Forums for action.
- It is the responsibility of the prescribing doctor to ensure Lithium bloods are taken and results available to all those professionals involved in the patient's care. If the prescribing Doctor is the GP the care coordinator/Lead professional must liaise with the surgery to obtain the most updated blood result and act upon any abnormal result.

26 Clinical Audit of Recording of Falls and Found on Floor on PARIS

Action Plan
- The falls documentation on PARIS must be fully completed and following the falls assessment being completed staff must revisit the documentation to complete it.
- An incident form must be completed following a fall or found on floor and sent to the Datix (Incident) team. The information contained within the incident form must be summarised in PARIS as per record keeping standards indicating also the incident number.
- In 100% of falls or found on floor the level of injury sustained must be documented. If no injury this must be stated. The area must not be left blank.
- Following a fall or found on floor a falls assessment must be requested and documented on PARIS within 24 hours of the incident.
- A re-audit be carried out in November 2011 following the release of the Falls Pathway.
- The findings of this report to be circulated to the MHSOP Clinical Governance Meeting (QAG) and discussed at team meetings to improve practice.

27 Clinical Audit of Obesity NICE CG43 - MHSOP

Action Plan
- All service users admitted to in-service user wards must have their BMI recorded on the Early Warning Score form. If the service user refuses this must be documented on the form and the results placed in PARIS.
- All service users admitted to in-patient wards must have their waist circumference recorded on Early Warning Score form. If the service user refuses this must be documented on the form and the results documented in PARIS.
- All service users identified as being overweight or obese must have an individualised intervention plan which will include providing the service user with information leaflets on healthy lifestyle/eating.
- All inpatient service users and carers should have access to information leaflets re healthy lifestyle/eating.

28 Clinical Audit of NICE Clinical Guideline 21 - Falls: the assessment and prevention of falls in older people

Action Plan
- Re-audit in 6 months time, a small audit of 4 wards.
- All patients will be asked if they have fallen in the last 12 months.
- All patients should have a multi-factorial falls assessment if they have been assessed as a falls risk and/or have fallen.
- Patients who have had multiple falls should have an MDT review.
- All patients who have fallen or are at risk of falling should have an intervention plan.
- Service Users/Carers should receive verbal and written falls prevention and management information following initial assessment.

29 Clinical Audit of NICE CG25 - Violence

Action Plan
- Ward Managers should ensure that risk assessments are completed for all patients on admission/transfer to their ward.
- Ward Managers should ensure that intervention plans reflect risks identified in the risk assessment.
- MHSOP Teams should be reminded that when physical intervention is used, a post-incident review must take place within 72 hours.
- Where ward information packs are given to patients or their carers, this should be recorded in the patient's record.
- The audit tool should be revised and improved to better reflect MHSOP patients and services.

30 Audit of NICE CG78 Borderline Personality Disorder: treatment and management – Team Manager's Questionnaire

Action Plan
- Develop clear and concise referral pathways between Adult Mental Health and Substance Misuse Directorates.
- Staff within Substance Misuse to be distributed with the screening tools required to suggest diagnosis of Personality Disorder.
- All staff within Substance Misuse to be given the opportunity to access training appropriate to role in relation to identifying and managing treatment for clients presenting with Personality Disorder.
- Open day with CMHT (service provision awareness for Personality Disorder).
- Group supervision given to Substance Misuse Teams facilitated by Psychotherapist.

31 Clinical Audit of Client Suspension from Treatment

Action Plan:-
- All substance misuse centres to be aware of the policies and responsibilities in relation to suspension of clients from treatment.
- All substance misuse centres to continue to monitor numbers of clients who are suspended from treatment, and to liaise with the Trust's security consultant where appropriate.
- Where clients are suspended from treatment for breach of equality and diversity legislation, the equality and diversity team should be informed of the situation, and the Trust's security consultant contacted for advice.

Apendix 2
Feedback from our stakeholders

Ref:-2010 – 2011 Quality Accounts for Tees Esk and Wear Valley Foundation Trust

Thank you for the opportunity to comment on the Tees Esk and Wear Valley Quality Accounts 2010 – 2011.

Darlington LINk feels that the Quality Accounts seem accurate and representative of the quality of service provided by Tees Esk and Wear Valley Foundation Trust from the information available and it has given us comprehensive details of the services delivered over the year.

LINk members did however find that there was some acronyms used within the document which can be found to be confusing. They were impressed with the general listening culture which appears to be developing and the desire to action problems when they are identified.

Darlington LINk would welcome the opportunity to continue to be involved in the development of the quality agenda and priorities in future years. They have been happy with the involvement of the trust with the LINk volunteers over the past year and each stakeholder event has been well attended and informative. All information given and shared has been adopted by the trust and we can only see what is already a very positive organisation going from strength to strength.

We hope the you will find the comments helpful. We look forward to working with you in the future.

Regards Diane

Diane Lax
LINk Team Leader Darlington

Tees, Esk and Wear Valleys - Quality Account 2010 – 2011

Response from Middlesbrough

Middlesbrough LINk have been involved in the early preparation of the Quality Accounts for TEWV NHS Foundation Trust, including the Quality Account workshop held on12th November 2010. This event was attended by a number of LINk members from within the TEWV area.

At this members identified six points for inclusion in the Quality Account, all these points have been addressed in the draft report.

The following comments have been discussed within the Middlesbrough LINk Mental Health working group and are as follows:

- We thought this was very useful, but the “Jargon” needs to be simplified and deleted as appropriate with the glossary notes giving clearer explanations for certain points.
- Overall, the group thought that the report in general, was well written. Most points were covered.
- The group is pleased with Crisis Services and are included in the priority for 2011/12 papers.
- The group thought that more work could be done to keep it better understanding and easier to read in future reports.
- The LINks recognised the excellent care given by TEWV that many have experienced and feel that this is reflected in the Quality Accounts.

The LINks did not identify any significant omissions of concern.

25th May 2011
Middlesbrough LINk

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26th May 2011

Martin Barkley
Chief Executive
Tees, Esk and Wear Valley NHS Foundation Trust
West Park Hospital
Edward Pease Way
Darlington
DL2 2TS

Dear Martin

Re: 2010/2011 Quality Accounts

Thank you for the opportunity to comment on the Tees, Esk and Wear Valley Foundation Trust's Quality Accounts for 2010/11.

We acknowledge the difficulties that the Trust has, caused by its wide, and diverse geographical area, in producing a consistent approach to treatment, quality control, communication and patient involvement, among a wide variety of Trust facilities and believe that the report shows that it is working hard to provide such a consistent approach, although it has a long way to go before achieving these aims.

The priorities that have been identified are valid and the Trust has shown that it is prepared to acknowledge the strengths and weaknesses in its achievements.

The preparedness to publish the account is to be commended as it sets out in detail comparable figures which enable stakeholders and others to contribute to the debate about improvement.

We would further like to add that the early opportunity to be involved with the account was much appreciated and that the events held in September 2010 and February 2011 were most valuable but that further work could be done to make the process more effective and inclusive,
and the LINk would be happy to work with the Trust to do this in the future.

One further comment that has been raised is the lack of reference in the report to the 'community' aspect of the Trust's work, which is extensive and perhaps the Trust may wish to consider including this in future reports.

We hope the Trust have found these comments helpful and look forward to working with you in the future.

Yours sincerely

Peter Irving
Chair
County Durham LINk

Stockton-On-Tees Local Involvement Network

Stockton-on-Tees LINk response to
Tees, Esk and Wear Valleys (TEWV)
NHS Foundation Trust Quality Account 2011

2010/11 Priorities

Stockton-on-Tees LINk was disappointed to see that not all targets had been met though reassured by the corrective action taken and that where targets haven't been met, they will continue to be an ongoing priority into 2011/12.

The LINk was encouraged to see improvements in service user involvement, including the innovative use of Dr Foster handheld devices and reacting to feedback in a swift manner. The LINk agree that it is appropriate to carry this forward into 2011/12. Indeed, improving effective service user involvement should be considered as a priority every year.

2011/12 Priorities

The LINk are pleased that progress has been made in transfers of care (as priority 2010/11). However, when planning is made for continuing improvement, some LINk members would like to emphasise the importance of having robust community teams and specialist services working together and developing an understanding of each others roles to improve the patient experience. LINk members specified this as a particular importance where lack of appropriate community support may prolong an inpatient stay unnecessarily.

When considering continuing improvements in effective service user feedback through 2011/12, Stockton-on-Tees would encourage TEWV to consider how they can include feedback from service users who may face communication barriers, whether this is due to language, sensory impairment or a learning disability. The LINk would expect that the 50% target for service user feedback would include a diverse and representative cross section of its service users.

The inclusion of improvements to the crisis team is also encouraging, considering ongoing multi-LINk concerns relating to this service. The LINk looks forward to feeding in relevant information which will assist in service improvements.

Other points

Although an informative set of quality accounts it is not a document that is accessible or easy to read for many people, Stockton-on-Tees LINk would hope to see a good executive summary and easy read version to ensure all service users have an opportunity to consider and comment on the TEWV quality accounts.

Stockton-on-Tees LINk found the density and volume of the document to be a barrier in disseminating the draft quality account to appropriate LINk participants and those who have experience of using TEWV services.

Finally, Stockton-on-Tees LINk members were encouraged to be invited to events to assist in the drawing together of the quality account and recent positive practice events but would hope that the relationship between TEWV and LINk members continues to develop during 2011/12 through regular progress reports on how TEWV are progressing towards its priority targets.

Quality Accounts – Tees, Esk and Wear Valleys NHS Foundation Trust

Members of the Health and Well Being Scrutiny Committee wish to offer it's thanks to the Trust for the opportunity to comment on the process of Quality Accounts. However, due to the restrictive time constraints on the Trust in publishing the draft Quality Accounts in April 2011 and the Local Elections Members input is fairly limited.

As Members of this Committee have been involved in the process, they wish to express the following comments at this stage of the Quality Accounts process:-

A Group of Members of the Health and Well Being Scrutiny Committee were tasked with scrutinising in detail the process of deciding on the quality priorities. Members have attended stakeholder events and met with Senior Directors from the Trust.

The Health and 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 note that the Trust has received full registration with the Care Quality Commission

Members are only able to express comment on performance as at Quarter three against last year's priorities, performance against quality metrics and performance against national targets and regulatory requirements. From the evidence presented by Senior Directors, Members are pleased with the performance against the Quality Priorities for 2010/11 and can see an improvement in all priority areas and are encouraged that the final Quarter performance data will to continue to improve. They welcome the inclusion of real life examples of how minor adjustments can advance performance, which enables a greater understanding to be gained.

Members welcome the involvement of stakeholders in the process of Quality Accounts, allowing them to influence the Trusts choice of Quality Priorities. Members' from this Committee have attended Stakeholder events and feel fully engaged with the process

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Your ref:
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Sharon Pickering
Director of Planning & Performance
Tees, Esk and Wear Valleys NHS Foundation Trust
Lanchester Road Hospital
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3 May 2011

Dear Sharon,

Tees Esk and Wear Valleys NHS Foundation Trust Quality Account for 2010/11 and priorities for improvement for 2011-2012

Members of the Council's Adults, Wellbeing and Health Overview and Scrutiny Committee have given consideration to the Trust's Draft Quality Accounts.

The Committee welcome the opportunity to provide comment and attached is a response to the Trust's Draft Quality Accounts.

As Chairman of the Committee, I would like thank yourself and colleagues from the Trust for engaging with members of the Committee to develop this year's Quality Accounts report.

Yours sincerely

Councillor Robin Todd
Chairman of Adults, Wellbeing and Health Overview and Scrutiny Committee

Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee

Comments on the Tees, Esk and Wear Valleys NHS Foundation Trust Quality Account for 2010/11 and priorities for improvement for 2011-2012

The Committee welcomes Tees, Esk and Wear Valleys NHS Foundation Trust's Quality Accounts and the opportunity to provide comment on it. This is the second year the Committee has provided comment and acknowledge progress by the Trust towards delivery of their priority areas for 2010/11. Within last year's response, Members commented on the timeliness of information and need for earlier engagement to identify forthcoming priorities. It is pleasing to report that Trust has engaged with the Committee to provide comment and shape priorities within this year's plan.

Durham County Council's Adults Wellbeing and Health OSC Chair and lead Scrutiny officer have attended both stakeholder workshops in September 2010 and February 2011. To this end we welcome the early opportunity to examine key issues identified during 2010/11 and also consideration of draft priorities for 2011/12.

On a more practical note, the County Council's Adults Wellbeing and Health Overview and Scrutiny Committee have engaged in several consultation exercises regarding changes to Mental Health Services in North Easington, South Durham and Darlington and Heathway, Seaham. Consistent messages arsing from these consultations have been the need for full and robust consultation with Service Users and Carers in respect of potential service changes. Furthermore, the issue of transport solutions where service users have to receive services from a different location needs to be considered before such changes are implemented and, again with full consultation with Service users and their carers/families.

To conclude, the Committee agree that from the information received from the Trust, the identified priorities for 2011/12 are a fair reflection of healthcare services provided by the Trust and note the progress made against the 2010/11 priorities. In addition, the Committee request to receive a six monthly progress report on delivery of 2011/12 targets.

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18 May 2011

Sharon Pickering
Director of Planning and Performance
Central Resources
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Dear Sharon

Tees, Esk and Wear Valleys NHS Foundation Trust Quality Accounts 2010/2010

Many thanks for forwarding me a draft copy of your quality account for 2010/2011. NHS County Durham & Darlington (NHSCDD) welcomes the opportunity to comment on the document. NHSCDD felt this report was a very honest and fair reflection of the trusts performance in relation to quality for 2010/2011.

I'm pleased to see that the process of producing the Quality Account has included wider stakeholder and governor input. The stakeholder events were informative and added richness to the trusts account of the quality of services delivered.

The Quality Account clearly reflects the extensive processes Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) has in place to ensure continued improvements in the key quality areas of patient safety, effectiveness and experience.

NHSCDD acknowledges the vast amount of work undertaken and achievement in the priorities set for 2010/2011. It is also noted the action to be taken where achievement of the targets has not been reached.

NHSCDD agree with the priorities for the coming year and the rationale for their choice. NHSCDD also believe they are achievable, and will work with the Trust to deliver these priorities. The plans for implementation and delivery will be monitored through the existing reporting mechanisms in place, and commissioner visits.

Passionate about health

Lady Ann Calman, Chair
Yasmin Chaudhry, Chief Executive

Commissioning for the health of the people of County Durham and Darlington

The coming year will hold many challenges not least which is delivering high quality, safe, and effective services during a time of economic uncertainty, major organizational challenges with the transfer of mental health services in North Yorkshire into the Trust as well as the wider NHS reforms. NHSCDD will continue to work collaboratively with TEWV to ensure that quality remains at the heart of everything we do in the NHS County Durham and Darlington.

I hope you find these comments helpful and contribute to your quality account and we look forward to working with you in the coming year.

Kind Regards

Debbie Edwards
Nurse Advisor/ Clinical Quality Lead

NHS Teesside

NHS Tees is the collaborative commissioner of NHS services across Teesside and consists of NHS Hartlepool, NHS Stockton on Tees, NHS Middlesbrough and NHS Redcar and Cleveland. NHS Tees welcomes the opportunity to comment on the Annual Quality Account for Tees, Esk and Wear Valley NHS Foundation Trust. NHS Tees can confirm that to the best of its ability, the information provided within the Annual Quality Account is an accurate and fair reflection of the Trust's performance for 2010/11.

Staff from NHS Tees were delighted to attend the stakeholder event and contribute towards the Quality Priorities for 2011/12. It is appropriate for NHS Tees to acknowledge the comments made by Sir John Oldham, National Director of Quality and Productivity at the Department of Health following a visit to the Trust.

NHS Tees continues to work closely with relevant key staff groups within Tees, Esk and Wear Valley NHS Foundation Trust in ensuring that the commissioning and provision of safe clinical care for the patients of Teesside remains a key priority. The hard work and dedication of staff across the Trust is tangible in continuing to maintain and promote the Trusts vision to provide high quality care and maintain a strong patient safety culture.

NHS Tees look forward to continuing to work in partnership with Tees, Esk and Wear Valley NHS Foundation Trust during 2011/12 to further improve the quality of services that the Trust provides for the people of Teesside.

Kind regards

Bev Reilly
Associate Director/Board Nurse
Quality Improvement, Patient Safety and Safeguarding

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17th May 2011

TEWV QUALITY ACCOUNTS 2010/11

Thank you for sharing with us the Tees, Esk and Wear Valleys NHS Foundation Trust Draft Quality Account 2010/11.

The Quality Account 2010/11 is a comprehensive report which provides a true and honest reflection of the quality of healthcare services provided to the residents of NHS North Yorkshire and York. We are very pleased with the excellent stakeholder engagement process that has been undertaken in both developing this report and in identifying future priorities.

It is clear that there have been a number of initiatives commenced in 2010/11 that are having very positive effects on the quality of patient care experienced by our patients, the use of kaizen principles within the TEWV Quality Improvement System being an examplar to the rest of the NHS.

That said there are still areas of performance that need to be improved to promote and improve the quality of care provided and we look forward to continuing to work positively and collaboratively with you in achieving a high standard of care for all the North Yorkshire patients who utilise your services.

Yours sincerely

Bill Redlin
Director of Standards

Apendix 3
Glossary

5 P's: a psychological approach to make sense of people's problems using the following criteria: presenting problems, precipitating factors, perpetuating factors, predisposing factors, protective factors.

Attention Deficit Hyperactivity Disorder (ADHD): one of the most common childhood disorders and can continue through adolescence and adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behavior, and hyperactivity (over-activity).

Affective Disorders: are mental disorders reflected in disturbances of mood. They may be regarded as lying along the affective spectrum a grouping of related psychiatric and medical disorders which may accompany bipolar, unipolar, and schizoaffective disorders at statistically higher rates than would normally be expected.

Agoraphobia: is an anxiety disorder defined as a fear of wide open spaces, crowds, or uncontrolled social conditions.

Body Dysmorphic Disorders: disorders where person is excessively concerned about and preoccupied by a perceived defect in his or her physical features (body image).

Bi-Polar Disorder: also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks.

Annual 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.

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) & Audit: describes the approach used in specialist mental health care to assess plan review and co-ordinate the range of treatment care and support needs for people in contact with secondary mental health services who have complex characteristics. It is a called "an approach" rather than just a system because the way that these elements are carried out is as important as the actual tasks themselves. The approach is routinely audited.

Care Quality Commission (CQC) (formerly the Health Care Commission and Mental Health Act Commission): the independent regulator of health and social care in England who regulate the quality of care provided in hospitals, care homes and people's own homes by the NHS, local authorities, private companies and voluntary organisations, including protecting the interests of people whose rights are restricted under the Mental Health Act.

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.

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.

DATIX: the Trust's computerised system for collating and reporting incidents and 'near misses' with an adverse affect on patient care and staff.

Dr Foster's Patient Experience Tracker: a system devised by the independent company Dr Fosters for enabling real-time recording by patients of the experience of care using a hand-held computerised tool.

Dual Diagnosis: a diagnosis referring to a person with both mental health needs complicated by an alcohol or drug problem.

Early Warning Score (EWS): a standardised system to highlight physical changes in older age patients to facilitate early intervention and prevention.

E-learning Programme: a means by which staff can complete specific training modules using web-based or cd-rom computer programmes that both educate and test competence.

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.

Falling Stars Initiative: standardised system to alert a risk of falling within older age patients to facilitate early intervention and prevention.

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 Care Associated Infections (HCAIs): treatment-resistant infection contracted as a consequence of being in contact with healthcare services, predominantly MRSA and c-difficile.

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.

Improving Access to Psychological Therapies (IAPT): the national programme for improving access to psychological therapies which led to the Trust as a lead / joint provider of IAPT services in County Durham, Darlington and Teesside. IAPTUS is the electronic record and reporting system that supports the IAPT Programme

Information Governance Toolkit & Assessment Report: is a national approach that provides a framework and assessment for assuring information quality against national definitions for all information that is entered onto computerised systems whether centrally or locally maintained.

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.

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.

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.

Monitor: the independent economic regulator for NHS Foundation Trusts.

National Audit of Psychological Therapies (NAPT): funded by the Healthcare Quality Improvement Partnership (HQIP) and is an initiative of the College Centre for Quality Improvement (CCQI). Aims to promote access, appropriateness, acceptability and positive outcomes of treatment for those suffering from depression and anxiety.

National Audit of Schizophrenia (NAS): an initiative of the Royal College of Psychiatrist's Centre for Quality Improvement (CCQI). Aims to support clinicians who treat people with schizophrenia in the community to assess the quality of their prescribing of antipsychotic drugs and monitoring of service users' physical health, and monitor service users' experience of treatment and its outcome plus carers' satisfaction with information and support.

National Confidential Inquiries (NCI) and National Clinical Audit: research projects funded largely by the National Patient Safety Agency (NPSA) that examine all incidents of, for example suicide and homicide by People with Mental Illness, with the aim is to improve mental health services and to help reduce the risk of these tragedies happening again in the future. Supported b y a national programme of audit.

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.

National Research Passport Scheme: a scheme to streamline procedures associated with issuing honorary research contracts or letters of access to researchers who have no contractual arrangements with NHS organisations who host research, and who carry out research in the NHS that affects patient care, or requires access to NHS facilities.

National Study of Randomised Injected Opiate Treatment Trial (RIOTT): a multi-site, 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.

National Strategic Executive Information System (STEIS): a new Department of Health system for collecting weekly management information from the NHS.

Overview & Scrutiny Committees (OSCs): statutory committees of the Local Authority provided to scrutinise the development and progress of strategic and operational plans of multiple agencies within the Local Authority area. One such OSC is for Health & Wellbeing.

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 Services 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 Reported Outcome Measures (PROMs): a rating undertaken by the patient on the effectiveness of their care and wellbeing.

Patient Experience Reflection Tool: a standardised tool used to help reflect on and assess the patient's experience of an incident of violence and aggression.

Patient Safety Walkrounds: a trade-marked technique for improving quality within the overall TEWV Quality Improvement System (QIS).

Payment by Results (PBR): 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.

Practice Based Commissioning (PBC): the precursor to GP Commissioning Consortia envisaged by the White Paper – Liberating the NHS for the transfer of 80% of the commissioning of local health services to GPs.

Productive Mental Health 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.

Quality & Assurance Committee (QuAC): sub-committee of the Trust Board responsible for quality and assurance.

Rapid Process Improvement Workshop (RPIW): a technique for improving quality within the overall TEWV Quality Improvement System (QIS).

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.

Serious Untoward Incidents (SUIs): defined as an incident that occurred in relation to NHS-funded services and care, to ether patient, staff or member of the public, resulting in one of the following: unexpected / avoidable death, serious / prolonged / permanent harm, abuse, threat to the continuation of the deliver of services, absconding from secure care.

Service Performance Dashboards: reports produced on a monthly basis for each Clinical Directorate setting out performance against measures and targets agreed by the Service and in support of the Trust's key performance targets.

TEWV Quality Improvement System (QIS): the Trust's framework and approach to continuous quality improvement based on Kaizen / Toyota principles.

Trust's Risk Register: a register of risks identified at a Trust level that have a probability and consequence associated with a high level of risk. The Trust risk register and mitigating actions are monitored routinely.

Visual Control Boards: a technique for improving quality within the overall TEWV Quality Improvement System (QIS).

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